

2024 QIPH Work Plan



SECTION 1: QUALITY PROGRAM STRUCTURE

ANNUAL EVALUATION (ANDREA SWAN)								
Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Annual Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. To develop a comprehensive evaluation of all Quality Improvement activities for 2024.	1. Ensure all required sections of the workplan meet DHCS, and NCQA requirements.	1/1/2024	Andrea Swan, Quality Improvement & Population Health Director	1 <sup>st</sup> update- On track to meet all quarterly updates to QIHEC with appropriate approvals, and no barriers noted. Workplan structure with initial goals was approved by QIHEC 2/2024.  2 <sup>nd</sup> update	1: No identified issues or barriers.	1. Continue with action plan.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	N/A
2.	2. Present for approval Quality Improvement workplan which contains all required sections for the evaluation.	3/31/2024 – 3/31/2024	Andrea Swan, Quality Improvement & Population Health Director				<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.	3. Ensure all quarterly updates are reviewed and approved by QIHEC.	3/31/24,6/30/2024,9/30/2024,12/31/2024	Andrea Swan, Quality Improvement & Population Health Director		2:	2:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	4.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
PROGRAM DESCRIPTION (ANDREA SWAN)								
Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Annual Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Finalize 2024 Program Description for presentation to QIHEC	1. Ensure all required sections of the workplan meet DHCS, and NCQA requirements.	1/31/2024-2/15/2024	Andrea Swan, Quality Improvement & Population Health Director	1 <sup>st</sup> update: Program description was finalized 5/15/2024. but has not been presented to QIHEW as it is currently being reviewed by NCQA team to ensure all elements have been met.	1: Program description completed in prior year were not sufficient to meet new DHCS and NCQA standards. Program description has been reviewed to meet all regulatory requirements.	1 Present finalized program description to QIHEW by the end of June 2024.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	N/A
2. Presentation of the Program Description to both the QIHEW, and QIHEC for approval by 3/31/2024	2. Submission of Program Description to QIHEW staff	2/1/2024-2/15/2024	Andrea Swan, Quality Improvement & Population Health Director				<input type="checkbox"/> Yes <input type="checkbox"/> No	

3.	Develop a comprehensive 2025 Quality improvement Program Description that outlines all required DHCS, and NCQA requirements.	3.	Review all DHCS, and NCQA requirements to ensure all sections included are relevant and share the template with business owners to begin writing.	9/30/2024-12/31/2024	Andrea Swan, Quality Improvement & Population Health Director	2 <sup>nd</sup> update:	2:	2:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.		4.							<input type="checkbox"/> Yes <input type="checkbox"/> No	

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. To executes a QI program annual work plan that reflects ongoing activities throughout the year and addresses all required DHCS, and NCQA requirements	1. Create a workplan that captures yearly activities, time frame for each activity's completion, staff members responsible for each activity, monitoring of previously identified issues, and evaluation of QI program.	1/1/2024-2/15/2024	Andrea Swan, Quality Improvement & Population Health Director	Qtr. 1: Workplan successfully completed, and approved at QIHEW, and QIHEC in the 1 <sup>st</sup> quarter of 2024. 1 <sup>st</sup> quarter updates have been completed pending presentation to QIHEW and QIHEC.  Qtr. 2  Qtr. 3:  Qtr. 4:	1: Current workplan needed to be updated to meet DHCS and NCQA requirements which was successfully completed.	1: Continue to work with business owners for timely submission, and ensuring work plan updates meet requirements and reflect progress towards goals.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	N/A
2. Ensure all workplan elements are properly documented and reflect appropriate follow up by each business owner.	2. Regular quarterly check-ins to review workplan entries, with regular feedback provided to business owners when applicable.	3/31/204,6/30/2024,9/30/2024,12/31/2024	Andrea Swan, Quality Improvement & Population Health Director				<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Review and approval of workplan quarterly by QIHEC	3. Review of all workplan entries prior to each committee to ensure appropriate documentation.	3/31/204,6/30/2024,9/30/2024,12/31/2024	Andrea Swan, Quality Improvement & Population Health Director		2:	2:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	4.				<input type="checkbox"/> Yes <input type="checkbox"/> No			



SECTION 2: QUALITY OF CLINICAL CARE

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Establish and launch Provider Partnership program	1. Sign up 4 providers by 3.31.24. 2. Do onsite meetings and observations by 4.31.24. 3. Develop and implement interventions for 1-2 MCAS measures at each site by 6.30.24. 4. Monitor and adjust interventions and MCAS rates 9.30.24	1/1/24-3/31/24  3/31/24-4/31/24  4/1/24-6/30/24  7/1/24-9/30/24	Alex Sanchez, Quality Improvement Advisor	Launched program and contacted providers.			<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Develop a comprehensive MCAS committee to capture, plan, and discuss quality improvement activities that will improve DHCS required MCAS measures, and NCQA HEDIS prioritized measures.  Goal will be to improve MCAS Measurement Year (MY) 2022 rates in Merced County under sanction to reach the minimum performance level (MPL) held to the 50 <sup>th</sup> percentile, or improve the by the 4%-6% minimal improvement threshold from: <ul style="list-style-type: none"><li>Childhood Immunizations - Combo 10 (CIS-10) - 16.06%.</li></ul>	1. Create project charter and project tracker. 2. Establish regular monthly check-in with committee to monitor activities. 3. Evaluation current intervention strategies against finalized audited measurement year (MY) MY2023 MCAS measure rates. 4. Request direction of interventions from.	1/1/2024-3/31/2024 3/1/2024-6/30/2024 6/17/23-8/31/2024 4/1/24-12/31/2024	Britta Vigurs, Quality Improvement Program Advisor	In Q1 2024 we drafted the MCAS Workgroup Meeting Charter and identified stakeholders across the Alliance to attend future meetings as core attendees or ad hoc. A topic tracker has been drafted to assist identifying standing agenda items and future topics based on priorities.  Initial MCAS rates for measurement year 2023 (reporting year 2024) in Merced County show slight worsening (-1-3%) on IMA-2, no improvement (0%) in LCS, slight improvements (1-3%) in CIS-10, CHL, W30-2+, minimal improvement (4-6%) in WCV, BCS, and moderately significant	The previous cross-departmental workgroup to address MCAS measures during the pandemic was structured more for reporting out, rather than allowing active work within the meeting to identify and flag barriers in projects.	This meeting will reoccur monthly.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	This MCAS committee meeting is structured to be an interdisciplinary workgroup to review and approve interventions, as well as serve as working sessions to problem solve barriers.  There were a number of new quality improvement projects within the provider network last year in 2023, which

