

Q4 2023 QIHET Workplan

Topic	Health Care Collaboratives - feedback from community engagement	Topic	Controlling Blood Pressure
Status	Goal Not Met	Status	Goal Partially Met
Topic	Health Services Division Member Outreach & Engagement Campaigns	Topic	Diabetes HbA1c >9% (poor control)
Status	Goal Met	Status	Goal Met
Topic	Member Support - Call Center	Topic	Women's Health Domain SWOT
Status	Goal Met	Status	Goal Met
Topic	Cultural and Linguistics (C&L) Services & Population Needs Assessment Education	Topic	Childhood Immunizations
Status	Goal Met	Status	Goal Met
Topic	CAHPS: How Well Doctors Communicate	Topic	Children's Domain SWOT
Status	Goal Not Met	Status	Goal Met
Topic	Annual Access Plan	Topic	Child and Adolescent Well-Care Visits in Merced County
Status	In Progress	Status	Goal Met
Topic	Provider Choice: In-Area Market Share	Topic	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) measure
Status	In Progress	Status	Goal Met
Topic	CAHPS Survey: Access Measures	Topic	Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total and Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total
Status	Goal Not Met	Status	Goal Met
Topic	Provider Satisfaction	Topic	Eating Disorders
Status	Goal Met	Status	Goal Partially Met
Topic	Under / Overutilization	Topic	Grievance and PQI Management
Status	Goal Met	Status	Goal Partially Met
Topic	Site of Care	Topic	Facility Site Review (FSR) Management
Status	Goal Met	Status	Goal Partially Met
Topic	Drug Utilization Review (DUR)		
Status	Goal Met		
Topic	Health Education and Disease Management		
Status	Goal Met		

PROGRESS SUMMARY

66%

Percent Complete

Composite Score

4

Sections above target

Q4 2023 QIS Workplan

SECTION 1: MEMBER EXPERIENCE

A: MEMBER EXPERIENCE

Topic	Health Care Collaboratives - feedback from community engagement
Domain	Member Experience
Priority	Alliance Operating Plan
Committee	MSEC
Goals	Determine baseline performance by calculating the number of ideas acted upon by the organization (as defined by: assessing feasibility of, starting or completing a project, taking direct action) against of ideas brought back to the organizations by Community Engagement Team from Health Care Collaborative meetings
Opportunities for Improvement	Staff input to the status report forms has not been consistent and my need leadership support.
Results Q4	0
Summary of Quarterly Activities Narrative	Metric has been canceled and will not be measured moving forward.
Known Barriers/Root Cause(s) (as applicable)	Adequate staff to perform activities
Next Steps	this metric will be rolled up into Organizational actions taken by all member voice.

Topic	Health Services Division Member Outreach & Engagement Campaigns
Domain	Member Experience Quality of Care Quality of Service
Priority	Core
Committee	QIHET-W, MSEC
Goals	Member outreach is critical to inform, foster dialogue, and support at risk Alliance members. Member outreach will consist of calling members impacted by the emergent issues, impact on access to care, and member voice assessments. Mobilize an internal team to identify members, develop scripting and information of appropriate resources and health education, and conduct telephonic outreach to high-risk, vulnerable members.
Opportunities for Improvement	Activities: 1. In 2023, track and monitor all ad hoc member outreach and engagement campaigns 2. Track each campaigns intervention, percentage of successful calls (information provided/LVM) vs. unsuccessful calls, and member counts 1. Coordinated collaboration with multiple sources in the development of member written materials and staff talking points 2. Development of member roster lists with the verification if there is more than one member in the same household on the list 3. Identification of the right level of staff to support these outreach campaigns (i.e., clinical vs. non-clinical) 4. Coordinated approach for documenting, tracking, and reporting the outcome of each outreach call 5. Develop enough time to train staff on talking points and new outreach campaigns
Results Q4	0%
Summary of Quarterly Activities Narrative	There were no ad-hoc member outreach campaigns completed in Q3 or Q4 2023.
Known Barriers/Root Cause(s) (as applicable)	Not applicable this quarter.
Next Steps	Teams are preparing for 2024 contract requirements and county expansion. If new member outreach campaigns are identified they will be reported accordingly.

Topic	Member Support - Call Center
Domain	Member Experience
Priority	Regulatory (DHCS)
Committee	MSEC
Goals	1. 95% of Calls to Member Services Answered Before Being Abandoned 2. 80% of Calls to Member Services Answered Within 30 Seconds
Opportunities for Improvement	Identify additional barriers to being able to continuously meet this requirement.
Results Q4	1. 97% 2. 86%
Summary of Quarterly Activities Narrative	During Q4 2023 the Alliance Member Services' Call Center focused on sharing redetermination information with members and ensuring that their mailing address is up updated. We have also started to receive calls from expansion members and have been providing them with basic Alliance information.
Known Barriers/Root Cause(s) (as applicable)	
Next Steps	Keep eye on member walk-in volume

