Q2 2023 QIHET Workplan

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

PROGRESS SUMMARY

66%

Percent Complete

Composite Score

4

Sections above target

Q2 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 Q2	0%
Summary of Quarterly Activities Narrative	Metric is on hold now and currently reassessing member input from these collaborative meetings. these meetings are with CBOs and do not get much member input from these meetings.
Known Barriers/Root Cause(s) (as applicable)	Adequate staff to perform activities
Next Steps	Meet with internal stakeholders and discuss steps for improvement.

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. 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
Opportunities for Improvement	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 Q2	79.00%
Summary of Quarterly Activities Narrative	During Q2 2023 the Alliance Quality and Health Programs team completed 120 Member Outreach calls for the DHCS SWOT for pediatric measures. Health Educators called members that were due for well-child visits in Merced County. Out of 120 calls a total of 95 were successful, this resulted in 79% success rate for Q2.
Known Barriers/Root Cause(s) (as applicable)	This project was in response to an assigned SWOT from DHCS. We learned from this project that parents/guardians need additional information and education regarding what well-child visits are and why timing for visits is part of being considered "up-to-date" with check-ups and vaccines for children under 15 months. Additionally the outreach team did not have access to the clinic schedules or chart information to provide any additional information for parents. Additionally we learned the data we pulled can be incorrect due to claims lags and other issues with the data being accurate. This takes additional time to validate for staff that are assigned to these projects.
Next Steps	It is recommended that this type of outreach be completed by the provider office staff. They will have the information needed to look up when in the records the child was last seen at the office and can schedule appointments immediately. Some parent/guardians asked why the clinic was not calling them directly. There can be issues with trust in the community and this is another reason outreach campaigns and outreach scripts should be closely reviewed and monitored by leaders coordinating different outreach efforts.

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 Q2	**1. 98% 2. 88%**
Summary of Quarterly Activities Narrative	**During Q2 2023 the Alliance Member Services' Call Center focused on sharing redetermination information with members and ensuring that their mailing address is up updated.**
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	Member Experience, Quality of Care, Quality of Service
Priority	**Regulatory (DHCS)**
Committee	**QIHET-W**
Goals	**To measure the performance of the Alliance C&L Services program and to make improvements accordingly (measure utilization per County).** **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	**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.** **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 Q2	**48.40%**
Summary of Quarterly Activities Narrative	**In Q2 2023 there was a 48.4% total increase compared to Q2 of 2022 of providers utilizing face-to-face (in-person) interpreting services.** **County specific data was as follows:** **Merced County had 470% increase in Q2 2023 compared to Q2 2022** **Santa Cruz County had 7% decrease in Q2 2023 compared to Q2 2022** **Monterey County had 37% increase in Q2 2023 compared to Q2 2022**
Known Barriers/Root Cause(s) (as applicable)	**In Q2 there continued to be a high increase in provider utilization of face-to-face interpreting services in Merced County. There was also an increase in Monterey County utilization. The C&L team will continue to monitor utilization rates to ensure member access.**
Next Steps	**In Q3-Q4 the C&L team will be working on county expansion efforts to ensure access to interpreting services in the new counties starting in 2024.**

Topic	**CAHPS: How Well Doctors Communicate**
Domain	Member Experience
Priority	**Regulatory (DHCS)**
Committee	**QIHET-W, MSEC**
Goals	**1. Achieve xx% in How Well Doctors Communicate - Child 2. Achieve x % in How Well Doctors Communicate - Adult**
Opportunities for Improvement	**Assess CAHPS surveys administered in 2022, determine thresholds and targets, and identify any improvements**
Results Q2	**Results anticipated in Q3/Q4 2023.**
Summary of Quarterly Activities Narrative	**Sample Frames for the 2023 Adult and Child CG CAHPS survey were submitted to the vendor in March. Field surveys anticipated to begin in April.**
Known Barriers/Root Cause(s) (as applicable)	**TBD**
Next Steps	**Review the finalized analysis by the vendor for 2023 survey results in Q3 2023**

