

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 st 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.	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 nd update	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 st 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 nd update:	2:	2:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.		4.							<input type="checkbox"/> Yes <input type="checkbox"/> No	

ANNUAL WORKPLAN (ANDREA SWAN)								
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 st quarter of 2024. 1 st quarter updates have been completed pending presentation to QIHEW and QIHEC. Qtr. 2 Quarter 1 updates presented and approved at QIHEW and QIHEC. Q2 updates completed pending update at QIHEW in August, and QIHEC in Sept. Qtr. 3: Qtr. 4:	1: Current workplan needed to be updated to meet DHCS and NCQA requirements which was successfully completed. 2: With the presentation of workplan goals within the QIPH committee feedback included in the need to establish clear baselines, and timeframes. The workplan was updated, and presented with changes, and approved.	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 checked="" 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		3:	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

MCAS INTERVENTION (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. 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	Sarina King, Quality and Performance Improvement Manager	Five practices enrolled by April 2024. 2 Focused measures selected per site, with project charters completed. Monthly practice coaching sessions and quarterly data review meetings began in April 2024. Data as of Sept. 2024 shows upward trends in 9 of the 10 selected measures for the 5 sites.	Difficulty scheduling and meeting with providers, slow start to interventions.	Continue to support practice with Care Gap closure reports and funding for additional clinic time.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	The Alliance provider liaisons and leadership team were persistent in their support, education and outreach to our Provider Partners. This persistence resulted in regular coaching meetings with our sites and appropriate escalations and support with interventions. The result is improved performance across MCAS measures with 9 of 10 tracked measures showing year over year improvement and 4 of 10 reaching MPL.

2.	<p>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.</p> <p>Overall strategic goal is to improve Merced County Pediatric Measures by a 5 percentile increase over MY 22 each year through 2026. In addition to children’s health measures sanctioned in Merced there were there are two women’s health measures that also fell below the minimum performance level (MPL) held to the 50th percentile. Goal is to reach the following:</p> <ul style="list-style-type: none">• Child and Adolescent Well-Care Visits (WCV) - 48.0% (45th percentile)• Childhood Immunizations - Combo 10 (CIS-10) - 24.5% (14th percentile).• Immunizations for Adolescents - Combo 2 (IMA–2) - 35.2% (50th percentile).• Lead Screening in Children (LSC) - 53.2% (25th percentile).• Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6)- (16th %ile)• Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits (W30-2) - 60.8% (28th %ile)• Breast Cancer Screening (BCS) - 52.6% (50th percentile). <p>Chlamydia Screening in Women (CHL-Tot) - 56.04% (50th percentile).</p>	<div><div>1.</div><div>Create project charter and project tracker.</div></div> <div><div>2.</div><div>Establish regular monthly check-in with committee to monitor activities.</div></div> <div><div>3.</div><div>Evaluation current intervention strategies against finalized audited measurement year (MY) MY2023 MCAS measure rates.</div></div> <div><div>4.</div><div>Request direction of interventions from.</div></div>	<div><div>1/1/2024-3/31/2024</div></div> <div><div>3/1/2024-6/30/2024</div></div> <div><div>6/17/23-8/31/2024</div></div> <div><div>4/1/24-12/31/2024</div></div>	Britta Vigurs, Quality Improvement Program Advisor	<p>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. Topic tracker has been drafted to assist identifying standing agenda items and future topics based on priorities.</p> <p>MCAS Measurement Year (MY) 2023 rates (Report Year 2024) in Merced County show improvements in all measures but Immunizations for Adolescents (IMA-2). Child and Adolescent Well-Care Visits (WCV), Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6+), Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30-2+), and Breast Cancer Screening met 2023 Target Goals. WCV, W30-6+ and BCS are on track for 2024.</p> <p>In Q2 the MCAS Workgroup discussed tracking of all projects/initiatives that may impact MCAS measures. QIPH interviewed key stakeholders across the organization to assess impact, and track information for further discussion in the MCAS Workgroup.</p> <p>In Q3 the MCAS Workgroup discussed barriers and improvement activities for servicing Alliance members in rural communities to close gaps in care. Assessment for projects/initiatives for MCAS measures continues with stakeholders across the organization.</p>	<p>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.</p> <p>In Q3 MCAS workgroup meetings were canceled due to competing hi-priority meetings and will work to see if meeting schedule should be modified for 2025.</p>	This meeting will reoccur monthly.	<div><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</div>	<p>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.</p> <p>There were a number of new quality improvement projects within the provider network last year in 2023, which would have helped drive improvements in targeted measures like BCS and W30-6+.</p>
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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.	1/1/2024-3/31/2024	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.	Competing priorities for staff, and limited staffing available to build and test reports.	1. No further action required.	<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