<ul style="list-style-type: none"> <li>Immunizations for Adolescents - Combo 2 (IMA–2) - 33.09%.</li> <li>Lead Screening in Children (LSC) - 46.47%.</li> <li>Breast Cancer Screening (BCS) - 49.65%.</li> <li>Chlamydia Screening in Women (CHL-Tot) - 52.56%.</li> <li>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6)- 36.72%.</li> <li>Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits (W30-2) - 58.09%.</li> </ul> <p>Child and Adolescent Well-Care Visits (WCV) - 45.64%.</p>				improvement (11-15%) in W30-6+. BCS has reached the MPL				would have helped drive improvements in targeted measures like BCS and W30-6+.
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CARE BASE INCENTIVE (CBI) (KRISTEN ROHLF)								
Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Enhance Provider Portal reports to streamline access to reports and increase availability of functions and measures monthly.	1. Create business requirements for a roll-up function that allows multiple clinics sites to see a combined monthly rate for measures available monthly on the Provider Portal Quality Report.  2. Develop workflow to extract and generate additional columns that note members meeting continuous enrollment specifications to applicable monthly Provider Portal Quality reports.  3. Create business requirements to add trending graphs to monthly quality reports.  4. Create business requirements to add a Gaps in Care report.  5. Create business requirements to generate email reminders for portal reports for providers.	1/1/2024-3/31/2024           1/1/2024-6/30/2024           6/30/2024-12/31/2024           4/1/2024-12/31/2024           4/1/2024-12/31/2024           1/31/2024-3/31/2024	Alex Sanchez, Quality Improvement Program Advisor, Magdalena Kowalska, Quality Improvement Program Advisor, Shannon Fletcher, Quality Improvement Program Advisor, Annecy Majoros, Quality Improvement Program Advisor	1. Roll-up function has been deployed on the Provider Portal Quality Reports in Q1 2024.  2. Work to start in Q2 2024.  3. Business requirements completed and submitted to ITS in Q1 2023.  4. Work to start in Q2 2024.  5. Completed draft language.	Competing priorities for staff, and limited staffing available to build and test reports.           Limited visual and report functionalities of the provider portal.	1. No further action required.  2. Submission of portal tickets, development, and testing.  3. Development and testing.  4. Awaiting development by ITS and QA of enhanced features.  5. Continued discussions with staff from Provider Services and Quality Improvement and Population Health on portal feature development, then development and testing of the function.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Initial reports with target dates in Q1 were successfully completed with no issues after collaborating on the easiest technological solution. Anticipate potential bandwidth challenges for the rest of the report enhancements due to regulatory and non-regulatory alliance projects.
2. Increase access to introductory CBI program information for network providers.	1. Record a CBI 2024 introductory video.  2. Create survey for feedback on training content.  3. Published video on the Alliance Webinars and Training website.	4/1/2024-5/30/2024.           4/1/2024-5/30/2024.	Annecy Majoros, Quality Improvement Program Advisor, Juan Velarde, Quality Improvement Program Advisor, Britta Vigurs, Quality Improvement Program Advisor, Tera Mendoza, Coding Resource Specialist	Work anticipated to start in Q2 2024.	Bandwidth of staff to complete the training videos in competition with regulatory and other project obligations.	Development of slide material and recording in Q2 2024 for introductory slides. Development in Q2-Q3 for DST and coding resources.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Updated the target completion date by one month for the CBI introductory video due to resources available with a later launch of the