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 Q2	**Access areas identified based on specific access criteria for compliance, operational impact, return on investment, strategic alignment and stakeholder value.**
Summary of Quarterly Activities Narrative	**Working w/ NDSC attendees to develop criteria to assist in ensuring appropriate prioritization of access 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 Q2	**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.**
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 xx% in Getting Care Quickly for Child and Adult CAHPS 2. Achieve xx% in Getting Needed Care for Child and Adult CAHPS
Opportunities for Improvement	Assess CAHPS surveys administered in 2022, determine thresholds and targets, and identify any improvements
Results Q2	Results anticipated in Q3 2023.
Summary of Quarterly Activities Narrative	Sample Frames for the 2023 Adult and Child CG CAHPS survey were submitted to the vendor in March. Field surveys anticipated to begin in April.
Known Barriers/Root Cause(s) (as applicable)	TBD
Next Steps	Review the finalized analysis by the vendor for 2023 survey results in Q3 2023

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 Q2	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	1. Coordinated collaboration with all sources of monitoring for over and underutilization. 2. Linking reporting from multiple sources to ensure compliance with monitoring.
Results Q2	Assessment: Q2 UMWP data reflects the following Claims activity, with percentages measured against Claims activity in prior quarter (Q1 2023). ACE at 11,105 claims, a 17% increase over prior quarter (n=9462). Breast Cancer Screening at 5273 claims, a 26% decrease over prior quarter (n=6631). Colorectal Cancer Screening at 4768 claims, a 21% decrease over prior quarter (n=5754). EMG at 195 claims, a 46% decrease over prior quarter (n=422). Initial Health Assessment at 58,191 claims, a 35% decrease over prior quarter (n=78,442). Lead Screening in Children at 4856 claims, a 20% decrease over prior quarter (n=5830). 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. Interventions: Newly developed report with notable increases in ACE metrics indicates progress in this area of assessment. Noted decreases in Breast Cancer Screening, IHA, lead and colorectal screening may be indicative of incomplete data sets and will need continued monitoring in quarters ahead to determine if this is an outlier with delayed data submissions or continued trend.
Summary of Quarterly Activities Narrative	Report finalized in Q1 and metrics updated for UMWP quarterly reporting. Continued development of depression screening metrics underway for Q2-3. Increases noted across the QI metrics of under utilization focus with decreased utilization in area of monitoring for potential over utilization (EMG). Continue to monitor for trends and opportunities for further intervention.
Known Barriers/Root Cause(s) (as applicable)	Lack of consolidation of all efforts toward oversight of over /utilization.
Next Steps	Dyadic codes, depression screening, doula benefits being added to report. Current report in place for Q1UMWG reporting.

Topic	**Site of Care**
Domain	Clinical Safety · Member Experience · Quality of Care
Priority	**Organizational Tactic**
Committee	**P&T, CQIC**
Goals	**1. 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. 2. Determine any barriers for Site of Care transition from members, prescribing providers, and infusion providers perspective.**
Opportunities for Improvement	**1. Improve access to home infusions and outpatient infusion center infusions for members. 2. Develop infusion provider and member relationship, which can eventually improve medication adherence and health outcomes.**
Results Q2	**100%**
Summary of Quarterly Activities Narrative	**We focused on completing the Site of Care transition for the members who were identified in Q1. We also chose a new target drug, ocrelizumab (Ocrevus) and identified 13 members who were eligible for our Site of Care program. We conducted outreach to all 13 members on ocrelizumab. Of these 13 members, two have accepted the program (15% -member acceptance rate). The two members who have accepted the program are pending provider decision. We have completed training for this program for of all pharmacy technicians and two out the three pharmacists.**
Known Barriers/Root Cause(s) (as applicable)	**1. Pharmacy staffing 2. Insufficient Home infusion and outpatient infusion contracted providers 3. Hospital contract limiting transition of infusions out of Hospital based outpatient infusions center. 4. Difficult to find the best contact information for providers. 5. Administrative tasks such as setting up member/provider letters and referrals are time consuming. 6. Tableau reports take time to create and modify. 7. 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. 8. 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	**Finish training the last pharmacy team member. Identify one new target drug and conduct member outreach. Finish transition to home infusion for all pending members who were originally identified in Q2.**