	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.	1/1/2024-6/30/2024 6/30/2024-12/31/2024 4/1/2024-12/31/2024 4/1/2024-12/31/2024 1/31/2024-3/31/2024		2. Work for business requirements completed 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 in Q1 2024.	Limited visual and report functionalities of the provider portal.	2. Awaiting ticket assignment, portal development, and testing. 3. Awaiting ticket assignment, portal development, and testing. 4. QA by QIPH and portal release. 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		the easiest technological solution. Anticipate potential bandwidth challenges for the rest of the report enhancements due to regulatory and non-regulatory alliance projects for programming.
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. Advertise video to network providers, with additional targeting for newly added Mariposa and San Benito County providers. 5. Create Data Submission Tool (DST) training video. 6. Create and record coding training material for MCAS/CBI.	4/1/2024-5/30/2024. 4/1/2024-5/30/2024. 6/1/2024-6/30/2024 7/1/2024-7/31/2024 6/1/2024-8/31/2024 6/1/24-8/31/24	Annecy Majoros, Quality Improvement Program Advisor, Juan Velarde, Quality Improvement Program Advisor, Britta Vigurs, Quality Improvement Program Advisor, Tera Mendoza, Coding Resource Specialist	Work completed for CBI Introduction video in Q2 2024. Coding Introduction video completed and posted to Alliance website in Q3.	Bandwidth of staff to complete the training videos in competition with regulatory and other project obligations.		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Planned activities were updated to combine the training videos for the CBI introduction, DST and provider portal reports into one training video for ease of use by provider clinics. Coding Introduction video will continue to be advertised in CBI forensics visits and at the CBI 2025 Workshop.

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
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.	1. The project team will reach out to internal departments that interact with members. Examples of teams: <div> a. Health Education team b. Member Services team c. Care Coordination team d. Community Engagement team </div> 2. Schedule presentations 3. Deliver Health Education and Member Health Rewards services presentation.	3/31/2024, 6/30/2024 9/30/2024, 12/31/2024	Kevin Lopez, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager	A total of 7 presentations on Health Education services and Member Health Rewards were coordinated and completed in Quarter 3. Presentations were delivered to the following audiences: <ul style="list-style-type: none"> Golden Valley Health Centers Community Health Worker team 	No issues to report in Q3.	The project team will continue to coordinate presentations for internal teams and external community partners in 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.

