SECTION 1: QUALITY PROGRAM STRUCTURE

ANNUAL EVALUATION (KRISTEN ROHLF)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Annual Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Execute completed Annual QI Evaluation meeting DHCS and NCQA standards. Finalize Annual Evaluation for presentation to QIHEC.	1. Update the 2024 Evaluation document, ensuring any regulatory updates, and assignment of sections for each respective business owner. 2. Monitor progress of evaluation update by business owners and provide feedback. 3. Create business requirements for a new section of the Alliance website to share evaluation.	8/1/2025-8/30/2025 9/1/2025-12/31/2025 12/1/2025-12/31/2025	Kristen Rohlf, MPH, Quality and Population Health Manager	1st update- The 2024 QI Annual evaluation is under review, set to complete by end of Q2 2025. The updates include new sections to capture the National Committee for Quality Assurance (NCQA) Health Equity (HE) Accreditation Section 5 requirements for Culturally and Linguistically Appropriate Services (CLAS) evaluation, and HE Section 6 Reducing Health Care Disparities report evaluation material. The first planned activities for the 2025 Annual QI Evaluation are set to begin in the middle of Q3.	1: No issues identified.	1. Once the 2024 annual QI evaluation is completed, assessment will begin for updated 2025 accreditation standard requirements, and any new contractual requirements from DHCS.	☐ Yes ☑ No	Planned activities are on track for completion.

PROGRAM DESCRIPTION (ANDREA SWAN)

Goals/Objectives for Calendar Year 2025	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 2025 Program Description for presentation to QI stakeholders.	1. Ensure all required sections of the workplan meet DHCS and NCQA requirements.	1/31/2025-2/15/2025	Andrea Swan, Quality Improvement & Population Health Director		1: No previously identified issues	1 N/A	☑ Yes ☐ No	

2. Presentation of the Program Description to both the QIHEW, and QIHEC for approval by 4/02/2025	2. Submission of Program Description to QIHEW staff	3/1/2025-3/24/2025	Andrea Swan, Quality Improvement & Population Health Director	1st update: 2025 Program Description was finalized and approved by QIHEC April 2025.			☐ Yes ☐ 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.	9/30/2025-12/31/2025	Andrea Swan, Quality Improvement & Population Health Director		2:	2:	☐ Yes ☐ No	
							☐ Yes ☐ No	

ANNUAL WORKPLAN (SARINA KING)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Execute a QI annual work plan that captures ongoing activities throughout the year and addresses all 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.	1/1/2025-2/24/2025	Sarina King, Quality and Performance Improvement Manager Georgia Gordon, Quality Improvement Program Advisor II	Qtr. 1:			☐ Yes ☐ No	
2. Ensure all workplan elements are properly documented and reflect appropriate follow-up by each business owner.	2. Regularly quarterly check-ins to review workplan entries with regular feedback provided to business owners when applicable.	3/30/2025 6/30/2025 9/30/2025 12/31/2025	Sarina King, Quality and Performance Improvement Manager Georgia Gordon, Quality Improvement Program Advisor II	Qtr. 2			☐ Yes ☐ No	
3. Review and approval of workplan quarterly by QIHEC.	3. Review of all workplan entries prior to each committee to ensure appropriate documentation.	3/30/2025 6/30/2025 9/30/2025 12/31/2025	Sarina King, Quality and Performance Improvement Manager Georgia Gordon, Quality Improvement Program Advisor II	Qtr. 3:			☐ Yes ☐ No	
1.	1.			Qtr. 4:			☐ Yes ☐ No	

SECTION 2: QUALITY OF CLINICAL CARE

MEDI-CAL MANAGED CARE SET (MCAS) INTERVENTION (KRISTEN ROHLF)

Goals/Objectives for Calendar Year 2025	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. Close pediatric care gaps in Merced and Mariposa County to have all pediatric measures at or above MPL or have a 5% increase in the measure. 2. Measurement Year (MY) 2023, Reporting Year (RY) 2024 MCAS rates for Merced County: 3. Child and Adolescent Well-Care Visits (WCV) - 50.49% 4. Childhood Immunizations - Combo 10 (CIS-10) - 19.71% 5. Immunizations for Adolescents - Combo 2 (IMA–2) - 32.02% 6. Lead Screening in Children (LSC) - 47.01% 7. Well-Child Visits in the First 15 Months—Six or More	1. Analyze data - Q1 2. Identify providers and measures- Q2. 3. Provide workforce care gap closure grants to providers with large member populations in Merced and Mariposa Q3. 4. Continue Provider Partnership program in Merced and expand to Mariposa County to support providers in their interventions that focus on measures that are below MPL Q4.	2/1/2025-12/31/2025	Sarina King, Quality and Performance Improvement Manager Alex Sanchez, Quality Improvement Program Advisor III Georgia Gordon, Quality Improvement Program Advisor II Jada Edwards, Quality Improvement Program Advisor II Juan Velarde, Quality Improvement Program Advisor IV Annecy Majoros, Quality Improvement Program Advisor III Jo Pirie, Quality Improvement Program Advisor III Britta Vigurs, Quality Improvement Program Advisor III	Qtr. 1: 2024 performance was analyzed for Provider Partnerships and the grant program. We looked at measure performance data, and qualitative feedback from practices and liaisons. In Q1 information was shared with department leadership, MCAS workgroup, QIPH department meeting, and Q1 Merced County Provider Meeting. A presentation and narrative summary were created detailing efforts. Data was analyzed for the 2025 grant that put practices in funding tiers based on the number of members that need to reach MPL. The first round of 2025 saw 8 Merced practices apply and receive the Workforce Grant Round two will begin in June 2025 targeting any Merced and Mariposa practices who were outreached to but didn't	Given the nature of continuous enrollment within CBI and our new counties, it was initially tough to get a clear picture of what measures they were struggling with.	Move on to our second waves of Workforce Grant applications in May and June. Continue to build upon and foster new relationships within Provider Partnerships.	☑ Yes ☐ No	All activities planned for Q1 have been completed, and activities for the rest of the year are ongoing.