Topic	Cultural and Linguistics (C&L) Services & Population Needs Assessment Education
Domain	<div>Member Experience</div> <div>Quality of Care</div> <div>Quality of Service</div>
Priority	Regulatory (DHCS)
Committee	QIHET-W
Goals	<p>To measure the performance of the Alliance C&L Services program and to make improvements accordingly (measure utilization per County).</p> <ol style="list-style-type: none"> 1. Increase Provider Utilization of the Alliance Language Assistance Services program by 5% when compared to the previous year 2. Increase the Alliance network provider's familiarity with the Alliance Language Assistance Services Program
Opportunities for Improvement	<p>Effective communication is critical for our members to ensure understanding, empowerment and provide high-quality care. The Alliance Language Assistance Services program ensures that Alliance members receive high-quality and appropriate language services by reducing health disparities related to language/cultural barriers.</p> <ol style="list-style-type: none"> 1. Explore the effectiveness of cultural competency services provided by the Alliance in ensuring that members receive high-quality, person-centered care and identifying opportunities for improvement where necessary 2. Monitor telephonic interpreting, face-to-face interpreting, translations, and readability requests 3. Monitor member and provider complaints and PQIs 4. Develop a Health Literacy Tool kit for the organization (PNA) 5. Collaborate with PS in the development and launching of provider cultural competency training (PNA) 6. Implement audio interpreting services for Telehealth visits 7. Promote the Alliance Language Assistance Services with our external network providers (i.e., quarterly fax blasts, training videos to support providers on how to use the services) (PNA)
Results Q4	11.33%
Summary of Quarterly Activities Narrative	<p>In Q4 2023 there was a 11.3% total increase compared to Q4 of 2022 of providers utilizing face-to-face (in-person) interpreting services.</p> <p>County specific data for face-to-face interpreting services was as follows: Merced County had 4.18% increase in Q4 2023 compared to Q4 2022 Santa Cruz County had 58.77% increase in Q4 2023 compared to Q4 2022 Monterey County had 50.29% increase in Q4 2023 compared to Q4 2022</p> <p>For telephonic interpreting services the data is not broken down by county. In Q4 2023 there was a 25.82% increase of providers and staff utilizing telephonic interpreting services compared to Q4 2022.</p>
Known Barriers/Root Cause(s) (as applicable)	<p>In Q4, there was a significant decrease in Monterey County face-to-face interpreting services utilization, as well as a significant increase in Santa Cruz County utilization. There was an increase in telephonic interpreter usage, which could be another reason for the decrease in face-to-face interpreting services usage. Merced and Monterey County continue to show an increased utilization for face-to-face interpreting services. The C&L team will continue to monitor utilization rates to ensure member access.</p>
Next Steps	<p>In Q4 the C&L team worked on county expansion efforts with vendors to ensure access to interpreting services in the new counties starting in 2024. All vendors, apart from United Way (which only serves Merced), have confirmed capacity within the new expansion counties. In 2024 Q1, the C&L team will continue to work closely with our interpreting vendors to address any language access gaps that may arise</p>

Topic	CAHPS: How Well Doctors Communicate
Domain	<div>Member Experience</div>
Priority	Regulatory (DHCS)
Committee	QIHET-W, MSEC
Goals	<ol style="list-style-type: none"> 1. Achieve 94.4% (BoB SRS) in How Well Doctors Communicate - Child 2. Achieve 92.7% (BoB SRS) in How Well Doctors Communicate - Adult
Opportunities for Improvement	Assess CAHPS surveys administered in 2022 for MY 2021, determine goals, and identify any improvements
Results Q4	<p>December 2023 newsletter included information on ASL interpreters and contact information for our Cultural and Linguistics Services team.</p> <p>Results for MY 2022 are below.</p> <p>Adult - 91.6% (flat from 91.5% in 2022) btw 25th-50th %tile nationally Child- 91.7% (down from 93.1% in 2022) below 25th %ile nationally. This was identified as one of our lowest performing measures for this population.</p>
Summary of Quarterly Activities Narrative	<p>December 2023 newsletter included information on ASL interpreters and contact information for our Cultural and Linguistics Services team.</p> <p>MY 2022 results were received and presentations are being created to share out organizationally.</p>
Known Barriers/Root Cause(s) (as applicable)	<p>The results of the child survey for this particular question were lower for Spanish Speakers, which made up 63% of respondents and rated this question 90.6% versus the aggregate 91.7%. The results were lowest in SC County at 89.2% and highest in Merced at 93.0%. There were multiple other areas including rating of personal doctor and rating of specialist, rating of health care, and rating of health plan customer service that also fell year over year, especially among Spanish Speakers.</p>
Next Steps	Report out the results to relevant stakeholders and develop a plan to address the results in 2024.

SECTION 2: QUALITY OF SERVICE

B: ACCESS & AVAILABILITY

Topic	Annual Access Plan
Domain	Member Experience Quality of Care Quality of Service
Priority	Regulatory, Core
Committee	NDSC
Goals	The Annual Access Plan focus areas and improvement goals are established in January of each year and are solidified by the NDSC. The 2023 Access Plan goals will be finalized in January 2023.
Opportunities for Improvement	The Access Plan will articulate identified areas within the Alliance provider network where targeted activities can increase or enhance choice and/or access. The 2023 improvement opportunities will be identified in January 2023.
Results Q4	The committee further discussed recruitment prioritization and socialized Provider Satisfaction Survey data which offers additional insight on the providers perception of access to care for their members.
Summary of Quarterly Activities Narrative	Working w/ NDSC attendees to develop criteria to assist in ensuring appropriate prioritization of access plan focus areas.
Known Barriers/Root Cause(s) (as applicable)	TBD
Next Steps	

Topic	Provider Choice: In-Area Market Share
Domain	Member Experience Quality of Service
Priority	Regulatory, Core
Committee	NDSC
Goals	1. 80% Market Share (PCP and Specialist) target with 75% lower threshold 2. Market Share stability with a no more than 5% decrease annually.
Opportunities for Improvement	1. Credential non-credentialed providers practicing at contracted locations. 2. Engage providers who have historically declined to contract.
Results Q4	Efforts were focused largely on the recruitment of providers in and around Mariposa and Benito counties to support service area expansion.
Summary of Quarterly Activities Narrative	St. Michael Nephrology agreed to contract with the Alliance in the San Luis Obispo area. Additionally a new psychiatrist in SLO also agreed to contract. Both providers have historically declined to contract with the Alliance.
Known Barriers/Root Cause(s) (as applicable)	Difficulty obtaining timely credentialing applications for new or existing providers, priority to engage new entities in contracting over credentialing providers at existing contracted sites.
Next Steps	