Topic	**Drug Utilization Review (DUR)**
Domain	Clinical Safety · Member Experience · Quality of Care
Priority	**Regulatory**
Committee	**P&T, QIHET-W**
Goals	**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. 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.**
Opportunities for Improvement	**Improve awareness among members on providers on any drug utilization is not in line with current clinical guidelines.**
Results Q2	**44%**
Summary of Quarterly Activities Narrative	**Drug utilization review was performed to identify members at increased risk for serious harms related to opioid therapy, based on Morphine Milligram Equivalent (MME) of their opioid's total daily dose. Out of 23,266 members with at least one opioid prescription during 2022, only 0.5% members were found to be at highest risk due to the high dosage of ≥ 100 MME. An educational article on opioid tapering was published in Provider Digest, and a letter was faxed to eight providers that have 2 or more members on high MME (90 or above). DUR was performed on members who were less than or equal to 18 years of age with a diagnosis of bipolar disorder and a prescription for a mood stabilizer medication. In 2022. 213 pediatric members with bipolar disorder were on a mood stabilizer, and there were more female members (138) on mood stabilizers than male members (75). We analyzed members who were on three or more mood stabilizers without seeing a provider board certified in psychiatry, and the investigation concluded that there were no prescribing concerns. Statin utilization was reviewed for Alliance members with Type 2 diabetes and ages 40-75. In 2022, about 63% of members received statins, whereas 37% did not. To increase statin utilization in members with Type 2 diabetes, a fax blast was sent to all providers with reminders of most recent American Diabetes Association guidelines. An educational article will be published in the Provider Bulletin with tips on how to manage statin related muscle pain in addition to ADA guideline recommendations. Statin utilization was reviewed for Alliance members with cardiovascular diseases and ages 20-75. In 2022, about 62% of members with cardiovascular disease received statins, whereas 38% did not. To increase statin utilization members with**

	cardiovascular disease, an article will be published in Member News regarding the importance of taking statins and how to manage the most common statin related side effect of muscle pain.
Known Barriers/Root Cause(s) (as applicable)	1. Limitation in report generation, requiring manual analyses that are time-consuming. 2.Competing priorities for pharmacists.
Next Steps	Results of DURs will be presented to P&T Committee for additional feedback. As less DURs are being performed than originally planned due to time constraints, topics will be prioritized based on regulatory and contractual requirements.

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) 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)
Opportunities for Improvement	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 Q2	83%
Summary of Quarterly Activities Narrative	In Q2 the Quality and Health Programs team completed 2 Healthier Living Program workshops series. The workshops were offered in the virtual and in-person modalities. One workshop series was offered in English and one workshop series was offered in Spanish.
Known Barriers/Root Cause(s) (as applicable)	There were no barriers to delivering this workshop series.
Next Steps	In Q3 the QHP team will be offering a telephonic workshop series and an in-person series in Salinas.

Topic	Controlling Blood Pressure
Domain	Quality of Care
Priority	Regulatory (DHCS Health Equity Goals), HEDIS
Committee	QIHET-W
Goals	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	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 Q2	1. Goal not met - pharmacy hypertension program has not yet been initiated. 2. Goal partially met - received verbal interest from Santa Cruz County Clinics in their interest in participating in the PLAD Hypertension program. 3. Goal not met - Mar 2023 CBP = 53%
Summary of Quarterly Activities Narrative	1. Project placed on hold until June while continuing to track BP recheck rates monthly.
Known Barriers/Root Cause(s) (as applicable)	1. Clinician and staff turnover limits clinics from participating in improvement activities (i.e. Lost Emeline medical director and clinic manager in Mar 2023) 2. New process may be slowly adopted, will need to focus on education and job aids.
Next Steps	1. Check back in with clinic to assess ability to continue working on improving CBP rates.