Well-Child Visits (W30-6) - 48.69% 8. Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits (W30-2) - 61.10% Note: Mariposa County will be reported for the first time in MY2024, RY 2025.				apply first round, as well as SC and Monterey Counties. Provider Partnerships has continued with four Merced practices and was expanded to San Benito Health Foundation (San Benito County) and Jon C. Fremont Clinic (Mariposa County). Liaisons are in the process of setting up time to meet with the practices.				
				Qtr. 2:			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	
1. Improve Follow-Up After ED Visit for Mental Illness - 30 days (FUM) and Follow-Up After ED Visit for Substance Use - 30 days (FUA) measure rates by establishing monthly data file sharing from all five County Behavioral Health departments to the Alliance. These data files will capture services performed by the county departments for carved out services for regulatory DHCS MCAS reporting. Goal is to exceed the MPL for MY24 or increase MY23 by 5%. 2. FUM MY 2023, RY 2024 rate was 34.55% Santa Cruz/Monterey,	1. Analyze last year's Merced, Monterey, and Santa Cruz County Behavioral Health Department MCAS ad hoc data files for process improvements in Q1. 2. Contact Merced, Monterey, Mariposa, Santa Cruz, and San Benito County Behavioral Health Departments for new monthly data sharing request during Q1-Q3. 3. Provide technology support and QA of received files for file layout compliance during Q1-Q4. 4. Creation of a new Alliance database to store county data in Q2-Q4.	1/1/25 -3/31/25, 1/1/25-9/30/25, 1/1/25-12/31/25, 3/1/25-12/31/25, 3/1/25-12/31/25	Magdalena Kowalska, Quality Improvement Program Advisor IV Shae Redwine, Behavioral Health Program Analyst	Qtr. 1: Completed analysis of data for last year's ad hoc data files from Monterey, Merced, and Santa Cruz Mental Health Plans. All counties received initial and follow-up data requests from CCAH by Q1.	Concerns that data sharing follows all applicable data protection guidelines for HIPAA privacy and 42 CFR part 2 Final Rule. DHCS MOUs are still in process with the Santa Cruz Mental Health Plan. Technology and staffing capacity to abstract data and share through the requested templates. Mariposa and San Benito could not accommodate the data request by the end of Q1. Mariposa additionally expressed	To re-engage data discussions with Mariposa and San Benito, and to start discussions with Santa Cruz, Monterey and Merced for monthly data file sharing.	☐ Yes ☐ No	All activities planned for Q1 have been completed, and activities for the rest of the year are ongoing.
				Qtr. 2:			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	

20.42% for Merced County Reporting. 3. FUA MY2023, RY 2024 rate was 39.37% for Santa Cruz/Monterey, and 39.97% for Merced. Note: Mariposa and San Benito Counties will be reported for the first time in MY2024, RY 2025. Single plan health plan rates will be submitted to NCQA, and county specific rates submitted to DHCS.	5. Integration of new files for HEDIS vendor software extraction in Q2-Q4.			Qtr. 4:	concerns about not having member level detailed information readily available.		☐ Yes ☐ No	

CARE-BASED INCENTIVE (CBI) (KRISTEN ROHLF)