Topic	CAHPS Survey: Access Measures
Domain	Member Experience Quality of Service
Priority	DHCS
Committee	HDC, QIHET-W, QIHET-C
Goals	1. Achieve 86.7% (C) 80.9% (A) (BoB SRS) in Getting Care Quickly for Child and Adult CAHPS 2. Achieve 84.4% (C) 82.3% (A) (BoB SRS) or hold steady at the 50th percentile in Getting Needed Care for Child and Adult CAHPS
Opportunities for Improvement	Assess CAHPS surveys administered in 2022, determine goals, and identify any improvements
Results Q4	Care gap clinics and grants to fund locum providers and staff overtime were rolled out in Q4. 1. Getting Care Quickly measured at 75.9% for the Adult Survey and 82.3% for the Child Survey in 2023. Although the question saw an increase in performance for adults from 73.4% in 2022, the survey sample was exponentially larger which shows the measure declining overall. Both measures were below the NCQA Quality Compass national benchmark. 2. Getting Needed Care was measured at 78.9% for the Adult survey and 79.4% for the Child Survey in 2023. Among the Medicaid Child population, Getting Needed Care had one of the biggest decreases compared to last year. Both measures were below the NCQA Quality Compass national benchmark.
Summary of Quarterly Activities Narrative	MY 2022 results were received and presentations are being created to share out organizationally. Locum provider grants were funded for multiple providers in Merced County to close care gaps. Merced County providers were chosen because this is where our biggest disparities are and the most opportunity to raise health equity and bring preventative services to members who struggle with access.
Known Barriers/Root Cause(s) (as applicable)	Provider availability is one of the biggest known barriers. By funding additional provider availability we are aiming to improve access and close care gaps.
Next Steps	Share the results with our provider network team and work collaboratively to address the issues in 2024.

C: PROVIDER EXPERIENCE

Topic	Provider Satisfaction
Domain	Quality of Service
Priority	Regulatory, Core
Committee	HDSC
Goals	Target of 88% of surveyed providers who are satisfied with the Alliance (annual measure based on Satisfaction Survey); lower threshold is 79.2%.
Opportunities for Improvement	Engage more providers in responding to the annual survey; continue to explore new or evolved questions to best inform the Alliance as to feedback in targeted areas
Results Q4	2022 results were 87% overall satisfaction with the Alliance
Summary of Quarterly Activities Narrative	Results final, presented to NDSC and CQIW-I in December. Overall Provider Satisfaction for 2022 was 87%.
Known Barriers/Root Cause(s) (as applicable)	None
Next Steps	

SECTION 3: QUALITY OF CLINICAL CARE

D: UTILIZATION

Topic	Under / Overutilization
Domain	Clinical Safety Quality of Care Quality of Service
Priority	Regulatory
Committee	UMWG, QIHET-W, QIHET-C, Program Integrity/Compliance Committee, Claims, Advanced Analytics, Health Services Finance Collaborative, PS/HS Collaborative
Goals	An interdepartmental over/underutilization report will be developed by December 31, 2023.
Opportunities for Improvement	<ol style="list-style-type: none"> Coordinated collaboration with all sources of monitoring for over and underutilization. Linking reporting from multiple sources to ensure compliance with monitoring.
Results Q4	Q4 UMWG data reflects the following Claims activity, with percentages measured against Claims activity in prior quarter (Q3 2023). ACE at 14,090 claims, a 15.9% increase over prior quarter (n=12,162). Breast Cancer Screening at 6,823 claims, a 35.5% increase over prior quarter (n=5,035). Colorectal Cancer Screening at 6,426 claims, a 31.6% increase over prior quarter (n=4,882). EMG at 336 claims, a 31.2% increase over prior quarter (n=256). Initial Health Assessment at 76,464 claims, a 18.2% increase over prior quarter (n=64,692). Lead Screening in Children at 5,157 claims, a 8.2% increase over prior quarter (n=4,765). Depression screening remains unchanged from prior quarter and likely reflects incomplete capture of screening activity with new metric, consistently noting fewer than 50 claims/quarter.
Summary of Quarterly Activities Narrative	Report finalized in Q1 and metrics updated for UMWG quarterly reporting. Continued

Topic	Site of Care
Domain	Clinical Safety Member Experience Quality of Care
Priority	Organizational Tactic
Committee	P&T, CQIC
Goals	<ol style="list-style-type: none"> Perform Site of Care outreach to 50% of Site of Care eligible members on targeted drugs in a form of informational letter and infusion provider phone calls. Determine any barriers for Site of Care transition from members, prescribing providers, and infusion providers perspective.
Opportunities for Improvement	<ol style="list-style-type: none"> Improve access to home infusions and outpatient infusion center infusions for members. Develop infusion provider and member relationship, which can eventually improve medication adherence and health outcomes.
Results Q4	100%
Summary of Quarterly Activities Narrative	Q4: We collected ideas for how to improve our Site of Care program for 2024.
Known Barriers/Root Cause(s) (as applicable)	<ol style="list-style-type: none"> Pharmacy staffing Insufficient Home infusion and outpatient infusion contracted providers Hospital contract limiting transition of infusions out of Hospital based outpatient infusions center. Difficult to find the best contact information for providers. Administrative tasks such as setting up member/provider letters and referrals are time consuming. Tableau reports take time to create and modify. The members who have declined the program have done so for multiple reasons, including not wanting anyone in their home or they would like to continue at their current site of care because they receive other services from that site at the same time. It takes a long time for the prescribers to send clinical information and medication orders to the infusion pharmacy. The infusion pharmacy must follow up with the provider multiple times to obtain all the necessary information from the prescriber.
Next Steps	We will decide on what changes we would like to implement for our Site of Care program.