2. A minimum of 2 presentations will be conducted per quarter.	4. Request input regarding presentation content and any member needs that they have encountered regarding Health Education services.			<ul style="list-style-type: none">Alliance Care Management teamAlliance QIPH Department OrientationAlliance Enhanced Care Management TeamAlliance Quality and Health Programs team new hiresAlliance Healthy Equity team new hire Dignity Health Merced staff				Additionally, in Q3 the project team presented to external audiences including 2 Merced County Provider sites. These presentations inform Alliance provider site teams of the services available to members accessing services at their clinics.
3. On a quarterly basis, inform members of Health and Wellness programs and self-management tools available to them in 2024.	<div>1. The project team will conduct outreach and education activities to inform members of services available to them via:<ul style="list-style-type: none">Member outreach callsMember workshopsMember mailingsMember newsletter articlesMSAG presentation</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	Veronica Lozano, Quality and Health Programs Supervisor Health Educator team Desirre Herrera, Quality and Health Programs Manager	<div>The following activities were completed in Q3 to inform members of Health and Wellness programs:</div> <ul style="list-style-type: none"><u>Member Newsletter</u>: The project team included 2 articles in the September 2024 Member Newsletter informing members of health education programs available to them including Healthy Moms and Healthy Babies, Healthy Weight for Life and member incentives.<u>Member outreach calls</u>: The Health Education team completed 2,451 outreach calls in Q3 to offer members health and wellness programs.	No issues to report in Q3.	<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 December 2024 Member Newsletter.</div>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<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 to ensure questions on program enrollment can be answered.</div> <div>In Q3 the Health Education Line received 878 incoming calls from members, providers and the community regarding Quality and Health Programs services.</div> <div>Additionally, the Health Educators received 231 PCP referrals to health education services in Q3.</div>

4.	On a quarterly basis, collect member feedback from participants in chronic disease management and wellness programs to evaluate impact.	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> 2. Request input from members regarding program and services.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Kevin Lopez, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager	Surveys with members will be completed in Q4.	Surveys were delayed due to timeline of NCQA consultant review of surveys which are included in larger Population Health Management Impact report.	Surveys with members will be completed in Q4.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Surveys were delayed due to timeline of NCQA consultant review of surveys which are included in larger Population Health Management Impact report. Surveys will be completed in Q4.
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 8 member workshops were coordinated in Q3. The following workshop modalities and languages were provided: <div><div>• 3 virtual Healthier Living Program (HLP) groups. 2 English, 1 Spanish.</div><div>• 1 virtual Live Better with Diabetes (LBD) group in Spanish.</div><div>• 1 in-person Healthier Living Program (HLP) in Spanish in Merced County (Planada).</div><div>• 1 in-person Healthier Living Program (HLP) in Spanish in Monterey County (CCAH Salinas).</div><div>• 1 virtual Healthy Weight for Life (HWL) group in English.</div><div>• 1 telephonic Live Better with Diabetes (LBD) group in English.</div></div>	No issues to report in Q3.	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 continues to experience high interest in member workshops.



SECTION 3: SAFETY OF CLINICAL CARE

FACILITY SITE REVIEW (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. 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. Enhance provider scheduling support by onboarding three additional QI RNs dedicated to conducting facility site reviews.</div> <div>2. Implement proactive planning by reviewing all upcoming site reviews one quarter in advance.</div> <div>3. Streamline scheduling by offering provider sites a selection of review dates two months before the review due date.</div> <div>4. Maintain continuous communication with provider sites until a review date is confirmed.</div>	07/01/2024-09/30/2024	Joana Castaneda, Quality Improvement Program Advisor, Tisha Criswell Senior Quality Improvement Nurse	<div>1. Achieved goal with a result of 15 out of 16 reviews completed (94%).</div> <div>2. Recruitment is underway for three FSR positions.</div> <div>3. Q4 reviews were proactively assessed during Q3 for planning.</div> <div>4. Initial communications have been sent to providers regarding Q4 reviews.</div>	To ensure adequate staffing levels, the organization has approved two new positions and one backfill position for an FSR nurse who resigned in Q3.	<div>1. Ongoing collaboration with HR to recruit three QI RN positions for FSR.</div> <div>Maintain communication with providers with site reviews due in Q4, ensuring follow-up on date selection until each review date is confirmed.</div>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	In the recruitment phase for hiring (3) FSR nurses.
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. Enhance CAP management support by onboarding three additional QI RNs for facility site reviews.</div> <div>2. Send email reminders to provider sites regarding upcoming CAP due dates.</div> <div>3. Directly contact non-responsive providers via phone, involving PRRs as necessary.</div>	07/01/2024-09/30/2024	Tisha Criswell Senior Quality Improvement Nurse	<div>1. Achieved goal results of 5 out of 12, or 42%.</div> <div>2. Currently in the recruitment phase for three FSR positions.</div> <div>3. Reminders regarding upcoming due dates have been sent to providers with CAPs.</div>	To ensure adequate staffing levels, the organization has approved two new positions and one backfill position for an FSR nurse who resigned in Q3.	<div>1. Ongoing collaboration with HR to recruit three QI RN positions for FSR.</div> <div>2. Maintain consistent communication with providers regarding CAP due dates.</div> <div>Follow up with non-responsive providers</div>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Historically, the site, resulting in the delay of seven CAPs, has successfully consolidated all FSRs and MRRs, enabling timely CAP closures without issue. For recent reviews conducted in Q3, each FSR and MRR