Topic	**Diabetes HbA1c >9% (poor control)**
Domain	**Quality of Care**
Priority	**Regulatory (DHCS Health Equity Goals), HEDIS**
Committee	**QIHET-W**
Goals	**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	**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 Q2	**1. Goal met in quarter 1.** **2. Goal met: Completed PLAD DM program: CSVS on 6/8/23; Start date pending: DoD**
Summary of Quarterly Activities Narrative	**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 plan the sessions.** **4. Generate registry list of members to track A1C and f/up visits throughout program.**
Known Barriers/Root Cause(s) (as applicable)	**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	**1. In planning phase with DoD to schedule sessions with pharmacist.** **2. Awaiting list of CBI QIP clinics interested in the DM PLAD Program to outreach to.**

F: PERFORMANCE IMPROVEMENT PROJECTS (STATE MANDATED)

Topic	**Women's Health Domain SWOT**
Domain	Quality of Care
Priority	**Statewide DHCS Performance**
Committee	**QIHET-W**
Goals	**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.** **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	**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.** **II. Three providers have been selected for targeted outreach.** **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.**
Results Q2	**I.:** **• Five provider applicants selected to make quality improvements in both chlamydia screening and breast cancer screening. Of those five, all providers requested additional assistance through practice coaching through program operations June-December 2023.** **• Two provider applicants selected to make quality improvements in Chlamydia Screening only. Of the two submissions, one provider requested additional assistance through practice coaching through program operations June-December 2023.** **• Eight provider applicants selected to make quality improvements in Breast Cancer Screening only. Of the eight submissions, five providers requested additional assistance through practice coaching through program operations June-December 2023.** **II: Determined large group providers for outreach with greatest EP and lowest compliance. Presently Merced Faculty Associates North, Golden Valley Health Centers, and Apex Medical Group are participating. Gettysburg is pending approval as a fourth provider as of 5/31/2023.** **• Provided best practice information to clinics for completing breast cancer and chlamydia screening during well-visits.** **• Provide member rosters for members due for breast cancer screening.** **• Host bi-weekly check-ins with clinics to address questions and to assist if any barriers arise.** **III: Drafted letter for specific Black Member recall, tested it for readability, and had it translated as of May 26, 2023. In addition to letter, mailer to include informatic from USPSTF related to Black women and their mortality statistics from undiagnosed Breast Cancer. Presently building rosters for a population of about 150 women.**
Summary of Quarterly Activities Narrative	**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.** **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.** **Member letters drafted and USPSTF flyer decided as outreach flyer for Black members for BCS mailer.** **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.**
Known Barriers/Root Cause(s) (as applicable)	**Due to QIPH staff limitations it was decided to focus on increasing breast cancer screening and chlamydia screening rates.** **QIPH staff has competing priorities with the completion of CB QIP applications and being low staffed.** **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.**

	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.
Next Steps	Reach out to additional clinics to partner on increasing breast cancer screening rates. Create PowerPoint presentation for MFA to take to leadership to get their approval to partner with QIPH. Generate member lists and provide best practice information. For Q2 QIPH will continue to meet with clinics to address barriers and provide updated member lists based on member enrollment.

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. 2. (2022 goal) CIS PIP SMART Goal: By December 31,2022, CFHC will increase CIS rates among the three targeted sites from a baseline of 12.22% to 19.51%
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 Q2	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. 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	
Results Q2	1A-1C) Member outreach project completed and results reported to PETF committee. 2A) Infant Wellness Map (IWM) dissemination in progress for Merced County CBOs and Clinics. 2B) Merced Co. Pediatrician-led Webinar focused on pediatric measures is in progress with aim for go-live Q3-2023. 3A) Promotion of DHCS 2024 Tech funding delayed due to no further information received from DHCS at this time. In lieu, staff are assisting the promotion of the MCGP and CDIII tech grants. 3B) Provider Portal Recall Best Practices/Training delayed due to internal and external staffing constraints. Staff are discussing incorporating recall best practices into broader training outlets to ensure this education is provided.