Topic	Drug Utilization Review (DUR)
Domain	<div>Clinical Safety</div> <div>Member Experience</div> <div>Quality of Care</div>
Priority	Regulatory
Committee	P&T, QIHET-W
Goals	<p>1. Perform retrospective drug utilization review on a quarterly basis, to assure that drug utilization is appropriate, medically necessary, and not likely to result in adverse events.</p> <p>2. Based on DUR, provide active and ongoing outreach to educate providers on common drug therapy problems (e.g., new prescribing guidelines and advisories) with the goals of improving prescribing and dispensing practices, increasing medication compliance, and improvement of over-all member health.</p>
Opportunities for Improvement	Improve awareness among members on providers on any drug utilization is not in line with current clinical guidelines.
Results Q4	89%
Summary of Quarterly Activities Narrative	<p>Q4:</p> <p>Drug utilization review was performed to evaluate the persistence of beta-blocker treatment after a heart attack. 74% of members who had a heart attack received a beta-blocker. A Provider Digest on "Beta-blocker use after myocardial infarction (MI) per AHA/ACC guidelines" was published to educate providers on AHA/ACC guidelines to reinforce appropriate beta-blocker prescribing after heart attack.</p> <p>Drug utilization review was performed to evaluate antipsychotic medication use in children. In 2022, 550 pediatric members were on an antipsychotic. We investigated the top medications and the top providers, and the conclusion was that there were no prescribing concerns.</p> <p>Two separate drug utilization reviews were performed to evaluate all members on 30 days or longer of overlapping opioid and sedative hypnotics therapy and opioid and benzodiazepine therapy. Of the 240 members with overlapping therapy, we identified 6 high-risk members who had 90MME per day or greater and did not have naloxone co-prescribed. Targeted outreach was performed to the prescribers of the 6 high-risk members to encourage therapy re-evaluation, tapering, and/or discontinuation of medications if appropriate and recommend co-prescribing naloxone. A Provider Flash was also published to all providers about risks of opioid and CNS depressants and tools for tapering and motivational interviewing.</p> <p>Drug utilization review was performed to evaluate the percentage of older adults (65 and older) with chronic kidney disease (CKD) who had filled a prescription for non-steroidal anti-inflammatory drugs (NSAIDs) during the year 2022. The results showed that about 11% received at least one prescription for NSAIDs. Majority of the members had only one fill mainly after procedures. Only 3 providers had members who were filling their NSAIDs on regular basis. A reminder article about appropriate use of NSAIDs in CKD is going to be published in Provider Digest.</p> <p>Drug utilization review was performed to evaluate the percentage of members 5–64 years of age with persistent asthma who had a ratio of controller medication to total asthma medications of 50% or greater during the year 2022. The average AMR for all counties was 79%. A subgroup of adolescents across all 3 counties were identified with lower-than-normal AMR ratio. 42 of those members had filled 4 or more rescue inhalers and no controller medication. These members were referred to care management to contact and counsel as needed. A targeted email was sent to the provider to offer them Pharmacist-Led Academic Detailing regarding new asthma guidelines and updates in the field. A Member News is expected to be posted on the Alliance website.</p>
Known Barriers/Root Cause(s) (as applicable)	<p>1. Limitation in report generation, requiring manual analyses that are time-consuming.</p> <p>2. Competing priorities for pharmacists.</p> <p>3. Limited access to relevant clinical information, such as stage of their chronic kidney disease as no eGFR was available.</p> <p>4. Medi-Cal Rx report had errors that prevented further analyses.</p>
Next Steps	<p>Q4: For 2024, pharmacists will be working with Advanced Analytics to automate many of the analyses for better efficiency. DUR topics are being reassessed to meet regulatory and contractual requirements while addressing competing priorities.</p>

E: ADULT PREVENTIVE CARE SERVICES

Topic	Health Education and Disease Management
Domain	Member Experience Quality of Care Quality of Service
Priority	Regulatory (DHCS)
Committee	QIHET-W
Goals	To increase member self-efficacy in performing self-management behaviors by having members participate in the Alliance Healthier Living Program. (Chronic Disease Self-Management Program)
Opportunities for Improvement	<ol style="list-style-type: none"> 1. By December 31, 2023, at least 50% of participants in the Healthier Living Program will have scored "Good/Very Good/Excellent" for their ability to manage their chronic health conditions after the workshop 2. Overall increasing improvements of the scores (i.e., poor to fair) <ol style="list-style-type: none"> 1. Increase participation in the Healthier Living Program workshop by prompting the member incentive and offering different format options. (Telephonic, virtual, and in-person) 2. Coordinated collaboration with multiple sources to ensure to expand the quality improvement system in the community by having a greater presence and promoting Alliance quality initiatives related to wellness and health promotion
Results Q4	78%
Summary of Quarterly Activities Narrative	In Q4 the Quality and Health Programs team completed 3 Healthier Living Program workshops series. The workshop was offered in three different modalities - virtual, telephonic and in-person in Salinas.
Known Barriers/Root Cause(s) (as applicable)	There were no barriers to delivering this workshop series.
Next Steps	The QHP team has started to prepare for Q1 2024 workshops and discuss outreach strategies to engage members from the new service counties.

Topic	Controlling Blood Pressure
Domain	Quality of Care
Priority	Regulatory (DHCS Health Equity Goals), HEDIS
Committee	QIHET-W
Goals	<ol style="list-style-type: none"> 1. Support the Pharmacy Team in initiating the Pharmacist-Led Academic Detailing Hypertension Program which will decrease the percentage of members with uncontrolled blood pressures (or BP greater than or equal to 140/90). 2. Identify a health care systems willing to partner with the Alliance team in implementing an evidenced based practice for members with Hypertension. 3. By 12/31/2023, the Santa Cruz County Clinics proportion of patients with BP at goal (or less than 140/90) will increase from 52% to 57%.
Opportunities for Improvement	<ol style="list-style-type: none"> 1. Improving accurate BP readings will allows clinical interventions such as the Pharmacists-Led Academic Detailing Hypertension Program to be more effective in improving BP control in members with uncontrolled hypertension. 2. Increase members that are accurately identified as having hypertension. 3. For those members with hypertension established accurate readings support the clinical management of the patient. 4. Establish this best practice in a busy ambulatory care center.
Results Q4	<ol style="list-style-type: none"> 1. Goal not met - pharmacy hypertension program planning is in progress. 2. Goal partially met - Santa Cruz County Clinics decided against participating in the new PLAD Hypertension program. Instead, requesting a one-time clinician focused training around the latest hypertension guidelines to be completed on 11/15/23. 3. Goal met - Santa Cruz County Clinics Q3 2023 CBI CBP (reported in Q4 2023) = 66.09%
Summary of Quarterly Activities Narrative	<ol style="list-style-type: none"> 1. Project placed on hold until June while continuing to track BP recheck rates monthly. 2. Per check-in with provider over the summer, they are not interested/able in a full PLAD project. Instead, requesting a one-time clinician focused training around the latest hypertension guidelines completed on 11/15/23.
Known Barriers/Root Cause(s) (as applicable)	
Next Steps	PLAD Hypertension program planning has been in progress and will continue in 2024.