	<div>4. Advertise video to network providers, with additional targeting for newly added Mariposa and San Benito County providers.</div> <div>5. Create Data Submission Tool (DST) training video.</div> <div>6. Create and record coding training material for MCAS/CBI.</div>	<div>6/1/2024-6/30/2024</div> <div>7/1/2024-7/31/2024</div> <div>6/1/2024-8/31/2024</div> <div>6/1/24-8/31/24</div>						<div>provider partnership program and volume of CBI forensics requests in Q2.</div>
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BASIC POPULATION HEALTH MANAGEMENT (DESIRRE HERRERA)								
Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Party	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
<div>1. On a quarterly basis, provide Health Education services and Member Health Rewards program presentations to Alliance internal department staff that interact with members to increase awareness of Health Education services and health rewards available for members as evidence by an increase of member incentives fulfilled by 2.5% over 2023 by 12/31/2024.</div>	<div>1. The project team will reach out to internal departments that interact with members. Examples of teams: <div> <div>a. Health Education team</div> <div>b. Member Services team</div> <div>c. Care Coordination team</div> <div>d. Community Engagement team</div> </div> </div> <div>2. Schedule presentations</div> <div>3. Deliver Health Education and Member Health Rewards services presentation.</div> <div>4. Request input regarding presentation content and any member needs that they have encountered regarding Health Education services.</div>	<div>3/31/2024, 6/30/2024</div> <div>9/30/2024, 12/31/2024</div>	<div>Kevin Lopez, C&amp;L Program Advisor</div> <div>Desirre Herrera, Quality and Health Programs Manager</div>	<div>A total of 4 presentations on Health Education services and Member Health Rewards were coordinated and completed in Quarter 1.</div> <div>Presentations were delivered to the following audiences: <ul style="list-style-type: none"> <li>UC Merced Health &amp; Wellness center staff</li> <li>New Alliance staff attending the QIPH Department Orientation</li> <li>Health Education team</li> <li>Community Engagement team</li> </ul> </div>	<div>Due to limited staffing in 2023 these types of presentations were not offered frequently.</div> <div>In 2024 we have filled staffing vacancies and have been able to increase offerings of the presentations for internal and external audiences.</div> <div>There have been no issues in 2024 with this goal or activities.</div>	<div>The project team will continue to coordinate presentations for internal departments and Alliance staff in Q2.</div> <div>A minimum of 2 presentations on Health Education Services and Member Incentives will be completed in Q2.</div> <div>Additionally, team members will explore offering the presentation to external audiences in Q2-Q4.</div>	<div><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</div>	<div>This goal has been successful in increasing awareness among member facing teams and ensuring Alliance staff are informed of the services available for members.</div> <div>Increased awareness of Health Education Services and Member Health Rewards programs allows Alliance staff to share information on a broader scale with members they are working with in day-to-day operations.</div>
<div>2. On a quarterly basis, inform members of Health and Wellness programs and self-management tools available to them in 2024 to increase utilization of services by 2.5% over the 2023 baseline by 12/31/2024.</div>	<div>1. The project team will conduct outreach and education activities to inform members of services available to them via: <div> <div>a. Member outreach calls</div> <div>b. Member workshops</div> <div>c. Member mailings</div> <div>d. Member newsletter articles</div> <div>e. MSAG presentation</div> </div> </div> <div>2. Request input from members regarding program and services.</div>	<div>3/31/2024,6/30/2024</div> <div>9/30/2024,12/31/2024</div>	<div>Veronica Lozano, Quality and Health Programs Supervisor</div> <div>Health Educator team</div> <div>Desirre Herrera, Quality and Health Programs Manager</div>	<div>The following activities were completed in Q1 to inform members of Health and Wellness programs: <ul style="list-style-type: none"> <li><u>Member Newsletter</u>: The project team included 1 article in the March 2024 Member Newsletter informing members of health and wellness programs available to them. The article includes how members can access</li> </ul> </div>	<div>No issues to report in Q1.</div>	<div>The project team will continue to conduct outreach calls each quarter.</div> <div>The project team will include health and wellness information in the June 2024 Member Newsletter.</div>	<div><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</div>	<div>The member newsletters result in higher calls to the Health Education Line regarding programs included in the newsletter. Health Education staff are aware of when notices are sent to members</div>

	3. Incorporate member feedback into bi-annual planning of health education activities.			<div>the services and reach out to the Health Education Line for any questions.</div> <ul style="list-style-type: none"><li><u>Member outreach calls:</u> The Health Education team completed 683 outreach calls in Q1 to offer members.</li></ul>				<div>to ensure questions on program enrollment can be answered.</div> <div>In Q1 the Health Education Line received 763 incoming calls from members, providers and the community regarding Quality and Health Programs services.</div>
3. Establish a survey tool to capture member feedback related to chronic disease management and wellness programs in order to evaluate utilization of services. 2024 will serve to both establish the baseline and determine interventions. By the end of 2024 have a well-developed survey, and an established baseline of participation and member feedback to determine interventions.	<div>1. The project team will conduct satisfaction surveys with members to evaluate:<div><div>a. Information about the overall program</div><div>b. Usefulness of the information shared.</div><div>c. Percentage of members indicating that the program helped them achieve health goals.</div></div></div> <div>2. Request input from members regarding program and services.</div> <div>3. Incorporate member feedback into bi-annual planning of health education activities.</div>	3/31/2024,6/30/2024 9/30/2024,12/31/2024	<div>Kevin Lopez, C&amp;L Program Advisor</div> <div>Desirre Herrera, Quality and Health Programs Manager</div>	<div>The following activities were completed in Q1 to collect member feedback regarding chronic disease management and wellness programs.</div> <ul style="list-style-type: none"><li><u>Member Satisfaction Surveys:</u> The project team completed a total of 44-member experience surveys.</li></ul>	No issues to report in Q1.	<div>The project team will continue to proactively reach out to members via outreach calls to request member feedback via satisfaction surveys.</div> <div>In Q3-Q4 the team will explore adding mailing options for satisfaction surveys.</div>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<div>According to the member feedback collected for chronic disease management programs:<div>1. Over 88% of members reported the highest rating of satisfaction with the HLP/chronic disease management program.</div><div>2. Over 92% reported the highest rating for usefulness of the HLP program.</div><div>3. Over 92% reported the highest rating for HLP helping them achieve health goals.</div></div> <div>According to the member feedback collected for wellness programs:<div>1. Over 75% of members reported the highest rating of satisfaction with the HWL/childhood</div></div>