Summary of Quarterly Activities Narrative	**1) SWOT 1 Actions A-C:** **QIPH Staff made outreach calls to Merced County members deficient* (or at risk of becoming ineligible) for W15 and CIS-10 immunizations to assess for trends in barriers to receiving care, and to connect member to PCP for appointments. Outreach completed 4/10/2023 and summary of results presented at 5/8/2023 and 7/31/2023 PETF committee meeting.** **Next Steps:** **• Share barrier data with PR team then PCPs that participated.** **• Encourage PCPs to perform member recall for W15 & CIS-10.** **2) SWOT 2 Action A:** **Staff are coordinating the promotion of the Infant Wellness Map (IWM) to Merced County CBOs and clinics that serve the target population to partner in disseminating the tool to parents to help them track WCVs and immunizations 0-15 months of life.** **In Q2, staff provided 200 copies (100 English, 75 Spanish, 25 Hmong) of the IWM to the Merced Office of Education - Head Start Program to give to new members of their program. Staff are meeting with Provider Relations team to discuss which clinics in Merced may benefit from targeted outreach.** **SWOT 2 Action B:** **Merced Pediatrician engaged in hosting a webinar focused on pediatric measures for Merced County providers. Staff are drafting webinar content in collaboration with MD and preparing various internal and external communications to promote webinar, which is tentatively set for September 2023. The webinar will be announced in the Alliance's Provider Digest to facilitate provider registration and attendance and may be recorded for posting to our provider resources website.** **Pre and post education will be assessed to measure effectiveness of webinar. Content may include Child Lead Screening, WCV, CIS-10, coding & billing, fluoride application and ACE screenings.** **3) SWOT 3 Action A:** **Due to delay in further information from DHCS re tech funding for 2024, QI staff are coordinating assisting our Grant and Program Development Department's tech funding currently available through the Alliance's Medi-Cal Capacity Grant Program (MCGP) or the CDIII grants for the statewide Data Sharing Agreement (DSA) requirement.** **Staff currently collaborating with Grants Department and Program Development to assist in promoting MCGP and CDIII funding to Merced County sites identified as benefiting from the tech funding grant(s).** **SWOT 3 Action B:** **Due to unanticipated internal and external staffing constraints some external outreach/training sessions (CBI Forensic visits, Practice Coaching, PIP engagements, etc.) with providers were delayed or postponed for Q3-23.** **Given that staffing could intermittently pause individual outreach sessions in 2023, CCAH staff are discussing disseminating Provider Portal recall best practices to larger groups by considering incorporating them into the annual CBI Provider Workshop, CBI Forensic Visit templates, targeting low-performers in the mid-year CBI report, and/or updating the webinar currently available on the Alliance's website.** **Staff are assessing the feasibility of implementing one of the broader approaches above in conjunction with individual outreach sessions.**
Known Barriers/Root Cause(s) (as applicable)	**Staff turnover, provider availability, member education**
Next Steps	**- Continue to promote and distribute the Infant Wellness Map in Merced County.** **- Conduct Pediatric webinar for Merced County providers.** **- Continue to promote internal and external tech grands/funding to Merced County providers.** **- Incorporate provider portal recall best practice training into CBI forensic visits and/or mid-year provider reports.** **- Prepare third and final progress update for DHCS due September 2023.**

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 Q2	**On 6/2/23 DHCS provided the final validation findings for our Module 4. Our confidence level for this PIP was determined to be High confidence (highest score possible) and all other requirements for Module 4 were met. No additional action was needed. This PIP has officially ended.**
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 30 Months of Life—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 Q2	**PIP design/first submission steps 1-6 due 9/8/2023 in draft. Next submission due September 2024 with 2023 baseline data for W30 (W15 6 visits in the first 15 months of life).**
Summary of Quarterly Activities Narrative	**PIP topic selection occurred in Q2. No further requirements from HSAG.**
Known Barriers/Root Cause(s) (as applicable)	**TBD**
Next Steps	**First Module submission due in September 2023**

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	**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 Q2	**HEDIS MY2022 FUA-30 final rates for SC/MON were 37.35% and 22.48% for Merced. HEDIS MY2022 FUM-30days final rates for SC/MON were 60.67% and 70.72% for Merced. All four rates were above the 50th percentile, with one HPL for FUA in SC/MON.**
Summary of Quarterly Activities Narrative	**Discussions with delegated Behavioral Health provider Carelon have been initiated to develop a data transfer process to identify Alliance members in the emergency department. Cross departmental work is in progress to establish member identification through claims and eCensus data, as well as file layout for data transfers to Carelon.** **PIP topic selection occurred in Q2. No further requirements from HSAG.**
Known Barriers/Root Cause(s) (as applicable)	**Patient privacy concerns for protected health information created barriers for notifications.**
Next Steps	**First Module submission due in September 2023**