						through direct phone calls involving PRRs as needed.		were coordinated directly with the Director of QA, who initially expressed difficulty completing the CAP due to a preference for unified training across the seven sites. In response, the CAP deadline was extended by Alliance FSR to October 10th, which the site’s Director of QA approved. Despite this extension, follow-up was sparse after the October 10th deadline, prompting the Alliance FSR nurse to close new member linkage on October 22 nd for the seven sites.
4.	4.						<input type="checkbox"/> Yes <input type="checkbox"/> No	Subsequently, the Alliance Provider Representative reached out to arrange a meeting with the site’s team; however, no response was received. Delays appear related to prolonged policy and leadership approvals. Moving forward, a revised approach has been agreed upon: reviews will start with a single site, allowing a month’s lead time for all other sites to develop CAPs and ensure readiness for the subsequent sites.

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 concerning potential medical quality of care issues are resolved within the regulatory timeframes for Member Grievances.	2. Establish due dates in SharePoint for PQIs that allow sufficient time for investigation, translation needs (if applicable), and for the Grievance Coordinator to resolve the case. 3. Promptly request medical records necessary for the PQI	07/01/2024-09/30/2024	Emily Kaufman, Clinical Safety Supervisor, Eleni Pappazisis, Quality Improvement Program Advisor, Naomi Kawabata, Senior Quality Improvement Nurse Nurse, Katie Lutz, Quality Improvement Nurse, Sandy Clay Senior Quality Improvement Nurse, and Bethany Fung, Quality Improvement Nurse	1. Achieved goal results of 100%, with all 127 cases closed on time. 2. Due dates have been established in SharePoint to facilitate the closure of regulatory PQIs.	1. Ensure staffing levels are adequate to balance regulatory PQIs, internal PQI referrals, collaborative efforts, and quality studies to enhance the quality of care for members.	2. Continue establishing due dates in SharePoint to prioritize promptly closing regulatory-based PQIs. 3. Maintain the practice of requesting medical records as needed for investigations to ensure timely case closures.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Recruiting one PQI nurse to backfill the position following the internal promotion to PQI Supervisor.

	investigation upon case assignment to the QI RN. 4. Ensure timely coordination of discussions if the case requires MD guidance or potential P2/P3 recommendations.			3. The QI RN requested medical records promptly for PQI investigations. 4. Timely discussions were conducted with MDs regarding P2/P3 cases.		4. Conduct weekly MD meetings to discuss potential P2/P3 cases requiring guidance, ensuring that these discussions do not hinder timely case resolution.		
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: <div> a. Known provider to tracking and trending. b. Provider on a CAP or involved in an open Quality Study c. LTSS member </div>	01/01/2024 – 03/29/2024 3/31/204,6/30/2024 9/30/2024,12/31/2024	Eleni Pappazisis, Quality Improvement Program Advisor, Naomi Kawabata, 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. Achieved goal results of 73%, with 24 out of 33 cases closed on time. 2. The team effectively triaged and prioritized incoming internal referrals for the following case types: <div> • Known providers for tracking and trending. • Providers on a CAP or involved in an open Quality Study. • LTSS members. </div>	1. Ensure staffing levels are adequate to balance regulatory PQIs, internal PQI referrals, collaborative efforts, and quality studies to enhance the quality of care for members.	2. Triage incoming 90-day referrals promptly. 3. Temporarily decline collaborative work and be selective about participating in Quality Studies until the team can achieve 100% compliance in closing regulatory and internal referral PQIs.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	PQI observed substantial progress in closing internal referrals within 90 days, highlighting advancements in key performance metrics. Recruitment efforts are currently focused on hiring a PQI nurse to backfill the internal promotion to PQI Supervisor. We expect that onboarding this new hire will further enhance the timely closure of referrals.
3:	3.						<input type="checkbox"/> Yes <input type="checkbox"/> No	