Topic	Diabetes HbA1c >9% (poor control)
Domain	Quality of Care
Priority	Regulatory (DHCS Health Equity Goals), HEDIS
Committee	QIHET-W
Goals	<ol style="list-style-type: none"> 1. Identify a health care system willing to partner with the Alliance team in implementing clinical practice recommendations on the latest pharmacologic recommendations for managing members with Diabetes Type II (ADA 2023: Pharmacologic Approaches to Glycemic Treatment) 2. Support the Pharmacy Team in initiating the Pharmacist-Led Academic Detailing Diabetes Program which will decrease the percentage of members with uncontrolled diabetes (or A1c > 9%).
Opportunities for Improvement	<ol style="list-style-type: none"> 1. Opportunities to engage with a practice with a cohort of members with DM and interest in improving and/or expanding services to these members. 2. For those clinics who do not have a member recall process for routine diabetes care follow-up, provide practice coaching to empower the clinic to develop a sustainable system. 3. Opportunity to connect members to Diabetes Self-Management Education (DSME) and grow our network of Certified Diabetes Educators.
Results Q4	<ol style="list-style-type: none"> 1. Goal met in Q1 2. Goal met in Q4. PLAD programs with DoD, Gettysburg, and Dr. Thao have been completed.
Summary of Quarterly Activities Narrative	<ol style="list-style-type: none"> 1. Conduct clinic outreach to identify clinics interested in program participation. 2. Develop/modify program content to meet clinic requests. 3. Meet with clinics to schedule PLAD program. 4. Generate registry list of members to track A1C and f/up visits throughout program. 5. Complete session with clinic. 6. Gather pre-post session data to analyze.
Known Barriers/Root Cause(s) (as applicable)	<ol style="list-style-type: none"> 1. Clinics are currently struggling to maintain staff and continue to care for members with COVID. 2. Limited capacity at many primary care offices to adopt a new initiative. (For some clinics (i.e. CSVS) have had to modify the intervention by limiting the number of sessions and allowing a larger group sizes to participate) 3. Limited network of accessible Certified Diabetes Educators. 4. Alliance members have few resources, may be limited to not having safe areas for physical activity or support to prepare healthy meals.
Next Steps	<ol style="list-style-type: none"> 1. Gather data to analyze pre-post session, program, and A1c data. 2. Planning for Q1 2024 CBI PLAD Program.

F: PERFORMANCE IMPROVEMENT PROJECTS (STATE MANDATED)

Topic	Women's Health Domain SWOT
Domain	Quality of Care
Priority	Statewide DHCS Performance
Committee	QIHET-W
Goals	<p>To increase Breast Cancer Screening and Chlamydia Screening rates by providing practice coaching and learning collaboratives to support provider implementation of QI interventions, and supporting providers through Alliance member recall and health education.</p> <ol style="list-style-type: none"> 1. By 11/11/2022 Submission 1 Technical Assistance PRN. 2. By 1/30/2023 Strategies, measurable action items and short-term objectives. 3. By 5/30/2023 Progress on strategies and action items. 4. By 9/30/2023 Progress on strategies and action items.
Opportunities for Improvement	<p>I. The Alliance created a Care-Based Quality Improvement Program (CB QIP) with the aim to provide financial investment for practices to make quality improvement interventions. This program is designed to assist practices who are performing below minimum performance levels (MPL) on prioritized MCAS measures to make sustained improvements in staffing, processes, and technology. The application opened to eligible contracted network providers on March 14, 2023 and closed on May 19th, 2023 with a total of 44 applications. Only one eligible provider chose to not apply to the program.</p> <p>II. Three providers have been selected for targeted outreach.</p> <p>III. Black members had the lowest rate of screening of all racial/ethnic groups in 2021 for BCS. Facilitate targeted mailing for this population to educate and to notify member of screening recommendations.</p>
Results Q4	DHCS concluded all SWOT activities on September 29th, 2024. No SWOT activities were required in Q4.
Summary of Quarterly Activities Narrative	<p>-- Golden Valley Health Center Merced has agreed to partner on improving breast cancer screenings in collaboration with their Care-Based Quality Improvement Project application. QIPH is continuing outreach for another clinic to partner on breast cancer screenings. QIPH will provide practice coaching, best practice information and a member recall list for clinics to outreach to members.</p> <p>-- Apex Medical Group has agreed to partner on chlamydia screenings. Merced Faculty Associates - North is requesting their leadership's approval to partner on chlamydia screenings. QIPH will provide practice coaching, best practice information and a member recall list for clinics to outreach to members.</p> <p>-- Member letters drafted and USPSTF flyer decided as outreach flyer for Black members for BCS mailer.</p> <p>-- For Q2 QIPH provided best practices information and slide presentations for Golden Valley Health Center and Merced Faculty Associates to get leadership approval to participate in SWOTs. Golden Valley Health Center is working with their operations team to create a team to work on the Breast Cancer Screening SWOT. QIPH met with Apex to address questions on the project, and provided best practice information.</p> <p>-- For Q3 QIPH provided member recall rosters for Apex Medical Group and MFA North showing members due for chlamydia screening and well-visits. Worked with GVHC to identify barriers within organization to implement member recall rosters in coordination with QI and Care Management teams. Worked with QI department to review member recall roster for potential exclusions to upload to the Alliance's Data Submission Tool for compliance.</p> <p>-- For Q4 QIPH met with DHCS, reviewing and concluding all SWOT activities. No further SWOT actions required.</p>
Known Barriers/Root Cause(s) (as applicable)	<p>-- Due to QIPH staff limitations it was decided to focus on increasing breast cancer screening and chlamydia screening rates.</p> <p>-- QIPH staff has competing priorities with the completion of CB QIP applications and being low staffed.</p> <p>-- Breast Cancer Screenings: having difficulty getting an additional clinic to partner on increasing breast cancer screenings. Looking at clinics who have chosen this measure as part of the CB QIP application and have low rates.</p> <p>-- Since chlamydia screenings population starts at age 16, it is a hard population to call in for screenings since outreach goes to the member, not the parent/guardian. QIPH will be focusing on members who have not had their well-visit for 2023, and educating partnering clinics to screen all members for Chlamydia screening with the option to opt out.</p> <p>-- For Q3 staffing heavily impacted all interventions due to staff on leave or loss of staff. MFA was assigned a CAP from FSR team and focused efforts on addressing CAP before working on intervention project. GVHC departments work in silo; QI comes up with interventions and then has challenges getting the necessary staff to implement intervention. GVHC has also taken on a lot of projects and is over stretched.</p> <p>-- For Q4 no SWOT activities were required.</p>
Next Steps	<p>-- Reach out to additional clinics to partner on increasing breast cancer screening rates.</p> <p>-- Create PowerPoint presentation for MFA to take to leadership to get their approval to partner with QIPH.</p> <p>-- Generate member lists and provide best practice information.</p> <p>-- For Q2 QIPH will continue to meet with clinics to address barriers and provide updated member lists based on member enrollment.</p> <p>-- For Q3 QIPH will continue to meet with clinics and address barriers, and provide updated member recall lists as needed.</p> <p>-- For Q4 no SWOT activities were required.</p>