Goals/Objectives for Calendar Year 2025	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. Increase CBI program resources and support to Mariposa and San Benito County participating providers. Goal is to increase county specific targeted December 2024 rates to exceed the MPL or increase by 5% by December 2025. Mariposa County CBI Measures of Focus as of December 2024: 2. Child and Adolescent Well-Care Visits (37.76%) 3. Controlling High Blood Pressure (20.56%) 4. HbA1c Poor Control >9% (66.97%) 5. Cervical Cancer Screening (25.16%) 6. Chlamydia Screening in Women (48.91%) San Benito County CBI Measures of Focus as of December 2024: 7. Developmental Screening in the First Three Years of Life (21.51%) 8. Controlling High Blood Pressure (11.07%) 9. HbA1c Poor Control >9% (89.84%) 10. Cervical Cancer Screening (43.78%)	1. Analyze CBI Forensics (CBIF) meeting requests from 2024 from Mariposa and San Benito in Q1-Q2 2. Analyze Alliance Provider Portal Data Submission Tool (DST) usage and training requests from 2024 from Mariposa and San Benito in Q1-Q2 3. Analyze CBI Q4 2024 final programmatic rates from Mariposa and San Benito CBI group providers in Q1-Q2 4. Outreach to providers in Mariposa and San Benito to schedule CBIF and additional provider portal report and DST submission training based on Q4 2024 performance, DST submission usage, and past forensics requests in Q2-Q3. 5. Create, record, and publish the CBI Intro Video to the Alliance website for the CBI 2025 program year. Add information on new portal reports like HEDIS (MCAS) Reports to training material. Complete in Q1-Q3	1/1/25-6/30/25, 1/1/25-6/30/25, 1/1/25-3/30/25, 3/1/25-8/30/25, 1/1/25-8/30/25	Alex Sanchez, MPH, Quality Improvement Program Advisor III Annecy Majoros, Quality Improvement Program Advisor III Britta Vigurs, Quality Improvement Program Advisor III Jo Pirie, Quality Improvement Program Advisor III Juan Velarde, Quality Improvement Program Advisor IV	Qtr. 1: The CBI team has assigned slides, and prep work for the planned activities for the CBI into video. Qtr. 2 Qtr. 3: Qtr. 4:	No current or prior issues identified.	Analysis the CBI forensics, data submission tool submissions, and Q4 2024 programmatic rates in preparation for outreach by end of Q2. Finalize the CBI intro slides and recording by end of Q3.	☐ Yes ☑ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Goals have not yet been met but are on track for completion by the target end date for the first activities due by the end of Q2.

BASIC POPULATION HEALTH MANAGEMENT (DESIRRE HERRERA)

Goals/Objectives for Calendar Year 2025	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. Provide members with chronic disease management programs and wellness programs. A minimum of 4 member workshops will be provided per quarter.	1. The Health Educators will conduct a minimum of 4 member workshops per quarter. 2. Health Educators will lead recruitment and outreach efforts to members to enroll in the programs.	1/1/2025 -3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Veronica Lozano, Quality and Health Programs Supervisor Health Educator team Desirre Herrera, Quality and Health Programs Manager	Qtr. 1: A total of **4 member workshops** were completed in Q1. The following workshop modalities and languages were provided: • 1 in-person Live Better with Diabetes (LBD) group in Spanish. Provided at the San Benito Health Foundation. • 1 telephonic Healthier Living Program (HLP) group in English. • 1 telephonic Live Better with Diabetes (LBD) group in Spanish 1 telephonic Healthier Living Program (HLP) group in Spanish.	No issues to report in Q1.	The project team will continue to schedule member workshops in Q2.	☑ Yes ☐ No	Member workshops have started off well in Q1 with a new in-person site (San Benito Health Foundation). The site has requested additional workshops to be scheduled in-person in 2025.
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	
2. On a quarterly basis, inform members of Health and Wellness programs and self-management tools available to them in 2024.	1. The project team will conduct outreach and education activities to inform members of services available to them via: • Member outreach calls • Member newsletter articles • MSAG presentation • Social media and/or texting campaigns	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Veronica Lozano, Quality and Health Programs Supervisor Health Educator team Desirre Herrera, Quality and Health Programs Manager	Qtr. 1: The following activities were completed in Q1 to inform members of Health and Wellness programs: • Member Newsletter: The project team included 1 article in the March 2025 Member Newsletter informing members of health and wellness programs available to them. • Member text campaign: In collaboration with the Communications team a text message was sent out to members on 2/26/25 to inform them of HWL workshops and linked to the health education programs website page.	No issues to report in Q1.	The project team will continue to conduct member informing activities in 2025.	☑ Yes ☐ No	The ongoing member informing activities have been successful at increasing member enrollment. The text message campaign exceeded expectations in member response and will continue to be used as a method of informing members of the services available.

				The page had a new member sign-up form that allowed members to sign up for programs they were interested in. This resulted in **83 members** signing up for programs immediately following the text message. • Member outreach calls: The Health Education team completed **1,224 outgoing outreach calls** in Q1 to offer members health and wellness programs. Additionally, the Health Education Line received **689 incoming calls** from members, providers and the community regarding Quality and Health Programs services. • PCP referrals: The Health Educators received **156 PCP referrals** to health education services in Q1.			☐ Yes ☐ No	
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	
3. On a bi-annual basis, collect member feedback from participants in chronic disease management and wellness programs to evaluate impact. A minimum of 50 surveys will be collected annually.	1. The project team will conduct member satisfaction surveys to evaluate: • Information about the overall program • Usefulness of the information shared • The percentage of members indicated that the program helped them achieve health goals. 2. Request input from members regarding program and services. 3. Incorporate member feedback into planning of health education activities.	1/1/2025-3/31/2025 7/1/2025-9/30/2025	Kevin Lopez, C&L Program Advisor Veronica Lozano, Quality and Health Programs Supervisor Desirre Herrera, Quality and Health Programs Manager	Qtr. 1: Surveys will be scheduled bi-annually. The team will report out survey results in Q2 report.	No issues to report in Q1.	The project team will schedule surveys to be completed in Q2.	☐ Yes ☑ No	
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	