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. c. Track and trend grievance data by demographics including language to analyze disparities. d. Identify actionable opportunities for improvement	04/01/2024-6/30/2024 3/31/204,6/30/2024 9/30/2024,12/31/2024	Sarah Sanders, Grievance and Quality Manager	Q3 updates: SGRC for 8/1 and 10/3 QIHEW 8/21 Q2 & Q3: June staffing deficiency & preparations for CMSR (Jiva) system replacement to ensure regulatory compliance.	Q3: Staffing deficiency impacted regulatory timeframes.	Continue monitoring regulatory compliance and trends. Active staffing recruitment planned for Q3-24 to ensure appropriate staffing to support regulatory compliance.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Close monitoring, communications and tracking of AG occurred
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.	04/01/2024 – 06/30/2024	Sarah Sanders, Grievance and Quality Manager	Q3 updates: n/a		QI action and monitoring for responsiveness	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

	b. Track grievance and appeals for access/QOC trends, system issues, and identify actionable corrections needed.	3/31/2024,6/30/2024 9/30/2024,12/31/2024						
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.	04/01/2024 – 06/30/2024 3/31/2024,6/30/2024 9/30/2024,12/31/2024	Sarah Sanders, Grievance and Quality Manager	Q3: Accuracy achieved. *Note updates to MCPD implemented for Q3.	Q3: n/a	Monitor for data to ensure new benefit types pulled for required MCPD reporting.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	New benefits added to the tableau reporting suite.
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.	04/01/2024 – 06/30/2024 3/31/2024,6/30/2024 9/30/2024,12/31/2024	Sarah Sanders, Grievance and Quality Manager	Q3: Discrimination reviews completed	Q3: n/a	Monitor outliers	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Results Achieved.

COC OF MEDICAL & BEHAVORIAL HEALTH (REBECCA MCMULLEN)								
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
1. Increase Utilization of BH benefit overall by 2.5% within the Behavioral health network in Merced County, from a baseline of 4.07% by 12/31/2024, by increasing provider and member education about BH benefits offered	-At minimum, annual BH team member attendance at PAG and QIHEC meetings to discuss BH services -At minimum, annual BH team member attendance at MSAG or other similar member forums to discuss BH services such as WCM advisory committee -Quarterly attendance at ER JOC meetings by BH team member to address questions related to BH benefit -increase in provider outreach and education via provider newsletters -Promotion of BH services at outreach activities (at least 3) in Merced County annually. -Meet with Delegate (Carelton) monthly and MHPs at minimum quarterly to track and discuss appropriate referrals and transitions to the NSMHS benefit. Outreach and engage local Merced Eds in collaboration on referrals to BH care.	By 10/31/2024 Attended by 2/8/2024 Ongoing, started 5/1/2024 By 12/31/2024 Ongoing, started in 5/1/2024 Ongoing, started 1/1/2024 By 12/31/2024	- Rebecca McMullen, BH Manager and/or Shae Redwine, BH Analyst - Communications department manager, Provider Services Manager, Member Services Manager	Q3 update: -BH Manager presented on BH benefits to MSAG group in 2/2024 and will present again in 2025. -BH Manager presented on BH benefits to WHM advisory committee in 3/2024 -BH Manager and QI presented at PAG in 5/2024 on current BH measures, including discussion from providers related to BH benefit -BH Manager attended outreach event in Merced County in 5/2024 on BH benefits -BH Managers invited to several of the hospital JOC meetings, where psychiatric hospitalizations (FUA FUM measure) were discussed. -Weekly meetings with Carelon to review data on BHT referrals and linkage to care, specifically. - BH Managers met with Monterey group of pediatricians in 9/2024 to discuss BH services	-Lack of accessible in person appointments within 10 business days for many BH providers/members not having initial appointment occur within 10 business days - Discovery of pending BHT referrals through Carelon not linked to services in a timely manner -BH team informed by BH providers of difficulty with credentialing timelines and referral questions -Local Eds lacking engagement and awareness of most appropriate referral options for BH care. -From Q4 2023 to Q3 2024, Merced County Membership for CCAH reduced by 2000 members	-BH services will be insourced in 7/2025 with goal to increase utilization and member and provider experience. -By 1/1/25, BH, along other applicable departments, will coordinate around annual communication to members and providers to ensure they are aware of BH benefits -BH Manager working with Carelon to update BHT referral form for ease of use for providers to reduce incomplete referrals and members not being linked to services. -Monthly meetings to continue with Carelon for ongoing monitoring of BHT data referrals. -BH Manager to meet monthly with Merced BHRS team to discuss Coordination of care for ED members and engage with local ED on outreach and referrals for BH care.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	The reason why goal was not met is due to several factors related to lack of education of BH benefit to members and providers, lack of available providers in the BH space, difficulty referring members to the BH benefit and lack of follow through on referrals submitted incorrectly or with insufficient information.