Topic	Childhood Immunizations
Domain	Quality of Care
Priority	Statewide DHCS PIP
Committee	QIHET-W
Goals	1. By April 21, 2023, complete final modules for DHCS PIP and summarize outcomes.
Opportunities for Improvement	1. For those providers who indicated that they do not have a member recall process for immunizations (Provider Access Survey), provide practice coaching to empower the clinic to develop a sustainable system. 2. Flu vaccinations are the limiting vaccine in CIS compliance; therefore, conducting focus groups to further understand the root causes of flu vaccine hesitancy in Merced County may help to develop more effective interventions.
Results Q4	N/A
Summary of Quarterly Activities Narrative	HSAG's final validation findings on the CIS PIP was received on 6/12/23 and no further submissions were required. Project completed.
Known Barriers/Root Cause(s) (as applicable)	Goal 1: No Barriers.
Next Steps	Project completed.

Topic	Children's Domain SWOT
Domain	Quality of Care
Priority	Statewide Department of Healthcare Services (DHCS) Performance
Committee	QIHEW
Goals	1) Outreach to high risk racial ethnic groups in Merced County who are deficient in CIS and/or W30 to address barriers to care and connect member with PCP. 2) Provide education on children's preventative services to Merced County clinics to support clinic staff in becoming subject matter experts (SME) for their clinic. 3) Support practices in maximizing data optimization through the Alliance Portal to prompt providers to order all recommended preventative services.
Opportunities for Improvement	1. By 11/11/2022 Submission 1 Technical Assistance PRN. 2. By 1/30/2023 Strategies, measurable action items and short-term objectives. 3. By 5/30/2023 Progress on strategies and action items. 4. By 9/30/2023 Progress on strategies and action items. Continue exploring options to collect direct member feedback on barriers to accessing care in Merced County.
Results Q4	All goals closed out in Q3.
Summary of Quarterly Activities Narrative	Q1-Q3: SWOT 1 Actions A-C: The Member Barrier outreach project was successful because we gained insight as to: - What the top barriers to accessing care were for this member sample. - The type of education QI PH needs to provide to parents/guardians to increase their understanding of the importance of regular well-child visits and timely immunizations. - Best practices when contacting members and sharing information regarding a potential or actual healthcare deficiency. These lessons learned will be taken into consideration for future outreach efforts made by QI PH staff. SWOT 2 Action A: Promoting the distribution and use of the Alliance's Infant Wellness Map (IWM) to Merced County CBOs, clinics, and members. This project was a success because QI PH staff successfully disseminated the tool in collaboration with the Merced County office of Education – Head Start Program and Merced County Public Health. Head Start received 200 copies of the IWM June 2023 (75 Spanish, 100 English and 25 Hmong) and are actively distributing the tool to their Alliance insured members. Additionally, staff have collaborated with Merced County Public Health, First Five of California, and Golden Valley Health Centers to host a Health Fair for the Merced community. The Health Fair occurred on 10/8/2023 and included: - An Alliance informational booth to pass out IWM. - Flu vaccinations, blood glucose checks, blood pressure checks, eye exams and more. - 35+ exhibitors with informational booths. - 'Passport' cards completed by visiting and learning about each exhibitor. - Completed cards can be entered into a raffle for prizes and a bonus raffle ticket is given to those that receive a flu vaccine at the fair. - Live radio broadcasting from a local Merced Spanish radio station. The flu vaccine has been a highlight for this Health Fair to raise awareness for the Merced community on the importance of flu vaccinations. SWOT 2 Action B: Pediatric Best Practices Webinar: This project was a success because we met our goal of conducting a live-session Pediatric Best Practices Webinar in Q3 of 2023 and exceeded the webinar attendance goal. 38 out of 69 (55%) external registrants attended from 35 different entities and clinics (including 19 from Merced County). The Pediatric Best Practices webinar was hosted by Dr. Carmela Sosa, a prominent and high-performing Merced County Pediatrician, with assistance from CCAH staff. The webinar recording is posted on the Alliance website as a resource for providers and office staff. The webinar content included: AAP Periodicity Schedule, Early Childhood & Adolescent Well Visits, Immunizations, Lead Screening, Fluoride Application, ACEs Screenings, Alliance Resources SWOT 3 Action A: Promote Healthcare Technology grants to Merced County physicians. This effort was a success because there were 3 entities from Merced County that applied for the Healthcare Technology Program grant; one application was approved, and two are pending. A grant of \$50,000 was awarded to Golden Valley Health Centers, who serves approximately 65,000 Alliance members within the county, to apply towards Epic Welcome & Tonic Health tablets for patient registration, scheduling, and health surveys and questionnaires. As of September 2023, there are 2 pending applications from Merced County providers that will be internally reviewed and, if recommended, go to the Board for approval in October.

SWOT 3 Action B:

As of 9/29/2023, staff has conducted Care Based Incentive (CBI) Forensic visits with 9 clinics from Merced Co. and anticipate further visits this year. In these visits, Alliance staff share our resources such as member incentives and provider portal reports, and discuss data for performance improvement. Additionally, QI PH will host a live-session 2024 CBI overview October 2023.

