

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. 2 nd 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 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	

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

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	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.		Intervention planning underway	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Overall, all roll-out goals have been met. Practices benefiting from constant collaboration with QIPA staff (2 liaisons per site). Education is an overwhelming gap identified and requested for CCAH assistance.
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. 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	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. Topic tracker has been drafted to assist identifying standing agenda items and future topics based on priorities. 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	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

<p>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>				<p>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>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.	<div>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.</div> <div>2. Develop workflow to extract and generate additional columns that note members meeting continuous enrollment specifications to applicable monthly Provider Portal Quality reports.</div> <div>3. Create business requirements to add trending graphs to monthly quality reports.</div> <div>4. Create business requirements to add a Gaps in Care report.</div> <div>5. Create business requirements to generate email reminders for portal reports for providers.</div>	<div>1/1/2024-3/31/2024</div> <div>1/1/2024-6/30/2024</div> <div>6/30/2024-12/31/2024</div> <div>4/1/2024-12/31/2024</div>	Alex Sanchez, Quality Improvement Program Advisor, Magdalena Kowalska, Quality Improvement Program Advisor, Shannon Fletcher, Quality Improvement Program Advisor, Annecy Majoros, Quality Improvement Program Advisor	<div>1. Roll-up function has been deployed on the Provider Portal Quality Reports in Q1 2024.</div> <div>2. Work for business requirements completed in Q2 2024.</div> <div>3. Business requirements completed and submitted to ITS in Q1 2023.</div> <div>4. Work to start in Q2 2024.</div> <div>5. Completed draft language in Q1 2024.</div>	<div>Competing priorities for staff, and limited staffing available to build and test reports.</div> <div>Limited visual and report functionalities of the provider portal.</div>	<div>1. No further action required.</div> <div>2. Submission of portal tickets, development, and testing.</div> <div>3. Development and testing.</div> <div>4. Development of business requirements by QIPH, development of report by ITS, and QA by QIPH.</div> <div>5. Continued discussions with staff from Provider Services and Quality Improvement and Population Health on portal feature development, then</div>	<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.

		4/1/2024-12/31/2024				development and testing of the function.		
		1/31/2024-3/31/2024						
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.	Bandwidth of staff to complete the training videos in competition with regulatory and other project obligations.	Development in Q2-Q3 coding training resources.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Planned activities were updated to combined the training videos for the CBI introduction, DST and provider portal reports into one training video for ease of use by provider clinics.

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. 2. A minimum of 2 presentations will be conducted per quarter.	1. The project team will reach out to internal departments that interact with members. Examples of teams: <ul style="list-style-type: none"> a. Health Education team b. Member Services team c. Care Coordination team d. Community Engagement team 2. Schedule presentations 3. Deliver Health Education and Member Health Rewards services presentation. 4. Request input regarding presentation content and any member needs that they have encountered regarding Health Education 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	A total of 6 presentations on Health Education services and Member Health Rewards were coordinated and completed in Quarter 1. Presentations were delivered to the following audiences: <ul style="list-style-type: none"> Member Services Call Center representatives Merced County Provider meeting Provider Relations team new hire Case Management teams Community Engagement team new hires Livingston Community Health Call Center staff 	In Q1 we were training and onboarding new staff. As we entered Q2 were able to offer and schedule more presentations.	The project team will continue to coordinate presentations for internal departments and Alliance staff in Q3. A minimum of 2 presentations on Health Education Services and Member Incentives will be completed in Q3. Additionally, team members will explore offering the presentation to external audiences in Q3-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. Additionally, in Q2 the project team presented to external audiences including Merced County provider representatives and at a Merced County site Livingston Community Health.

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:<div>a. Member outreach callsb. Member workshops c. Member mailings d. Member newsletter articles e. MSAG presentation</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>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 Q2 to inform members of Health and Wellness programs:</div> <div><div>• <u>Member Newsletter:</u> The project team included 1 article in the June 2024 Member Newsletter informing members of member incentive programs available to them.</div><div>• <u>Member outreach calls:</u> The Health Education team completed 671 outreach calls in Q2 to offer members.</div></div>	No issues to report in Q2.	<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 September 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 Q2 the Health Education Line received 903 incoming calls from members, providers and the community regarding Quality and Health Programs services.</div>
4. On a quarterly basis, collect member feedback from participants in chronic disease management and wellness programs to evaluate impact.	<div>1. The project team will conduct satisfaction surveys with members to evaluate:<div>a. Information about the overall program b. Usefulness of the information shared. c. Percentage of members indicating that the program helped them achieve health goals.</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&L Program Advisor</div> <div>Desirre Herrera, Quality and Health Programs Manager</div>	<div>The member survey efforts are under review with NCQA Health Plan accreditation consultants. There were no additional surveys completed in Q2 after the in the last report.</div> <div>Once NCQA consultants approve the report and surveys submitted additional outreach be completed. This is anticipated for Q3 and Q4.</div> <div>In the previous report, member feedback surveys were completed in Q2 to evaluate services in Q1. These were included in the Q1 report.</div> <div><u>Member Satisfaction Surveys completed in Q1-Q2:</u></div> <div>The project team completed a total</div>	In Q2 the member survey data collected was reported and shared with NCQA consultants. The approval for the report is in progress. Once approved, surveys will continue with members in Q3.	Once NCQA consultants approve the reporting metrics the project team will continue to proactively reach out to members via outreach calls to request member feedback via satisfaction surveys.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Member feedback surveys were placed on hold in late Q2 in order to allow time for NCQA Health Plan accreditation consultants to review the data collected. Once approved surveys with members will continue.