				<div>-Carelton to provide the BH service until 6/30/25</div> <div>-Workgroup started with Merced BHRS in 6/2024 on high utilizers and ED visits.</div> <div>-CCAH BH Manager attended in person collaborative to discuss with Merced BHRS high utilizers and ED visits and possible interventions in ED for BH needs.</div> <div>-Outreach events attended by BH manager in our 2 new counties</div> <div>-CCAH BH Manager attended AHEAD conference in Merced at Merced BHRS with other community entities</div>		<div>- BH team to coordinate presentation date in Q1 or Q2 at MSAG on BH benefits.</div>		
							<div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>	
							<div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>	
							<div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>	



SECTION 4: MEMBER EXPERIENCE

MEMBER SATISFACTION SURVEY – CAHPS (SARINA KING)								
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	Medi-Cal CAHPS were fielded in Q3 2024 and CG CAHPS fielding began.	Previously fielding was not always completed in a timely manner which led to delayed results.	<ul style="list-style-type: none"> Medi-Cal CAHPS results processed and shared 	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Creating the workflows and timelines and coordinating with all involved parties led to do timely fielding of the Medi-Cal and CG CAHPS surveys.
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 1. Begin outreach to chiefs/admins to present CAHPS overview and high-level rates to organization at all-staff or division meetings	3/1/2024 – 10/31/24 Same timeline as above	Sarina King, Quality Performance Improvement Manager	In Q3 2024, MY2023 surveys were fielded, and results calculated.	Current issues that we are working through involve getting organizational involvement and alignment on CAHPS interventions based on previous MY results.	Prepare MY2023 results and present to Operations Committee.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	We have continued to lay the groundwork for organizational support and alignment to focus on CAHPS interventions. Once we have MY23 results, we will be sure to add the interventions to the workplan and measure specific improvement efforts.



SECTION 4: QUALITY OF SERVICE

ACCESS & AVAILABILITY (AA) (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 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	<div>Q3: PAAS vendor has begun the provider outreach. Current completion metrics are greater for CY 2024 than CY 2023.</div> <div>There are currently 4 weeks remaining of outreach to be performed by vendor ForisMazars, set to be complete by November 15, 2024</div>	none	Q4: complete PAAS survey and report outcomes.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	PAAS vendor has begun the provider outreach. Currently completion metrics are greater for CY2024 than CY2023. There are still multiple weeks remaining for outreach to be performed by vendor ForisMazars, and is set to be complete prior to the end of the year.
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	<div>Q3: Review and any outcomes. Based on the policy standards, are well within compliance for provider to member ratios for all provider types, minus two. Out of compliance with:</div> <div><div>- Internal Medicine- 1:2,000 is target ratio for compliance: Reported ratio is 1:2,559 for Medical</div></div>	none	<div>- Inform Grants of specialties where we aren't in compliance.</div> <div>- Inform Network Develop Team of necessary new specialties for recruitment.</div> <div>Continue monitoring quarterly for compliance.</div>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Current metrics are in line with requirements, except Allergy & Immunology and Internal Medicine. Next Steps will be taken during Q4.