								obesity prevention program. 2. Over 75% reported the highest rating for usefulness of the HLP program. 3. Over 75% reported highest rating for HWL helping them achieve health goals.
4. On a quarterly basis increase the number of member workshops provided by the Health Education Team in comparison to 2023 baseline.  In 2023 there were on average 2 workshops scheduled per quarter. In 2024 the team will double this number and offer at minimum 4 workshops per quarter.	1. The Health Educators will conduct a minimum of 4 member workshops per quarter. 2. Health Educators will lead recruitment and outreach efforts to members to enroll in the programs. 3. Health Educators will lead.	3/31/2024, 6/30/2024, 9/30/2024, 12/31/2024	Veronica Lozano, Quality and Health Programs Supervisor  Health Educator team  Desirre Herrera, Quality and Health Programs Manager	A total of 9 member workshops were completed in Q1. The following workshop modalities and languages were completed: <ul style="list-style-type: none"><li>• 3 telephonic HLP groups in Spanish</li><li>• 4 telephonic HLP groups in English</li><li>• 1 virtual HWL group in Spanish</li><li>• 1 in-person HWL group in Spanish held in Merced County</li></ul>	No issues to report in Q1.	The project team will continue to schedule workshops to meet the quarterly goal of a minimum of 4 workshops per quarter.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	The project team exceeded the minimum goal requirements being able to fill 9 workshop groups in Q1. This was due to the high interest from members to join workshop groups.



SECTION 3: SAFETY OF CLINICAL CARE

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 80% of existing primary care provider sites with an FSR/MRR due this quarter are completed within three years of their last FSR date.	<div>1. Address current staffing to support provider scheduling by onboarding three additional QI RNs to perform facility site reviews.</div> <div>2. Review upcoming reviews one quarter prior.</div> <div>3. Schedule reviews by sending the provider sites multiple review dates to choose from two months before the review due date.</div> <div>4. Continue communication with the provider site until a review date is confirmed.</div>	01/01/2024 – 03/29/2024	Joana Castaneda, Quality Project Specialist, Tisha Criswell Senior Quality Improvement Nurse, Nicole Lyles, Senior Quality Improvement Nurse	<div>1. Goal results: 100%</div> <div>2. An additional QI RN was added to the FSR team with (2) positions approved for 2024.</div> <div>3. Upcoming reviews for Q2 have been reviewed for planning in Q1.</div> <div>4. Communications to providers for Q2 reviews have been initiated.</div>	<div>1. Staffing to perform site reviews. (2) Positions were approved and are awaiting HR posting.</div>	<div>1. Continued engagement with HR regarding (2) approved QI RN positions for FSR.</div>	<div><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</div>	Tisha Criswell began onboarding Nicole Lyles in Q1 2024. Onboarding Nicole will continue through Q2 2024. However, Nicole has been able to quickly engage in the work since she was hired as a DHCS master trainer. Tisha and Nicole will continue to onboard and align scoring techniques in preparation for (2) new hires anticipated for Q2 2024.
2. 100% of practices with Corrective Action Plans (CAPs) arising from FSR/MRR submit a plan to address the CAP within regulatory timeframes.	<div>1. Address current staffing to support CAP management by onboarding three additional QI RNs to perform facility site review.</div> <div>2. Send email reminders to provider sites with CAP due dates.</div> <div>3. Address non-responsive providers with direct phone calls and PRR involvement.</div>	<div>01/01/2024 – 03/29/2024</div> <div>3/31/2024,6/30/2024</div> <div>9/30/2024,12/31/2024</div>	Tisha Criswell Senior Quality Improvement Nurse, Nicole Lyles, Senior Quality Improvement Nurse	<div>1. Goal results: 100%</div> <div>2. An additional QI RN was added to the FSR team with (2) positions approved for 2024.</div> <div>3. Communications were sent to providers with CAP to remind the site of due dates.</div> <div>4. There were no non-responsive providers during this quarter.</div>	<div>1. Staffing to perform site reviews. (2) Positions were approved and are awaiting HR posting.</div>	<div>1. Continued engagement with HR regarding (2) approved QI RN positions for FSR.</div>	<div><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</div>	Tisha Criswell began onboarding Nicole Lyles in Q1 2024. Onboarding Nicole will continue through Q2 2024. However, Nicole has been able to quickly engage in the work since she was hired as a DHCS master trainer. Tisha and Nicole will continue to onboard and align scoring techniques in preparation for (2) new



								hires anticipated for Q2 2024.
4.	4.						<input type="checkbox"/> Yes <input type="checkbox"/> No	