				of 44-member experience surveys.				
<div>4. On a quarterly basis increase the number of member workshops provided by the Health Education Team in comparison to 2023 baseline.</div> <div>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.</div>	<div>1. The Health Educators will conduct a minimum of 4 member workshops per quarter.</div> <div>2. Health Educators will lead recruitment and outreach efforts to members to enroll in the programs.</div> <div>3. Health Educators will lead.</div>	3/31/2024, 6/30/2024, 9/30/2024, 12/31/2024	<div>Veronica Lozano, Quality and Health Programs Supervisor</div> <div>Health Educator team</div> <div>Desirre Herrera, Quality and Health Programs Manager</div>	<div>A total of 5 <u>member workshops</u> were completed in Q2. The following workshop modalities and languages were completed:</div> <div><ul style="list-style-type: none">2 virtual Live Better with Diabetes (LBD) groups (1 English, 1 Spanish)1 telephonic Healthier Living Program (HLP) group in Spanish2 virtual Healthy Weight for Life (HWL) groups (1 English, 1 Spanish)</div>	No issues to report in Q2.	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

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: 11/13 or 85%</div> <div>2. Worked with HR to develop FSR-specific position description and will post (2) FSR positions in Q3 2024.</div> <div>3. Upcoming reviews for Q3 have been reviewed for planning in Q2.</div> <div>4. Communications to providers for Q3 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>2. Communicate with providers with site reviews due in Q3 regarding date selection until a date is confirmed.</div>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Preparation for hiring (2) FSR positions has taken longer than anticipated. However, having FSR-specific position descriptions outlining DHCS expectations and maintenance of certification and IRR participation, as outlined in APL 22-017, was critical for job requirements.
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: 11/12 or 92%</div> <div>2. Worked with HR to develop FSR-specific positions and will post (2) FSR positions in Q3 2024.</div> <div>3. Communications were sent to providers with CAP to remind the site of due dates.</div> <div>4. (1) provider was reported to DHCS for failed Medical Record Review (MRR) CAP in Q2. Emails, letters, phone calls, and PRR involvement were used as interventions.</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>2. Continue communication with providers regarding CAP due dates.</div> <div>3. Address any non-responsive providers with direct phone</div>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Failed CAP Timeline: 1. 1/11/24 MRR 62%, 1 st failure. PRR was made aware of MRR results and CAP. 2. 1/15/24 MRR CAP issued due 2/26/24. 3. 1/16/24 key stakeholders in the organization were made aware of the provider's MRR results and to freeze membership. 4. 1/23/24: incomplete CAP response submitted by

						calls and PRR involvement.		the provider. 5. On 2/21/24, the provider was sent a letter (PRR cc'd) of the upcoming CAP due date for all XAP elements. 6. The provider states he is in Mexico for a family emergency and will complete it by 5/3/24. 7. 5/6/24: Letter sent by MD regarding CAP. 8. 5/13/24 CAP closed and verified. 9. On 7/26/24, DHCS was notified of the failed CAP submission outside of the due dates outlined in APL 22-017. 10. Focused Review is due by 1/11/25.
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	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. Goal results: 100%; 98/98 of 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.	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. Identification of LTSS members. We are implementing a retrospective review approach (vs. proactive identification) based on claims reports for PQIs investigated that quarter for DHCS Critical Incident reporting.	3. Continue creating due dates in SharePoint to prioritize promptly closing regulatory-based PQIs. 4. Continue requesting medical records when needed for investigation and timely case closure. 5. Continue weekly MD meetings to discuss potential P2/P3 cases requiring guidance not to inhibit timely case closure. 6. Continue retrospective review approach to capture LTSS members for DHCS Critical Incident reporting pending brainstorming with key departments to develop a “flag” in HSP or JIVA.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Project work with Health Services Operations regarding LTSS implementation of APLs 23-004, 023, and 027.
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:	01/01/2024 – 03/29/2024	Eleni Pappazisis, Quality Improvement Program Advisor, Naomi Kawabata, Senior Quality Improvement Nurse, Emily Kaufman, Senior Quality Improvement Nurse, Katie Lutz, Quality Improvement	1. Goal results: 57%; 20/30 cases closed on time. 2. The team triaged and prioritized incoming internal	1. Staffing to balance regulatory PQIs, internal PQI referrals, collaboration work, and/or quality studies focused on	1. Continue to triage incoming 90-day referrals.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	QI RNs prioritize regulatory PQIs based on member complaints. This prioritization and