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.	1. The Call Center is continuously monitoring this metric as it is also included on the Operational Dashboard. Improvement efforts slated for 2024: <ul style="list-style-type: none">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.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.Developing additional call circles (queues) to:Optimize resource availability.Improve speed to answer.Reduce representative training time.Increase member satisfaction.Computer Telephone Enhance HSP/Finesse	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Veronica Olivarria, MS Call Center Manager Lilia Chagolla, Member Services Director	Goal not met (63%). The call center has hired additional staff to support the calls and member walk-in volume. Coordinate lunch and break schedules to maximize the peak/busy times. Assign staff to support offices to assist member walk-ins. Eliminate unnecessary meetings and focus meetings/training on business needs. Call Center Supervisors review Queue data throughout the day to determine if changes need to be made for the day - such as schedules. Trainings coordinated in small teams to maximize service level.	Quarter 1 is the busiest time of the year in the Call center, the company was also in a Common Spirit negotiation that impacted 7600 members and the Call center was short staffed. Q2- we hired an additional 5 MSR's that helped maximize coverage and increase service level to 90% and higher monthly. Q3- We hired 2 Call Center Supervisors, 2 FTE's and onboarded 2 Temps Reps to back fill for staff who recently promoted to other departments. ns	The Call Center team will continue to ensure we are fully staffed by continuing to review the needs of our callers and ensure our staff have the most current resources and/or trainings.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	This goal has been successful in increasing every month by ensuring we are fully staffed to meet the needs of our membership and ensuring Alliance staff are informed and trained about the services available to members. We are currently in the process of reviewing a new phone system and a Workforce management tool. Call center Supervisors are focused on coaching real time, ensuring resources are available and HSP updates are current to allow staff to focus on the needs of the caller.