Q4: One final meeting with the DHCS closed the project on October 25, 2023 from the final submission on September 29, 2023..

Staff turnover, provider availability, member education

- Continue to promote and distribute the Infant Wellness Map in Merced County.
- Post virtual Pediatric Best Practices Webinar on Provider website.
- Continue to promote internal and external tech grants/funding to Merced County providers.

Known Barriers/Root Cause(s) (as applicable)

Next Steps

Topic	Child and Adolescent Well-Care Visits in Merced County
Domain	Quality of Care
Priority	Statewide Department of Healthcare Services (DHCS) Performance Improvement Project (PIP)
Committee	QIHET-W
Goals	1. By April 21, 2023, complete final modules for DHCS PIP and summarize outcomes: 2. WCV PIP SMART Goal: By December 31, 2022, use key driver diagram interventions to increase the percentage of child and adolescent members who receive at least one child and adolescent well-care visit with a PCP or OB/GYN practitioner during the intervention period among MCO members ages 3-17 years old, linked to Golden Valley Health Centers - Los Banos, from 32.65% to 48.56% (rate of peer benchmark [Taylor Farms Family Health & Wellness Center – Gonzales, CA] in Monterey/reference county).
Opportunities for Improvement	1. Providers need to block out time for dedicated staff to do recall outreach and schedule members who are non-compliant for a well care visit. 2. Prioritize health equity strategies by increasing outreach to populations with lower rates.
Results Q4	N/A - Project Completed; Goal Met on Q2
Summary of Quarterly Activities Narrative	Our final rate for the WCV PIP was 62.61%; 14.05% above our goal rate for this project. Module 4 was submitted to DHCS on April 21, 2023. DHCS provided validation findings on June 2, 2023. We met all requirements and given a High confidence level rating for this PIP. No further actions need to be taken; this PIP cycle is officially closed.
Known Barriers/Root Cause(s) (as applicable)	No barriers identified
Next Steps	None.

Topic	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) measure
Domain	Quality of Care
Priority	Statewide Department of Healthcare Services (DHCS) Clinical Performance Improvement Project (PIP) 2023-2026
Committee	QIHET-W
Goals	Reduce disparity in well-child visits in the first 15 months among Hispanic Population living in Merced County. 1. By quarter 3 2023, complete first modules for DHCS PIP.
Opportunities for Improvement	1. Prioritize health equity strategies by increasing outreach to populations with lower rates.
Results Q4	Initial validation of CCAH's 2023–26 Clinical PIP submission performed by the Health Services Advisory Group (HSAG) was shared with the health plan and resubmitted 11/1/23 with corrections to HSAG.
Summary of Quarterly Activities Narrative	2023-2026 DHCS W30-6 PIP submission was completed. Analysis performed to identify Merced providers with highest potential for impact. No further requirements from HSAG.
Known Barriers/Root Cause(s) (as applicable)	TBD
Next Steps	Pull baseline data for 2023 after year-end and allowing for claim lag (likely May 2024). Determine provider to work with on PIP.

Topic	Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total and Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total
Domain	Quality of Care
Priority	Statewide Department of Healthcare Services (DHCS) Non-Clinical Performance Improvement Project (PIP) 2023-2026
Committee	QIHET-W
Goals	By quarter 3 2023, complete first modules for DHCS PIP.
Opportunities for Improvement	<ol style="list-style-type: none"> 1. Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within 7 days of emergency department (ED) visit. 2. Increase data sharing to Behavioral Health Delegate.
Results Q4	<ol style="list-style-type: none"> 1. In progress. 11/29/23 resubmission of 2023-2026 Non-Clinical PIP Step 1-6 documents sent to HSAG and DHCS. 2. Successful. Initial ED notification file sent to Carelon in December 2023.
Summary of Quarterly Activities Narrative	<p>Validation of the 2023-2026 non-clinical PIP September submission was performed by the Health Services Advisory Group (HSAG) and shared with the health plan on October 30th. Alliance elected to set up a Technical Assistance (TA) call with HSAG and DHCS on 11/20/23 in advance for further clarification of project aim. PIP documentation for steps 1-6 were resubmitted on 11/29/23 with corrections to HSAG and DHCS.</p> <p>Discussions with delegated Behavioral Health provider Carelon have been ongoing, and an initial notification file was submitted to Carelon in December, identifying Alliance members in the emergency department with a substance use disorder or mental health diagnosis matching the FUA and FUM NCQA HEDIS specifications for the Medi-Cal Accountability Set (MCAS).</p>
Known Barriers/Root Cause(s) (as applicable)	Patient privacy concerns for protected health information created barriers for notifications.
Next Steps	<p>First Module submission due in September 2023.</p> <p>Resubmission in Q4 for validation findings from HSAG.</p> <p>Analyze initial and subsequent Emergency Department data notification process with Carelon and Behavioral Health team in early 2024.</p>

G: BEHAVIORAL HEALTH

Topic	Eating Disorders
Domain	Clinical Safety Member Experience Quality of Care Quality of Service
Priority	Operating Plan
Committee	UMWG, CQIC, Beacon Oversight Committee, Health Services Finance Committee
Goals	By December 21, 2023, improve workflow process for coordinating and expediting eating disorder referrals to Behavioral Health through pilot project and then scaling results to all counties.
Opportunities for Improvement	
Results Q4	As intended, the initiative has resulted in improved communication with county partners. Project to improve workflow process for coordinating and expediting eating disorder referrals, treatment and coordination is in process. Santa Cruz County Behavioral Health and Administration is following newly identified process and Alliance is reviewing and reimbursing per MOU.
Summary of Quarterly Activities Narrative	Designed and initiated a workflow and process with Santa Cruz County Behavioral Health and Administration.
Known Barriers/Root Cause(s) (as applicable)	Competing priorities for key project staff including JIVA and County Expansion.
Next Steps	Continue to engage in partnership discussions with County Mental/Behavioral Health department staff and leverage the information learned for process refinement.