POTENTIAL QUALITY ISSUES (DEANNA LEAMON)								
Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 100% of member grievances received by QI related to the potential medical quality of care issues are completed within Member Grievance regulatory timeframes.	2. Create due dates in SharePoint for PQIs that provide enough time for investigation and translation needs (if applicable) and for the Grievance Coordinator to resolve the case.  3. If medical records are needed for the PQI investigation, request timely upon case assignment to QI RN.  4. Coordinate timely discussion if the case requires MD guidance or potential P2/P3 recommendation.	01/01/2024 – 03/29/2024  3/31/204,6/30/2024  9/30/2024,12/31/2024	Eleni Papazisis, Quality Improvement Program Advisor, Naomi Kwabata, Senior Quality Improvement Nurse, Emily Kaufman, Senior Quality Improvement Nurse, Katie Lutz, Quality Improvement Nurse, Sandy Clay Senior Quality Improvement Nurse, and Bethany Fung, Quality Improvement Nurse	1. Goal <b>results:</b> 100%; 112/112 cases closed timely. 2. Due dates were created in SharePoint and used to guide the closure of regulatory PQIs. 3. Medical records were requested timely for PQI investigations by QI RN. 4. Timely discussions were held with MD for P2/P3 cases.	Staffing to balance regulatory PQIs, internal PQI referrals, collaboration work, and/or quality studies focused on improving the quality of care for members.	1. Continue creating due dates in SharePoint to prioritize promptly closing regulatory-based PQIs. 2. Continue requesting medical records when needed for investigation and timely case closure. 3. Continue weekly MD meetings to discuss potential P2/P3 cases requiring guidance not to inhibit timely case closure. 4. Decline collaborative work and be selective regarding Quality Studies until the team can close regulatory and internal referral PQIs at 100% compliance.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	QI RNs prioritize regulatory PQIs based on member complaints. This prioritization and current staffing have caused internal referral PQIs to go over their assigned 90-day due dates and have impacted collaboration work outside of regulatory PQIs, such as Academic Detailing in collaboration with Pharmacy and focused Quality Studies, such as opioid/benzo co-prescribing and reports to isolate impacted members by inappropriate co-prescribing.
1. 80% of non-grievance related PQIs are completed within 90 calendar days.	2. Triage and prioritize incoming internal referrals for the following case types: a. Known provider to track and trend. b. Provider on a CAP or open Quality Study c. LTSS member 3. Consider revising the PQI policy to expand the due date to 120 days.	01/01/2024 – 03/29/2024  3/31/204,6/30/2024  9/30/2024,12/31/2024	Eleni Papazisis, Quality Improvement Program Advisor, Naomi Kwabata, Senior Quality Improvement Nurse, Emily Kaufman, Senior Quality Improvement Nurse, Katie Lutz, Quality Improvement Nurse, Sandy Clay Senior Quality Improvement Nurse, and Bethany Fung, Quality Improvement Nurse	1. Goal <b>results:</b> 83%; 25/30 cases closed timely. 2. The team triaged and prioritized incoming internal referrals to the best of their ability for the following case types: a. Known provider to track and trend. b. Provider on a CAP or open Quality Study c. LTSS member	1. Staffing to balance regulatory PQIs, internal PQI referrals, collaboration work, and/or quality studies focused on improving the quality of care for members. 2. The team has been proactive in triaging incoming internal PQI referrals. However, the Alliance's current systems do not provide an easy way to identify LTSS members, causing a workaround for DHCS Critical Incident reporting.	1. Continue triaging incoming internal PQIs to the best of the team's ability and continue workaround processes to capture LTSS members for DHCS Critical Incident reporting. 2. Decline collaborative work and be selective regarding Quality Studies until the team can close regulatory and	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	QI RNs prioritize regulatory PQIs based on member complaints. This prioritization and current staffing have caused internal referral PQIs to go over their assigned 90-day due dates. The team aims to increase this metric to 100%. They have been proactive in triaging incoming internal PQI

						<div>internal referral PQIs at 100% compliance.</div> <div>3. Consider revising the PQI policy to expand the due date to 120 days.</div>		<div>referrals. However, the Alliance's current systems do not provide an easy way to identify LTSS members for DHCS's quarterly reporting on critical incidents. This lack of proactive LTSS identification leads to a workaround. LTSS members are identified based on billing codes, and critical incidents are reported based on incoming referral information, not after the case investigation. The DHCS reporting criteria require cases that were opened during the quarter. Unfortunately, most of the critical incidents reported to DHCS were internal PQIs that were in progress and had not been investigated due to the team's current staffing and bandwidth limitations, which significantly impact their workload.</div>
3:	3.						<div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>	

GRIEVANCE & APPEALS REVIEW (SARAH SANDERS)								
Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. On a quarterly basis, provide grievance updates to interdisciplinary groups including SGRC and QIHEW.	a. Monitor and process concerns within regulatory timeframes. b. Provide internal communications on appeal and grievances trends and outcomes.	01/01/2024 – 03/29/2024  3/31/204,6/30/2024	Sarah Sanders, Grievance and Quality Manager	Q1-Q2 updates: SGRC for 2/15 & 4/11 QIHEW 2/29 & 5/29	Q1-Q2: n/a	Continue monitoring regulatory compliance and trends.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Close monitoring, communications and tracking of AG occurred

	c. Track and trend grievance data by demographics including language to analyze disparities. d. Identify actionable opportunities for improvement	9/30/2024,12/31/2024						
2. Support Members by resolving issues of dissatisfaction with the Alliance.	a. Ensure that where appropriate, corrective action is implemented and effective in improving identified problems.  b. Track grievance and appeals for access/QOC trends, system issues, and identify actionable corrections needed.	01/01/2024 – 03/29/2024  3/31/204,6/30/2024 9/30/2024,12/31/2024	Sarah Sanders, Grievance and Quality Manager	Q1-Q2 updates: ROLT	ROLT Transport	QI action and monitoring for responsiveness	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	ROLT Transport CAP occurred in Q2
3. Quality Data: External Report requirements are met 100% of the time.	a. Monitor timely data and state submissions to ensure completeness.  b. Evaluate and identify opportunities to improve the data accuracy of AG information.	01/01/2024 – 03/29/2024  3/31/204,6/30/2024 9/30/2024,12/31/2024	Sarah Sanders, Grievance and Quality Manager	Q1-Q2: Accuracy achieved.  *Note updates to MCPD to expand benefit types for AG proposed by DHCS for Q3 implementation	Q1-Q2: n/a	Monitor for when new benefit types are required for MCPD reporting.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	New tableau reports created for NCQA & planning for benefit additions for go-live in August.
4. Ongoing monitoring of AG results to support that appropriate action is taken when occurrences of poor performance are identified. Identify and track allegations of discrimination.	a. Identify and, when appropriate, act on substantiated issues in a timely manner. Monitor and report findings bi-monthly. Complete audits for allegations of discrimination to monitor, prevent and identify any discriminatory practices.	01/01/2024 – 03/29/2024  3/31/204,6/30/2024 9/30/2024,12/31/2024	Sarah Sanders, Grievance and Quality Manager	Q1-Q2: Discrimination reviews completed	Q1-Q2: n/a	Monitor outliers	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Results Achieved.