4. On a quarterly basis, provide Health Education services and Member Health Rewards program presentations to Alliance internal and external partners. A minimum of 2 presentations will be conducted per quarter.	1. The project team will reach out to internal and external partners to schedule presentations. 2. Deliver Health Education and Member Health Rewards services presentations. 3. Request input regarding presentation content and any member needs that they have encountered regarding Health Education services.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Kevin Lopez, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager	Qtr. 1: 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: • Monterey County Public Health • Merced County Public Health • Alliance Member Services team • Alliance Quality Improvement and Population Health Orientation • Alliance Provider Relations team • Alliance Health Educator team.	No issues to report in Q1.	The project team will continue to schedule internal and external presentations in Q2.	☑ Yes ☐ 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. There has been an increased interest in presentations for external audiences including providers and community-based organizations to increase knowledge of services available for members.
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	

SECTION 3: SAFETY OF CLINICAL CARE

FACILITY SITE REVIEW (DEANNA LEAMON)

Goals/Objectives for Calendar Year 2025	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.	1. Enhance provider scheduling support by onboarding three additional QI RNs dedicated to conducting facility site reviews. 2. Implement proactive planning by reviewing all upcoming site reviews one quarter in advance. 3. Streamline scheduling by offering provider sites a selection of review dates two months before the review due date. 4. Maintain continuous communication with provider sites until a review date is confirmed.	01/01/2025-03/31/2025	Joana Castaneda, Quality Improvement Program Advisor; Tisha Criswell, Senior Quality Improvement Nurse, Yvette Sullivan, Quality Improvement Nurse, and Breena Siliznoff, Quality Improvement Nurse	Qtr. 1: Achieved goal with 13 out of 14 reviews completed (93%). Onboarding is underway for three FSR positions. Q1 reviews were proactively assessed during Q4 for planning. Initial communications have been sent to providers regarding Q1 reviews. Qtr. 2: Qtr. 3: Qtr. 4:	Due to current staffing constraints and the limited availability of only one DHCS master-trained nurse, a recent PCP site review could not be completed as scheduled. This gap has been identified as a key issue impacting our ability to meet site review requirements. To address this, the onboarding of three additional FSR QI Registered Nurses is currently in progress. Completion of their training and certification is anticipated in Q4 2025 or Q1 2026, at which point the team will be adequately staffed to meet site review obligations across all five counties.	Ongoing collaboration with HR to recruit three QI RN positions for FSR. The DHCS master trained QI RN has been promoted to Clinical Safety Supervisor for Facility Site Review and will collaborate with Human Resources to initiate the recruitment process for a backfill position. Maintain communication with providers with site reviews due in Q2 2025, ensuring follow-up on date selection until each review date is confirmed.	☑ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	The FSR team successfully met the Q1 2025 goal, completing 93% of required primary care provider site reviews exceeding the 80% target. Proactive planning and early outreach to providers supported timely scheduling despite staffing limitations. One review fell out due to the limited capacity of a single DHCS master-trained nurse, highlighting a critical staffing gap. In response, onboarding three additional QI RNs is in progress with full deployment expected by Q4 2025 or Q1 2026. Additionally, promoting the DHCS-certified nurse to

								Clinical Safety Supervisor strengthens leadership capacity, with efforts underway to backfill the vacated position. Continued collaboration with HR and ongoing provider engagement will maintain momentum into Q2 2025.
2. 100% of practices with Corrective Action Plans (CAPs) arising from FSR/MRR submit a plan to address the CAP within regulatory timeframes.	1. Enhance CAP management support by onboarding three additional QI RNs for facility site reviews. 2. Send email reminders to provider sites regarding upcoming CAP due dates. 3. Directly contact non-responsive providers via phone, involving PRRs as necessary.	01/01/2025-03/31/2025	Joana Castaneda, Quality Improvement Program Advisor; Tisha Criswell, Senior Quality Improvement Nurse, Yvette Sullivan, Quality Improvement Nurse, and Breena Siliznoff, Quality Improvement Nurse	Qtr. 1: Achieved goal results of 14 out 14 (100%). Onboarding is underway for three FSR positions. Reminders regarding upcoming due dates have been sent to providers with CAPs. Qtr. 2: Qtr. 3: Qtr. 4:	Due to current staffing constraints and the limited availability of only one DHCS master-trained nurse, a recent PCP site review could not be completed as scheduled. This gap has been identified as a key issue impacting our ability to meet site review requirements. To address this, the onboarding of three additional FSR QI Registered Nurses is currently in progress. Completion of their training and certification is anticipated in Q4 2025 or Q1 2026, at which point the team will be adequately staffed to meet site review obligations across all five counties.	Ongoing collaboration with HR to recruit three QI RN positions for FSR. The DHCS master-trained QI RN has been promoted to Clinical Safety Supervisor for Facility Site Review and will collaborate with Human Resources to initiate the recruitment process for a backfill position. Maintain consistent communication with providers regarding CAP due dates. Follow up with non-responsive providers through direct phone calls involving PRRs as needed.	☑ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	The FSR team achieved full compliance in the review period, completing 100% of required site reviews (14 out of 14). This success reflects strong proactive coordination and consistent provider communication, including timely reminders for CAP due dates. However, staffing limitations remain a known risk, as the team continues to rely on a single DHCS master-trained nurse. In response, onboarding for three new FSR QI RNs is underway, with full capacity expected by Q4 2025 or Q1 2026. The recent promotion of the DHCS-certified nurse to Clinical Safety Supervisor for FSR further strengthens leadership, and recruitment for the backfill position is in progress. Sustained collaboration with HR and direct provider follow-up, including PRR involvement when needed, will support ongoing compliance and review readiness.