	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.	3/31/204,6/30/2024 9/30/2024,12/31/2024	Nurse, Sandy Clay Senior Quality Improvement Nurse, and Bethany Fung, Quality Improvement Nurse	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	improving the quality of care for members.	2. Decline collaborative work and be selective regarding Quality Studies until the team can close regulatory and internal referral PQIs at 100% compliance. 3. Consider revising the PQI policy to expand the due date to 120 days.		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.
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	01/01/2024 – 03/29/2024 3/31/204,6/30/2024 9/30/2024,12/31/2024	Sarah Sanders, Grievance and Quality Manager	Q2 updates: SGRC for 2/15 & 4/11 QIHEW 2/29 & 5/29 Q2: June staffing deficiency & preparations for CMSR (Jiva) system replacement to ensure regulatory compliance.	Q2: n/a	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. 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	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.	01/01/2024 – 03/29/2024	Sarah Sanders, Grievance and Quality Manager	Q2: Accuracy achieved.	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 & MCPD

	b. Evaluate and identify opportunities to improve the data accuracy of AG information.	3/31/204,6/30/2024 9/30/2024,12/31/2024		*Note updates to MCPD to expand benefit types for AG proposed by DHCS for Q3 implementation				benefit additions planned for go-live in Q3-24.
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	Q2: Discrimination reviews completed	Q2: 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 -Meet with Delegate (Carelton) monthly and MHPs at minimum quarterly to track and discuss appropriate referrals and transitions to the NSMHS benefit.	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	- Rebecca McMullen, BH Manager and/or Shae Redwine, BH Analyst - Communications department manager, Provider Services Manager, Member Services Manager	Q2 update: -BH Manager presented on BH benefits to MSAG group in 2/2024 -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, along with other alliance and carelon staff, in 7/2025 to discuss BH services and referral process and barriers. -Carelton to provide the BH service until 6/30/25 -Workgroup started with Merced BHRS in 6/2024 on high utilizers and ED visits	-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	-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. -Weekly meetings to continue with Carelon at minimum through August and into September 2025 for ongoing monitoring of BHT data referrals. -BH Manager to meet with Monterey Pediatrician team again in 9/2025 for follow up on BH services.	<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.

				-Outreach events attended by BH manager in our 2 new counties				
							<input type="checkbox"/> Yes <input type="checkbox"/> No	
							<input type="checkbox"/> Yes <input type="checkbox"/> No	
							<input type="checkbox"/> Yes <input type="checkbox"/> No	



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	Medicaid fielding has been completed. IHSS fielding ended 8/5. Benchmark results are expected in Q4.	Previously fielding was not always completed in a timely manner which led to delayed results.	<ul style="list-style-type: none"> Medicaid fielding stops – CG CAHPS planning begins. ECHO CAHPS planning for MY2024 begins. Results will be received and shared in Q4/Q125 	<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 Medicaid and IHSS 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 Q2, meetings with Member Services and Provider Services Directors were held to discuss results and interventions.	Current issues that we are working through involve getting organizational involvement and alignment on CAHPS interventions based on previous MY results.	Work with the Project Management Office and the executive leadership team to get organizational support on MY 2023 CAHPS interventions.	<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

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">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:<ul style="list-style-type: none">Optimize resource availability.Improve speed to answer.Reduce representative training time.Increase member satisfaction.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.Computer Telephone Integration: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.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Veronica Olivarría, MS Call Center Manager Lilia Chagolla, Member Services Director	<p>Goal not met (63%).</p> <p>The call center has hired additional staff to support the calls and member walk-in volume.</p> <p>Coordinate lunch and break schedules to maximize the peak/busy times.</p> <p>Assign staff to support offices to assist member walk-ins.</p> <p>Eliminate unnecessary meetings and focus meetings/training on business needs.</p> <p>Call Center Supervisors review Queue data throughout the day to determine if changes need to be made for the day - such as schedules.</p> <p>Trainings coordinated in small teams to maximize service level.</p>	<p>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.</p> <p>Q2- we hired an additional 5 MSR's that helped maximize coverage and increase service level to 90% and higher monthly.</p> <p>Q3- We hired 2 Call Center Supervisors and a Call Center Manager.</p>	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. 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	<p>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.</p> <p>We are currently in the process of reviewing a new phone system and a Workforce management tool.</p>