SECTION 4: MEMBER EXPERIENCE

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start& end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. CAHPS survey fielded timely, and results reported out to internal stakeholders within 8 weeks of receiving results	1. CAHPS workflows, processes, and timelines documented and reviewed in Q1 2024, and steps are taken to begin MY2023 surveys	2/8/24 – 3/31/24	Alex Sanchez, Quality Improvement Program Advisor	Workflows and timelines have been drafted and reviewed for all active Press Ganey projects. MY2023 surveys for Medicaid CAHPS currently being fielded, MY2023 IHSS sample frames uploaded for fielding in June.	There was not a documented process or workflow for working with SPH to ensure CAHPS were administered timely. Additionally, the turnover in QI leadership caused the team to relearn and map out process to move forward.	<ul style="list-style-type: none"><li>• Medicaid fielding stops – results finalized.</li><li>• IHSS fielding begins.</li><li>• CG CAHPS planning begins.</li><li>• ECHO CAHPS planning for MY2024 begins.</li></ul>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Creating the workflows and timelines took many hours over the course of 3 months to complete and involved multiple teams, including QI, HSAG, Press Ganey, CCAH Contracts, CCAH finance, CCAH IT which led to some confusion about needs. Documenting these steps has allowed us to feel more confident moving forward and we will be able to loop in other teams early to maintain consistency and timeliness.
2. Increase organizational awareness of what CAHPS is and current what current rates are	2. Present MY 2022 CAHPS rates to targeted and appropriate stakeholders	3/1/2024 – 10/31/24	Sarina King, Quality Performance Improvement Manager	In Q1 MY2022 CAHPS results as well as an overview of the CAHPS program was presented to Chiefs	With the turnover in QI leadership that took place in 2023, best practices for presenting CAHPS results and implementing	Determine what more should be presented and to whom so that when MY 2023 results come in, we	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	The work was done to create and share out a presentation that

	1. Begin outreach to chiefs/admins to present CAHPS overview and high-level rates to organization at all-staff or division meetings	Same timeline as above		and Directors in March Operations Committee.	interventions were lost. We are working to reinstate a process.	can share appropriately and address the rates.		offered an overview of CAHPS and MY2022 results. There was conversation with a couple teams of interventions to be done in 2023, but more is needed here. We will continue to broaden organizational awareness of each departments' impact on CAHPS scores so that we may improve them.
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SECTION 4: QUALITY OF SERVICE

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Semi-Annual Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met  <input type="checkbox"/> Yes <input type="checkbox"/> No	Evaluation
1. Comply with DMHC Timely Access Survey Requirements	<div>1. Ensure 90% of After-hours triage compliance in Timely Access Survey. (Provider Appointment Availability Survey [PAAS]).</div> <div>2. Ensure 75% Urgent and routine appointment access compliance, as well as next available follow up appointment for non-physician mental health care, within required time frames.</div> <div>3. PAAS work begins in the summer with vendor engagement and finalization of the project plan and contact lists. The survey is launched from August to November/December. Results are available in Q1 of the subsequent year.</div>	7/1/2024-12/31/2024	Jessie Dybdahl, Provider Service Director	None	None	None	<input type="checkbox"/> Yes <input type="checkbox"/> No	none
2. Quarterly review of provider to member ratios for PCPs and High-volume/high-impact Specialties. To ensure all ratios meet regulatory requirements.	<div>1. Ensure provider to member ratios are w/in compliance and mitigate if out of compliance on a quarterly basis.</div> <div>2. Tableau report is monitored no less than quarterly to ensure provider to member ratios are met for each required provider type.</div>	1/1/2024-3/31/2024	Jessie Dybdahl, Provider Service Director	None	None	None	<input type="checkbox"/> Yes <input type="checkbox"/> No	none

3.	3.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	4.						<input type="checkbox"/> Yes <input type="checkbox"/> No	