POTENTIAL QUALITY ISSUES (DEANNA LEAMON)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 100% of member grievances received by QI concerning potential medical quality of care issues are resolved within the regulatory timeframes for Member Grievances.	1. Establish due dates in SharePoint for PQIs that allow sufficient time for investigation, translation needs (if applicable), and for the Grievance Coordinator to resolve the case. 2. Promptly request medical records necessary for the PQI investigation upon case assignment to the QI RN. 3. Ensure timely coordination of discussions if the case requires MD guidance or potential P2/P3 recommendations.	01/01/2025-03/31/2025	Emily Kaufman, Clinical Safety Supervisor; Eleni Pappazisis, Quality Improvement Program Advisor; Naomi Kawabata, Senior Quality Improvement Nurse; Katie Lutz, Senior Quality Improvement Nurse; Sandy Clay, Senior Quality Improvement Nurse; Karen de Leon, Quality Improvement Nurse and Bethany Fung, Quality Improvement Nurse	Qtr. 1: Achieved goal results of 100% with 124 cases closed on time. Due dates have been established in SharePoint to facilitate the closure of regulatory PQIs. The QI RN requested medical records promptly for PQIs investigations. Timely discussions were conducted with MDs regarding P2/P3 cases. Qtr. 2: Qtr. 3: Qtr. 4:	Ensure staffing levels are adequate to balance regulatory PQIs, internal PQI referrals. CAP management collaborative efforts, and quality studies to enhance the quality of care for members.	Continue establishing due dates in SharePoint to prioritize promptly closing regulatory-based PQIs. Maintain the practice of requesting medical records as needed for investigations to ensure timely case closures. Conduct weekly MD meetings to discuss potential P2/P3 cases requiring guidance ensuring that these discussions do not hinder timely case resolution.	☑ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Although 100% of member grievances received by the Quality Improvement (QI) team concerning potential medical quality of care issues are resolved within the required regulatory timeframes, this work area demands most of the QI RN's time and focus to maintain compliance. With current process improvement efforts underway for the exempt grievance workflow, member grievance oversight, and Potential Quality Issue (PQI) volume have seen a noticeable increase. As a result, the team's capacity has been primarily directed toward managing regulatory PQIs and ensuring timely grievance resolution. Consequently, other QI responsibilities—such as 120-day PQI reviews and quality study referrals—have been impacted. At this time, 120-day PQIs are the team's second priority, while referrals to quality studies will be deferred until performance goals are consistently met for regulatory and 120-day PQI cases.
2. 80% of non-grievance related PQIs are completed within 120 calendar days.	1. Triage and prioritize incoming internal referrals for the following case types: 2. Known providers for tracking and trending. 3. Providers on a CAP or involved in an open Quality Study.	01/01/2025-03/31/2025	Emily Kaufman, Clinical Safety Supervisor; Eleni Pappazisis, Quality Improvement Program Advisor; Naomi Kawabata, Senior Quality Improvement Nurse; Katie Lutz, Senior Quality Improvement Nurse; Sandy Clay, Senior Quality Improvement Nurse; Karen de Leon, Quality Improvement Nurse	Qtr. 1: Achieved goal results of 56% with 29 out of 52 cases closed on time. The team effectively triaged and prioritized incoming internal referrals for the following case types. • Known providers for tracking and trending. • Providers on a CAP or involved in an open Quality Study.	Ensure staffing levels are adequate to balance regulatory PQIs, internal PQI referrals, collaborative efforts, and quality studies to enhance the quality of care for members.	Ensure staffing levels are adequate to balance regulatory PQIs, internal PQI referrals. CAP management collaborative efforts, and quality studies to enhance the quality of care for members.	☐ Yes ☑ No	See above.