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- We hired 2 Call Center Supervisors and a Call Center Manager.	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	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.
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 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 <u>3 presentations</u> on C&L services were coordinated and completed in Quarter 2. Presentations were delivered to the following audiences: <ul style="list-style-type: none">Care Management teamsProvider Relations team new hireCommunity Engagement team new hires	In Q1 we were training and onboarding new staff. As we entered Q2 were able to offer and schedule more presentations.	The project team will continue to coordinate presentations for internal departments and Alliance staff in Q3. A minimum of 1 presentation on C&L Services will be completed in Q3. Additionally, team members will explore offering the presentation to external audiences in Q3-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. In Q3-Q4 we will explore increasing awareness for network providers.
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: <ul style="list-style-type: none">a. Member newsletter articlesb. MSAG presentation 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 Q2 to inform members of C&L Services: <u>Social Media Post:</u> In April 2024 language assistance services were highlighted on the Alliance Facebook page.	No issues to report in Q2.	The project team will continue to collaborate with internal departments to ensure members are informed of language assistance services.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Social media posts allow members to be informed on a larger scale and when the social media post is clicked it leads members to our Alliance website for additional information.
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">a. Individual ratings of access to language services.b. Overall rating of interpretation services.c. Access to language services at a health care encounter.d. Gather individual experiences with the services. 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 member survey efforts are under review with NCQA Health Equity accreditation consultants. There were no additional surveys completed in Q2 after the in the last report. Once NCQA consultants approve the report and surveys submitted additional outreach be completed. This is anticipated for Q3 and Q4. In the previous report, member feedback surveys were completed in Q2 to evaluate services in Q1. These were included in the Q1 report. <u>Member Satisfaction Surveys completed in Q1-Q2:</u> The project team completed a total of 53 member experience surveys.	n Q2 the member survey data collected was reported and shared with NCQA consultants. The approval for the report is in progress. Once approved, surveys will continue with members in Q3.	Once NCQA consultants approve the reporting metrics the project team will continue to proactively reach out to members via outreach calls to request member feedback via satisfaction surveys.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Member feedback surveys for C&L services was placed on hold in late Q2 in order to allow time for NCQA Health Equity accreditation consultants to review the data collected. Once approved surveys with members will continue.
4. Increase provider utilization of language assistance services quarterly by a minimum of 5% in comparison to 2023 baseline utilization data.	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. 2. Use quarterly utilization data to identify potential need to training of provider network on language assistance services.	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 Q2 was as follows: <u>Phone interpreting services:</u> There was a total of 6,904 total calls in Q2 by provider sites. This reflects an increase of 45% compared to Q2 in 2023. <u>Face-to-Face (F2F) interpreting services:</u> There was a total of 1,542 requests in all service counties for	No issues to report in Q2.	The project team will review Q1-Q2 utilization data to identify potential need for training on language assistance services of providers in Q3-Q4.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	There were significant increases in utilization of language assistance services by providers in Q1-Q2 2024 compared to Q1-Q2 of 2023. According to the data there is little

5.	Establish baseline rate, and demographic profile of members who utilize interpreter services to determine any disparity to help determine additional interventions.				<p>F2F. This reflects an increase of 18.65% compared to Q2 in 2023.</p> <ul style="list-style-type: none"> <u>Santa Cruz County</u> had 627 requests in Q2. This was a 35% increase compared to Q2 2023. <u>Merced County</u> had 507 requests in Q2. This was a 20% increase compared to Q2 2023. <u>Monterey County</u> had 404 requests in Q2. This was a 2% decrease compared to Q2 of 2023. <u>San Benito County</u> had 4 requests in Q4. This is a new service county and there was no comparison for 2023. <u>Mariposa County</u> had 0 requests in Q2. This is a new service county and there was no comparison for 2023. 				utilization in the new service counties. The C&L team will reach out to collaborate with the Provider Relations team to ensure the providers in the new service counties are familiar with the language assistance services for Alliance members.
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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 Programs Manager. Andrea Swan, Quality Improvement & Population Health Director	2. All delegate reports for the 1 st quarter were received and reviewed with no gaps identified. 3. No issues with delegate reports. QIPH working with Compliance to ensure all delegate reports meet NCQA requirements.	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	