GEO ACCESS (TIMELY ACCESS) (JESSIE DYBDAHL)								
Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Semi-Annual Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Comply with Time or Distance Standards set forth by DHCS	<div>1. Ensure the network meets time or distance standards in compliance with DHCS requirements when a provider is available.</div> <div>2. Monitor areas where no provider is available and ensure alternative access requests are in place on a quarterly basis.</div> <div>3. Evaluate the non-contracted provider network to determine if recruitment might remedy access gaps. Launch recruitment efforts as applicable.</div>	<div>1/1/2024-3/31/2024</div> <div>1/1/2024-3/31/2024</div>	Jessie Dybdahl, Provider Service Director	none	none	none	<input type="checkbox"/> Yes <input type="checkbox"/> No	none
2.	2.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.	3.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	4.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
PROVIDER SATISFACTION SURVEY (JESSIE DYBDAHL)								
Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Semi-Annual Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Provider Satisfaction Survey	<div>1. Monitor Provider Satisfaction annually. Ensure no less than 5% decrease in overall satisfaction with the plan from prior year.</div> <div>2. The Provider Satisfaction Survey (PSS) is launched in the summer with vendor engagement in spring. Contact lists are sent for primary care, specialty care, and non-physician mental health care. The survey is launched from July to August. Results are available in quarter 4.</div>	7/1/2024 - 12/31/2024	Jessie Dybdahl, Provider Service Director	none	none	none	<input type="checkbox"/> Yes <input type="checkbox"/> No	none
2.	2.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.	3.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	4.						<input type="checkbox"/> Yes <input type="checkbox"/> No	

TELEPHONE ACCESS (VERONICA OLIVARRIA)								
Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 80% of calls to Member Services answered within 30 seconds.	<p>1. The Call Center is continuously monitoring this metric as it is also included on the Operational Dashboard.</p> <p>Improvement efforts slated for 2024:</p> <ul style="list-style-type: none"><li>• The adoption of a Workforce Management Tool to assist with call forecasting and representative scheduling, ensuring we have appropriate levels of staff supporting the queues at any given time/day.</li><li>• Call Audit Optimization: We are developing formal call audit guidelines and defined audit methodology to ensure staff is adhering to Alliance updates and processes. This will ensure representatives are provided with the appropriate resources and are getting through calls, timely.</li><li>• Developing additional call circles (queues) to:<ul style="list-style-type: none"><li>○ Optimize resource availability.</li><li>○ Improve speed to answer.</li><li>○ Reduce representative training time.</li><li>○ Increase member satisfaction.</li></ul></li><li>• Leverage technology to reduce wait times for members where their inquiries can be filled by the system. Example: Interactive voice response to check eligibility or change PCP.</li><li>• Computer Telephone Integration:</li><li>• Enhance HSP/Finesse by adding a screen pop up of member's demographics when a member calls into the call center. This will reduce time on phone for the MSR and will make each call more efficient.</li></ul>	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Veronica Olivarría, MS Call Center Manager	Goal not met (63%).	none	additional FTEs and moving call quality auditing to MS Ops team, WFM tool to be implemented with new phone system.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	N/A

2. Call abandonment rate will not exceed 5% of calls to Member Services answered before being abandoned.	2. The Call Center is continuously monitoring this metric as it is also included on the Operational Dashboard. (Same as above)	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Veronica Olivarria, MS Call Center Manager	Goal not met (6%)	none	Working on additional FTEs and moving call quality auditing to MS Ops team, WFM tool to be implemented with new phone system.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	N/A
3.	3.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	4.						<input type="checkbox"/> Yes <input type="checkbox"/> No	

CULTURE & LINGUISTICS (DESIRRE HERRERA)								
Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. On a quarterly basis, provide C&L services presentations to Alliance internal department staff that interact with members to increase awareness of C&L services available for members with a goal of increased member baseline by 12/31/2024.	1. The C&L team will reach out to internal departments that interact with members. Examples: <ul style="list-style-type: none"><li>QIPH new hire orientation</li><li>Member Services team</li><li>Care Coordination team</li><li>Community Engagement team</li></ul> 2. Schedule C&L services presentation 3. Deliver C&L services presentation. 4. Request input regarding presentation content and any member needs that they have encountered regarding C&L services.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Osiris Ramon, C&L Program Advisor  Desirre Herrera, Quality and Health Programs Manager	A total of 2 presentations on C&L services were coordinated and completed in Quarter 1.  Presentations were delivered to the following audiences: <ul style="list-style-type: none"><li>QIPH Department staff</li><li>New Alliance staff attending the QIPH Department Orientation</li></ul>	Due to limited staffing in 2023 these types of presentations were not offered frequently.  In 2024 we have filled staffing vacancies and have been able to increase offerings of the presentations for internal and external audiences.  There have been no issues in 2024 with this goal or activities.	The project team will continue to coordinate presentations for internal departments and Alliance staff in Q2.  A minimum of 1 presentation on C&L Services will be completed in Q2.  Additionally, team members will explore offering the presentation to external audiences in Q2-Q4.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	This goal has been successful in increasing awareness among member facing teams and ensuring Alliance staff are informed of the services available for members.  Increased awareness of C&L Services allows Alliance staff to share information on a broader scale with members they are working with in day-to-day operations.
2. On a quarterly basis, inform members of C&L Services available to them in 2024 with a goal of increasing member utilization by 2.5% compared to the 2023 baseline by 12/31/2024.	1. The C&L team will conduct outreach and education activities to inform members of services available to them via: <ul style="list-style-type: none"><li>Member newsletter articles</li><li>MSAG presentation</li></ul> 2. Request input from members regarding program and services. 3. Incorporate member feedback into bi-annual planning of health education activities.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Osiris Ramon, C&L Program Advisor  Ivonne Munoz, Quality and Health Programs Supervisor	The following activities were completed in Q1 to inform members of C&L Services: <u>Member Newsletter</u> : The project team included 1 article in the March 2024 Member Newsletter informing members of language assistance services available to them. The article includes how members can access the services and reach out to the Health Education Line for any questions.	No issues to report in Q1.	The project team will continue to collaborate with internal departments to ensure members are informed of language assistance services.  The QHP leadership team will start collaborative discussions with the Community Engagement team to discuss ways to inform members of these services.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	The member newsletters result in higher calls to the Health Education Line regarding programs included in the newsletter. Health Education staff are aware of when notices are sent to members to ensure questions on services can be answered.