	4. LTSS members.		and Bethany Fung, Quality Improvement Nurse	• LTSS members. Qtr. 2: Qtr. 3: Qtr. 4:			 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	

APPEALS & GRIEVANCE REVIEW (SARAH SANDERS)

Goals/Objectives for Calendar Year 2025	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. Meet regulatory requirements 98% of the time for timely acknowledgments and resolutions.	1. Monitor appeal and grievance inventory for daily, weekly, and monthly oversight. 2. Ensure standard appeals and grievances are acknowledged within 5 days and resolutions occur within 30 calendar days.	24Q4- March 31, 2025 25Q1-May 30, 2025 25Q2-Aug 29, 2025 25Q3-Oct 31, 2025	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor	Qtr. 1: Achieved goal by meeting regulatory timeframes with grievance correspondence 99% of the time during 25Q1. Correspondence reports went live in Q125 to better monitor real-time activities. Qtr. 2 Qtr. 3: Qtr. 4:	Staffing concerns emerging due to continued high volume and filings.	Continue close monitoring of approaching due dates and raise staffing concerns. Explore additional efficiencies through process improvement project.	☑ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Regulatory timeframes with member correspondence was met during this timeframe. *Note that provider responses impact resolution timeframes due to delayed or incomplete provider responses which causes a downstream impact on timely and complete resolutions.
2. Monitor and maintain Grievance rates below 2 per 1,000 members per month for Quality-of-Care concerns; below 2 per 1,000 members per month for Quality-of-Service concerns (NCQA standard).	1. Track and trend appeal & grievance data by both NCQA primary categories & DHCS categories for quality of care (QOC), quality of service (QOS) and access issues. 2. Track grievance and appeals for emerging quality of care and service trends. Inclusive of access trends, system issues, and actionable corrections needed.	24Q4- March 31, 2025 25Q1-May 30, 2025 25Q2-August 29, 2025 25Q3-Oct 31, 2025	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor	Qtr. 1: Achieved goal by restructuring reports into NCQA category structure and maintaining a rate below 2 in these areas. Emerging trends around Community Support and ECM providers. Qtr. 2:	Requesting business owners bring actions to SGRC (Staff Grievance Review Committee) around trends and corrections occurring.	Continue tracking and trending issues. Encourage business owners to propose corrections for actionable trends.	☑ Yes ☐ No ☐ Yes ☐ No	

				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	
3. Improve Appeal and Grievance (AG) data quality and reporting.	1. Identify reporting needs, gaps and areas for improvement. 2. Develop report for substantiated grievances to support identification of systemic issues and opportunities for improvement.	24Q4- March 31, 2025 25Q1-May 30, 2025 25Q2-August 29, 2025 25Q3-Oct 31, 2025	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor	Qtr. 1: Achieved goal by launching the AG Process Improvement Project. Initial steps included development and implementation of reports on substantiated grievances.	Requesting continued interdepartmental engagement to refine the AG process, initiate efficiencies, improve quality, and complete resolutions. Provider Services monitor, respond and share actions when needed.	Continue improving quality with data and reporting by providing timely feedback.	☑ Yes ☐ No	
				Qtr. 2:			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	
4. Improve monitoring and documented oversight.	1. Initiate reportable notes within appeals and grievance (AG) system to improve transparency with oversight. 2. Develop report to quality oversight activities.	24Q4- March 31, 2025 25Q1-May 30, 2025 25Q2-August 29, 2025 25Q3-Oct 31, 2025	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor	Qtr. 1: Achieved goal by launching the AG process improvement project which will refine oversight. Developed reportable notes to support future reports on oversight.	No previously identified issues.	Continue implementing monitoring and oversight activities.	☑ Yes ☐ No	
				Qtr. 2:			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	

SECTION 4: MEMBER EXPERIENCE

MEMBER SATISFACTION SURVEY – CAHPS (SARINA KING)

Goals/Objectives for Calendar Year 2025	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. Improve CAHPS rates for "How Well Doctors Communicate" for members 0-18 years from 91.5% to 94.4%.	1. Elicit feedback from relevant teams to develop interventions. 2. Implement interventions. 3. Study and adjust interventions.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025,	Jada Edwards, Quality Improvement Program Advisor Sarina King, Quality and Performance Improvement Manager Alex Sanchez, Quality Improvement Program Advisor Additional intervention collaboration from QIPH staff, provider relations	Qtr. 1: Planning and execution of a system wide CAHPS workgroup. The aim of 2025 is to provide direction, and support for on-going strategies/interventions to target member satisfaction rates. Made up of 15 teams/departments, workgroup administration documents and tracks interventions made throughout the system in our focus area.	Will need to ensure there is proper awareness across the organization on the primary objectives of the workgroup as there is much overlap in priorities, as to not duplicate efforts.	Monthly workgroup. Share and track interventions.	☑ Yes ☐ No	
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	
2. Improve CAHPS rates for "Health Plan Customer Service" for adult members from 87.8% to 89.8%.	1. Elicit feedback from relevant teams to develop interventions. 2. Implement interventions. 3. Study and adjust interventions.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025	Jada Edwards, Quality Improvement Program Advisor Sarina King, Quality and Performance Improvement Manager Alex Sanchez, Quality Improvement Program Advisor	Qtr. 1:			☐ Yes ☐ No	
				Qtr. 2			☐ Yes ☐ No	

			Additional intervention collaboration from customer service team, member services	Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	

SECTION 4: QUALITY OF SERVICE

ACCESS & AVAILABILITY (AA) (JESSIE DYBDAHL)

Goals/Objectives for Calendar Year 2025	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. Comply with DMHC Timely Access Survey Requirements	1. Ensure 90% of After-hours triage compliance in Timely Access Survey. (Provider Appointment Availability Survey [PAAS]). 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. 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.		Jessie Dybdahl, Provider Service Director	Qtr. 1: MY2024 PAAS Survey results were received in Q12025, below is an overview of the results: **For the IHSS line of business**: Non-Urgent appointments received a compliance rate of 67% for all provider survey types. **For the Medi-Cal line of business**: Non-Urgent appointments received a compliance rate of 76% for all provider survey types. **For the IHSS line of business**: Urgent appointments received a compliance rate of 84% for all provider survey types **For the Medi-Cal line of business**: Urgent appointments received a compliance rate of 66% for all provider survey types. Within both lines of business there was an increase in compliance for non-urgent appointments for all surveyed provider types.	No previously identified issues.	Begin preparing for the kickoff of the MY2025 PAAS Survey.	☑ Yes ☐ No	On track for the kick off of the MY2025 PAAS.