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 Q2	**(1) 4/23/2023 Met with SCBHS to determine EDO process for accessing care and repayment of services (2) Project accepted for PI Academy.**
Summary of Quarterly Activities Narrative	**Project Charter was adopted by the Deputy Medical Director and the Process Improvement workflow group launched kick-off and is in the process of documenting current state mapping.**
Known Barriers/Root Cause(s) (as applicable)	**1. Eating disorders post pandemic have increased significantly. Unclear pathways have caused delays in treatment. 2. Gaps in handoffs between levels of care.**
Next Steps	**Complete next level of current state mapping. Conduct analysis of current state. Complete root cause analysis. Engage in partnership discussions with County Mental Health department staff.**

SECTION 4: CLINICAL SAFETY

H: CLINICAL SAFETY

Topic	**Grievance and PQI Management**
Domain	**Clinical Safety**
Priority	**Regulatory**
Committee	**QIHET-W**
Goals	**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	**Maintain adequate staffing of program; expedite training of new hires.**
Results Q2	**Data as of 7/31/2023** **1. 147/149 (99%) PQIs were closed within timeframe this quarter.** **13/15 (87%) of internally referred PQIs were completed within 90 calendar days or less; and** **134/134 (100%) of Member Grievance PQIs were completed within 30 calendar days or less; and** **2. 46 QoS member grievances closed by QI RN will be audited by Medical Director for IRR (results pending).**
Summary of Quarterly Activities Narrative	**This quarter:** **- The team successfully onboarded two Medical Directors to assist in processing member Grievances, PQIs, and Quality Studies. The additional support has reduced administrative burden between Medical Directors and increased QI RN access to clinical input for Quality concerns; and** **- The team is in collaboration with Grievance and Provider Relations teams regarding Provider communication for QoC member grievances and PQIs to better inform providers of our grievance and PQI review process. The goal is to decrease unnecessary contact with Providers and to educate them on the difference between member grievance processing and PQI processing; and** **- The team delivered an updated "Potential Quality Issue Overview" presentation to QI staff and plans to review the presentation with Alliance staff outside of QI to increase understanding of the program and promote internal referrals.**
Known Barriers/Root Cause(s) (as applicable)	**1. Retaining qualified and well-trained staff.**
Next Steps	**- Continue to collaborate with Grievance and Provider Relations regarding Provider communications for QoC grievances and PQIs.** **- Present PQI Overview to Alliance staff and/or post PowerPoint to the intranet.**

Topic	**Facility Site Review (FSR) Management**
Domain	**Clinical Safety**
Priority	**Regulatory**
Committee	**QIHET-W**
Goals	**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	**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 Q2	**1. 100% (7/7) 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% (2 of 2) of practices where Critical Elements Corrective Action Plans (CE CAPs) arising from FSRs are resolved within 10 business days.** **3. 91% (10 of 11) of practices with a Corrective Action Plans (CAPs) arising from FSR submit a plan to address the CAP within 45 calendar days.** **4. 80% (8 of 10) 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	**1. Attend collaborative meetings to plan the implementation of the DHCS mandated Manage Care Site Review Portal (MSRP);** **2. Collaborate with Alliance Application Services to create an 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; and** **4. Attend Statewide Managed Care Plan collaborative to continue education, align continued implementation of FSR tools and standards, and share resources.**
Known Barriers/Root Cause(s) (as applicable)	**1. PCP office short staffed due to employee health issues and personal time off;** **2. Failed scores due to expanded DHCS FSR Tool create larger than normal CAP; and** **3. Natural Disaster caused site to close and postpone completion of CAP.**
Next Steps	**1. Continue to update resources in the current Corrective Action Plan template to ensure that providers are supported in implementing improvements;** **2. Attend Inter Rater Reliability IRR for Certified Master Trainer recertification; and** **3. Test MSPR interface.**