								In Q1 the Health Education Line received 763 incoming calls from members, providers and the community regarding Quality and Health Programs services.
3. On a quarterly basis, collect member feedback on their experience with language assistance services in a clinical setting  to target improvements in 2025.	1. The project team will conduct satisfaction surveys with members to evaluate: <ul style="list-style-type: none"><li>a. Individual ratings of access to language services.</li><li>b. Overall rating of interpretation services.</li><li>c. Access to language services at a health care encounter.</li><li>d. Gather individual experiences with the services.</li></ul> 2. Request input from members regarding program and services. 3. Incorporate member feedback into bi-annual planning of health education activities.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Osiris Ramon, C&L Program Advisor  Desirre Herrera, Quality and Health Programs Manager	The following activities were completed in Q1 to collect member feedback regarding language assistance services in a clinical setting. <u>Member Satisfaction Surveys:</u> The project team completed a total of 53-member experience surveys.	No issues to report in Q1.	The project team will continue to proactively reach out to members via outreach calls to request member feedback via satisfaction surveys.  In Q3-Q4 the team will explore adding mailing options for satisfaction surveys.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	According to the member feedback collected for language assistance services in a clinical setting: 1. Over 75% of members reported the highest rating of satisfaction with the interpreter at their doctor’s visit. 2. Over 96% reported they would use the interpreting services again. 3. When asked for recommendations to improve the experience 85% of members reported no improvements needed. 10% shared recommendations such as interpreters shortening explanations when communicating to the doctor. 5% shared they would like more help with the overall visit such as checking in with the front desk, asking questions of the front desk and not just interpreting with the doctor. The C&L team will take this input and share feedback



								with the interpreting services vendors to work on these recommendations.
<p>4. Increase provider utilization of language assistance services quarterly by a minimum of 5% in comparison to 2023 baseline utilization data.</p> <p>5. Establish baseline rate, and demographic profile of members who utilize interpreter services to determine any disparity to help determine additional interventions.</p>	<p>1. The project team will track utilization for the following services:</p> <ul style="list-style-type: none"> <li>Phone interpreting services.</li> <li>Face-to-Face (F2F) interpreting services.</li> </ul> <p>2. Use quarterly utilization data to identify potential need to training of provider network on language assistance services.</p>	<p>3/31/2024 6/30/2024 9/30/2024 12/31/2024</p>	<p>Osiris Ramon, C&amp;L Program Advisor</p> <p>Ivonne Munoz, Quality and Health Programs Supervisor</p>	<p>Provider Utilization for Q1 was as follows:</p> <p><u>Phone interpreting services:</u> There was a total of 5,949 total calls in Q1 by provider sites. This reflects an <b>increase</b> of 37% compared to Q1 in 2023.</p> <p><u>Face-to-Face (F2F) interpreting services:</u> There was a total of 1,550 requests in all service counties for F2F. This was a 26.5% <b>increase</b> compared to Q1 2023.</p> <ul style="list-style-type: none"> <li><u>Santa Cruz County</u> had 807 requests in Q1. This was a 97% <b>increase</b> compared to Q1 2023.</li> <li><u>Merced County</u> had 467 requests in Q1. This was a 20% <b>increase</b> compared to Q1 2023.</li> <li><u>Monterey County</u> had 275 requests in Q1. This was a 35% <b>decrease</b> compared to Q1 of 2023.</li> <li><u>San Benito County</u> had 1 request in Q1. This is a new service county and there was no comparison for 2023.</li> <li><u>Mariposa County</u> had 0 requests in Q1. This is a new service county and there was no comparison for 2023.</li> </ul>	No issues to report in Q1.	The project team will review quarterly utilization data in Q2 to identify the potential need for training on language assistance services of providers in Q3-Q4.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<p>There were significant increases in utilization of language assistance services by providers in Q1 2024 compared to Q1 2023.</p> <p>The C&amp;L team continues to monitor trends and work closely with the language assistance vendors to ensure effective service delivery for Alliance members.</p>

DELEGATION OVERSIGHT (ANDREA SWAN)								
Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Ensure all activities delegated on behalf CCAH and the QIPH department meet all DHCS, DMHC, and NCQA regulations.	1. Quarterly review of delegate reports to ensure compliance, and identification of any issues.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	DeAnna Leamon, Clinical Safety Quality Manager. Kristen Rohlf, Quality Improvement & Population Health. Desirre Herrera, Quality Health Programs Manager. Andrea Swan,	1. All delegate reports for the 1 <sup>st</sup> quarter were received and reviewed with no gaps identified.	No previous issues identified	Continue with quarterly review	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	N/A

			Quality Improvement & Population Health Director					
2. Ensure oversight of all delegated activities by governing board.	2. Present quarterly updates of all reviewed activities with identification of any issues to the governing board for review, and feedback.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	DeAnna Leamon, Clinical Safety Quality Manager. Kristen Rohlf, Quality Improvement & Population Health. Desirre Herrera, Quality Health Programs Manager. Andrea Swan, Quality Improvement & Population Health Director	All delegate reports for the 1 <sup>st</sup> quarter were received and reviewed with no gaps identified.	No previous issues identified	Continue with quarterly review	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
3.	3.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	4.						<input type="checkbox"/> Yes <input type="checkbox"/> No	