				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3			☐ Yes ☐ No	
				Qtr. 4			☐ Yes ☐ No	
2. Quarterly review of provider to member ratios for PCPs and High-volume/high-impact Specialties. To ensure all ratios meet regulatory requirements.	1. Ensure provider to member ratios are w/in compliance and mitigate if out of compliance on a quarterly basis. 2. Tableau report is monitored no less than quarterly to ensure provider to member ratios are met for each required provider type.		Jessie Dybdahl, Provider Service Director	Qtr. 1: Review ratios and any outcomes. Based on the policy, standards are well within compliance for provider to member ratios for all provider types, minus two. - Medi-Cal Internal Medicine - Medi-Cal Allergy & Immunology Those that we are not within compliance with, we will continue to monitor quarterly and work with necessary departments to address.		- Inform Grants of specialties where we aren't in compliance. - Inform Network Develop Team of necessary new specialties for recruitment. - Continue monitoring quarterly for compliance.	☐ Yes ☐ No	Current metrics are in line with requirements, except Allergy & Immunology and Internal Medicine.
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	

GEO ACCESS (TIMELY ACCESS) (JESSIE DYBDAHL)

Goals/Objectives for Calendar Year 2025	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	1. Ensure the network meets time or distance standards in compliance with DHCS requirements when a provider is available. 2. Monitor areas where no provider is available and ensure		Jessie Dybdahl, Provider Service Director	Qtr. 2			☐ Yes ☐ No	

	alternative access requests are in place on a quarterly basis. 3. Evaluate the non-contracted provider network to determine if recruitment might remedy access gaps. Launch recruitment efforts as applicable.			Qtr. 4:			☐ Yes ☐ No	

PROVIDER SATISFACTION SURVEY (JESSIE DYBDAHL)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	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	1. Monitor Provider Satisfaction annually. Ensure no less than 5% decrease in overall satisfaction with the plan from prior year. 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.	7/1/2025 - 12/31/2025	Jessie Dybdahl, Provider Service Director	1st update:			☐ Yes ☐ No	

TELEPHONE ACCESS (VERONICA OLIVARRIA)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 80% of calls to Member Services answered within 30 seconds.	1. The Call Center is continuously monitoring this metric as it is also included on the Operational Dashboard. Improvement efforts slated for 2024: • 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	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Lilia Chagolla, Member Services Director Veronica Olivarria, Call Center Manager	Qtr. 1: The call center has hired additional staff to support the calls and members walk-in volume. Coordinate lunch and break schedules to maximize the peak/busy times. Ensure staff are available during peak hours 11am-2:30pm. Trainings coordinated in small teams to maximize service level. Call Center Supervisors review Queue data throughout the day to determine if changes need to made immediately.	This goal was met for Q1 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.	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.	☑ Yes ☐ No	This goal was met and will be 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.

	staff are adhering to Alliance updates and processes. • Developing additional call circles (queues) to: 1. Optimize resource availability. 2. Improve the speed of answering. 3. Reduce representative training time. 4. Increase member satisfaction. • Computer Telephone 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 the phone for the MSR and will make each call more efficient. Integration: Assess staffing needs due to increase in membership			Qtr. 2 Qtr. 3: Qtr. 4:			☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
2. The call abandonment rate will not exceed 5% of calls to Member Services answered before being abandoned.	The Call Center is continuously monitoring this metric as it is also included on the Operational Dashboard.	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Lilia Chagolla, Member Services Director Veronica Olivarria, Call Center Manager	Qtr. 1: The call center has hired additional staff to support the calls and members walk-in volume. Coordinate lunch and break schedules to maximize the peak/busy times. Assign staff to support offices to assist with member walk-ins. Eliminate unnecessary meetings and focus meetings/trainings 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. Qtr. 2 Qtr. 3: Qtr. 4:	Q1 is the busiest time of the year in the Call center, we prepared by hiring and training staff to be Ready to assist callers for Jan 1.	Working on additional FTEs for new WFM tool and phone system upgrade, Behavior Health and DSNP integration	☑ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	This goal was met by ensuring the Call center is fully staffed, trained and prepared to meet the needs of our members via phone or face to face. Call center Supervisors are focused on coaching real time, ensuring resources are available and HSP updates are current to allow staff to focus on the needs of the caller.