SECTION 4: CLINICAL SAFETY

H: CLINICAL SAFETY

Topic	Grievance and PQI Management
Domain	Clinical Safety
Priority	Regulatory
Committee	QIHET-W
Goals	<ol style="list-style-type: none"> 1. By December 31, 2023, 100% of Potential Quality Issues (PQI) are completed within 90 calendar days of receipt. 2. By December 31, 2023, 100% member grievances opened as PQIs are closed within 30-days or less per regulatory requirement. 3. By December 31, 2023, quarterly MD IRR of QoS grievances shall be in 100% agreement, indicating QI RNs are resolving cases with consistent methodology. Quarterly MD IRR shall be a 10% sample of QoS Grievances resolved by QI RN.
Opportunities for Improvement	<ol style="list-style-type: none"> 1. Maintain adequate program staffing; expedite training of new hires. 2. Operational improvements.
Results Q4	<ol style="list-style-type: none"> 1. 154/154 (100%) PQIs were closed within the timeframe this quarter. 2. 17/18 (94%) of internally referred PQIs were completed within 90 calendar days, and 136/136 (100%) of Member Grievance PQIs were completed within 30 calendar days or less. 3. 36/36 (100%) of Quality of Service member Grievances will be audited by the Medical Directors.
Summary of Quarterly Activities Narrative	<ol style="list-style-type: none"> 1. The team continues participating in JIVA training and is working with Member Grievances regarding the QI RN Clinical Assessment elements that should transfer from Essette to JIVA. 2. The FSR team is migrating operational work to SharePoint for transparency of pending reviews, standardizing processes, and efficiency. 3. The PQI team has paused the automation of Track & Trend to Tableau due to the Clinical Safety QI Program Analyst being on leave of absence. 4. Staffing constraints caused a shift in the teams to prioritize regulatory work in PQI and FSR.
Known Barriers/Root Cause(s) (as applicable)	<ol style="list-style-type: none"> 1. An FSR nurse resigned, leaving one FSR nurse certified to perform the DHCS audit tools. To alleviate the need in the FSR team, one nurse, previously DHCS certified, moved from the PQI team to assist the current FSR nurse, when applicable, in meeting regulatory timelines for FSR/MRR. 2. Along with the shift in staffing to support FSR, one PQI RN was on leave of absence. Due to the PQI RN team shortage of two nurses, regulatory Member Grievance processing was prioritized, and internal 90-day PQI case processing was deferred until 1) the FSR nurse was onboarded and 2) the PQI RN returned from a leave of absence. 3. The Clinical Safety QI Program Analyst is on leave of absence, causing a shift of work to the QI Project Specialist, resulting in delays in operational work impacting IRR, Track & Trend, and audit deliverables.
Next Steps	<ol style="list-style-type: none"> 1. Continue to participate in JIVA training. 2. Continue projects in Clinical Safety to enhance Clinical Safety operations and eliminate siloed manual work and regulatory reporting. 3. Continue working with HR in Q1 2024 for FSR RN backfill onboarding. The candidate is a DHCS Master Trainer and will come to the team ready to assume the role. 4. Work with HR in Q1 2024 to expand the Clinical Safety team by means of promotional opportunities and the release of new FSR RN positions.

Topic	Facility Site Review (FSR) Management
Domain	Clinical Safety
Priority	Regulatory
Committee	QIHET-W
Goals	<ol style="list-style-type: none"> 1. By December 31, 2023 100% of existing primary care provider sites that had an FSR due this quarter were completed within three years of their last FSR date. 2. By December 31, 2023 100% of practices where Critical Elements Corrective Action Plans (CE CAPs) arising from FSRs are resolved within 10 business days. 3. By December 31, 2023 100% of practices with a Corrective Action Plans (CAPs) arising from FSR submit a plan to address the CAP within 45 calendar days. 4. By December 31, 2023 100% of practices with a CAP arising from FSR complete all planned actions within 90 calendar days as evidenced by verification by the FSR team.
Opportunities for Improvement	<ol style="list-style-type: none"> 1. Ensure to carve out the appropriate amount of time to complete the entire Medical Record Review according to the expanded tool guidelines; 2. Initiate request to gain Electronic Medical Record access for Medical Record Review (MRR) at time of scheduling to ensure timely MRR; and 3. Update resources in the current Corrective Action Plan template to ensure that providers are supported in implementing improvements;
Results Q4	<ol style="list-style-type: none"> 1. 87% (13 of 15) of existing primary care provider sites that had an FSR due this quarter were completed within three years of their last FSR date. 2. 100% (5 of 5) of practices where Critical Elements Corrective Action Plans (CE CAPs) arising from FSRs are resolved within 10 business days. 3. 73% (11 of 15) of practices with a Corrective Action Plans (CAPs) arising from FSR submit a plan to address the CAP within 45 calendar days. 4. 100% (13 of 13) of practices with a CAP arising from FSR complete all planned actions within 90 calendar days as evidenced by verification by the FSR team.
Summary of Quarterly Activities Narrative	<ol style="list-style-type: none"> 1. Attend collaborative meetings to plan the implementation of the DHCS mandated Manage Care Site Review Portal (MSRP) to continue education, align continued implementation of FSR tools and standards, and share resources.; 2. Collaborate with Alliance Application Services to create and test interface for MSRP to effectively meet DHCS reporting requirements; 3. Collaborate with Anthem DHCS Certified Master Trainer to ensure a smooth expansion to San Benito and Mariposa counties; 4. Interviewing to fill open FSR RN position.
Known Barriers/Root Cause(s) (as applicable)	<ol style="list-style-type: none"> 1. Site review team is short staffed. Recently lost 1 FSR RN. Only 1 FSR RN employed. 2. MSRP delays at the state level. Will have second round of testing soon. 3. Providers dictate when we can schedule reviews. Delays can be due to staff availability and preferences that are outside our control.
Next Steps	<ol style="list-style-type: none"> 1. Moved PQI RN to FSR to support remaining FSR RN. 2. Continue to update resources in the current Corrective Action Plan template to ensure that providers are supported in implementing improvements. 3. Volunteered to beta test for next round of MSRP interface upload testing. 4. Working with HR to hire for open FSR position. 5. Meeting regularly with operations team and will reinforce conducting periodic reviews 2 months early.