	<div>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. Integration:</div> <div><div>○</div>Assess staffing needs due to increase in membership</div>							
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 Lilia Chagolla, Member Services Director	Goal not met (63%) The call center has hired additional staff to support the calls and member walk-in volume. Coordinate lunch and break schedules to maximize the peak/busy times. Assign staff to support offices to assist member walk-ins. Eliminate unnecessary meetings and focus meetings/training on business needs. Call Center Supervisors review Queue data throughout the day to determine if changes need to be made for the day - such as schedules. Trainings coordinated in small teams to maximize service level.	Q1 is the busiest time of the year in the Call center, the company was also in a Common Spirit negotiation that impacted 7600 members and the Call center was short staffed. Q2- we hired an additional 5 MSR’s that helped maximize coverage and increase service level to 90% and higher monthly. Q3- Onboarded 2 Call Center Supervisors, 2 FTE’s and 2 Temps Reps to back fill for staff who recently promoted to other departments.	Working on additional FTEs and moving call quality auditing to MS Ops team, WFM tool to be implemented with new phone system.	<div><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</div> <div><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</div>	This goal has been successful in increasing every month by ensuring we are fully staffed to meet the needs of our membership and ensuring Alliance staff are informed and trained about the services available to members. We are currently in the process of reviewing a new phone system and a Workforce management tool. Call center Supervisors are focused on coaching real time, ensuring resources are available and HSP updates are current to allow staff to focus on the needs of the caller.
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 at least 1 C&L services presentations to Alliance internal department staff that interact with members to increase awareness of C&L services available for members.	1. The C&L team will reach out to internal departments that interact with members. Examples: <div><div>a. QIPH new hire orientation</div><div>b. Member Services team</div><div>c. Care Coordination team</div><div>d. Community Engagement team</div></div> 2. Schedule C&L services presentation3. 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 4 presentations on C&L services were coordinated and completed in Quarter 3 . Presentations were delivered to the following audiences: <ul style="list-style-type: none">QIPH department orientationNew hire – Health Equity teamNew hires – QHP teamMember Services Advisory Group (MSAG)	No issues to report in Q3.	The project team will continue to coordinate presentations for internal departments and Alliance staff in 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 utilizing at least 1 member informing modality.	1. The C&L team will conduct outreach and education activities to inform members of services available to them via: <div><div>a. Member newsletter articles</div><div>b. MSAG presentation</div></div> 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 Q3 to inform members of C&L Services: Member Services Advisory Group (MSAG) presentation – In August 2024 the C&L team provided an overview of language assistance services to the MSAG. Information about services was shared and the C&L team gathered input regarding services for members and how to improve them. One suggestion was to increase awareness of the services among the Alliance provider networks.	No issues to report in Q3.	The project team will work on planning efforts to increase awareness of language assistance services to the provider network.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	MSAG provided feedback to increase awareness among the provider network about language assistance services available.
3. On a quarterly basis, collect member feedback on their experience with language assistance services in a clinical setting.	1. The project team will conduct satisfaction surveys with members to evaluate: <div><div>a. Individual ratings of access to language services.</div><div>b. Overall rating of interpretation services.</div><div>c. Access to language services at a health care encounter.</div><div>d. Gather individual experiences with the services.</div></div> 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	Surveys with members will be completed in Q4.	Surveys were delayed due to timeline of NCQA consultant review of surveys which are included in larger Health Equity evaluation report.	Surveys with members will be completed in Q4.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Surveys were delayed due to timeline of NCQA consultant review of surveys which are included in larger Health Equity evaluation report. Surveys will be completed in Q4.

4. Increase provider utilization of language assistance services quarterly by a minimum of 5% in comparison to 2023 baseline utilization data.	<div>1. The project team will track utilization for the following services:<ul style="list-style-type: none">Phone interpreting services.Face-to-Face (F2F) interpreting services.</div> <div>2. Use quarterly utilization data to identify potential need to training of provider network on language assistance services.</div>	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	Provider Utilization for Q3 was as follows: Phone interpreting services: There was a total of 6,697 total calls in Q3 by provider sites. This reflects an increase of 16% compared to Q3 in 2023. Face-to-Face (F2F) interpreting services: There was a total of 1,742 requests in all service counties for F2F in Q3 . This reflects an increase of 42% compared to Q3 in 2023. <ul style="list-style-type: none">Santa Cruz County had 656 requests in Q3. This was a 35% increase compared to Q3 2023.Merced County had 591 requests in Q3. This was a 20% increase compared to Q3 2023.Monterey County had 494 requests in Q3. This was a 64% increase compared to Q3 of 2023.San Benito County had 1 request in Q3. This is a new service county and there was no comparison for 2023.Mariposa County had 0 requests in Q3. This is a new service county and there was no comparison for 2023.	No issues to report in Q3.	The utilization data from Q1-Q3 reflects very low to no utilization of in-person/F2F interpreting services in the new expansion counties. The C&L team will reach out to the Provider Relations team to share this information and inquire how to best support the providers in the expansion counties with language assistance services access.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	There continues to be increases in utilization of language assistance services by providers in 2024 compared to 2023. The utilization data for Q1-Q3 show little to no utilization of language assistance services in the new expansion counties. The C&L team will work with the Provider Relations team to address this gap.
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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, Quality Improvement & Population Health Director	1. All delegate reports for the 1 st 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
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	2. All delegate reports for the 1 st 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	

			Programs Manager. Andrea Swan, Quality Improvement & Population Health Director	3. No issues with delegate reports. QIPH working with Compliance to ensure all delegate reports meet NCQA requirements.				
3.	3.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	4.						<input type="checkbox"/> Yes <input type="checkbox"/> No	