CULTURE & LINGUISTICS (DESIRRE HERRERA)

Goals/Objectives for Calendar Year 2025	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. Increase provider utilization of language assistance services quarterly by a minimum of 5% in comparison to 2024 baseline utilization data.	1. The project team will track utilization for the following services: • Phone interpreting services. • Face-to-Face (F2F) interpreting services. 2. Use quarterly utilization data to identify potential need to training provider network on language assistance services.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Osiris Ramon, C&L Program Advisor Ivonne Munoz, Quality and Health Programs Supervisor Desirre Herrera, Quality and Health Programs Manager	Qtr. 1: **Provider Utilization for Q1** was as follows: **Phone interpreting services:** There was a total of **8,284 total calls in Q1** by provider sites. This reflects an **increase of 39%** compared to Q1 in 2024. **Face-to-Face (F2F) interpreting services:** There was a total of **1,745 requests in all service counties for F2F in Q1**. This reflects an **increase of 12%** compared to Q1 in 2024. • **Santa Cruz County** had 747 requests in Q1. This is 7% decrease compared to Q1 2024. • **Merced County** had 394 requests in Q1. This is 15% decrease compared to Q1 2024. • **Monterey County** had 580 requests in Q1. This is 110% increase compared to Q1 2024. • **San Benito County** had 24 requests in Q1. This is 2300% increase compared to Q1 2024. • **Mariposa County** had 0 requests in Q1. There is no change compared to Q1 2024.	No issues to report in Q1.	The C&L team will continue informing providers of the services available and offer training and support services as requested.	☑ Yes ☐ No	There continues to be increases overall in utilization of language assistance services by providers.
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	

2. On a bi-annual basis, collect member feedback on their experience with language assistance services in a clinical setting. A minimum of 50 surveys will be collected annually.	1. The project team will conduct satisfaction surveys with members to evaluate: • Individual ratings of access to language services. • Overall rating of interpretation services. • Access to language services at a health care encounter. • Gather individual experiences with the services. 2. Request input from members regarding programs and services. 3. Incorporate member feedback into planning and identifying areas of improvement for the services.	1/1/2025-3/31/2025 7/1/2025-9/30/2025	Osiris Ramon, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager Ivonne Munoz, Quality and Health Programs Supervisor	Qtr. 1: Surveys will be scheduled bi-annually. The team will complete surveys in Q2. Qtr. 2 Qtr. 3: Qtr. 4:	No issues to report in Q1.	The project team will schedule surveys to be completed in Q2.	☐ Yes ☑ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Evaluation will be completed in Q2.
3. On a quarterly basis, inform members and providers of language assistance services utilizing at least 1 member and 1 provider informing modality.	1. The C&L team will conduct outreach and education activities to inform members and providers of services available: a. Member newsletter articles b. Provider bulletin articles c. Education materials including flyers d. MSAG presentation 2. Request input from members regarding program and services. 3. Incorporate member feedback into planning health education activities.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Osiris Ramon, C&L Program Advisor Ivonne Munoz, Quality and Health Programs Supervisor	Qtr. 1: The following activities were completed in **Q1** to inform members of C&L Services: • <u>Member Newsletter:</u> The project team included 1 article in the March 2025 Member Newsletter informing members of language assistance services available to them. • <u>Provider Bulletin:</u> The project team included 1 article in the March 2025 Provider Bulletin informing providers of language assistance services and how to access the services to support communication with members. Qtr. 2 Qtr. 3: Qtr. 4:	No issues to report in Q1.	The project team will continue to work on planning efforts to increase awareness of language assistance services to the provider network in 2025.	☑ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Utilization of language assistance services continues to increase each quarter. These increases can be partly attributed to consistent information being available regarding the availability of these services. Consistent messaging also allows new members to receive the information.

4. On a quarterly basis, provide at least 1 C&L services presentations to Alliance internal department staff that interact with members or providers to increase awareness of language assistance services available for members.	1. The C&L team will reach out to internal and external partners to schedule C&L services presentations. 2. Deliver C&L services presentation. 3. Request input regarding presentation content and any member needs that they have encountered regarding C&L services.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Osiris Ramon, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager	Qtr. 1: A total of **4 presentations** on C&L services were coordinated and completed in **Quarter 1**. Presentations were delivered to the following audiences: • Alliance Member Services team • Alliance Quality Improvement and Population Health Orientation • Alliance Provider Relations team • Alliance Health Educator team	No issues to be reported in Q1.	The project team will continue to coordinate presentations for internal departments and external partners in 2025.	☑ Yes ☐ No	
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	

DELEGATION OVERSIGHT (ANDREA SWAN)

Goals/Objectives for Calendar Year 2025	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.	3/31/2025,6/30/2025 9/30/2025,12/31/2025	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	Qtr. 1: Delegate reports reviewed with no issues identified.	No previously identified issues.	Continue monitoring	☑ Yes ☐ No	
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	

				Qtr. 4:			☐ Yes ☐ No	
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.	3/31/2025,6/30/2025 9/30/2025,12/31/2025	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	Qtr. 1: Delegate reports reviewed with no issues identified.	No previously identified issues.	Continue monitoring	☑ Yes ☐ No	
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	