Q3 2023 QIHE plan

pic	Health Ca e C llab atives - feedbac f m c mmunit engagement	pic	C nt lling Bl d P essu e	PROGRESS SUMMARY
Status	G al N t Met	Status	In P g ess	66%
pic	Health Se vices Divisi n Membe Out each & Engagement Campaigns	pic	Diabetes HbA1c >9% (p c nt l)	Pe cent C mplete
Status	In P g ess	Status	G al Met	
pic	Membe Supp t - Call Cente	pic	men's Health D main SWO	C mp site Sc e
Status	G al Met	Status	In P g ess	4
pic	Cultu al and Linguistics (C&L) Se vices & P pulati n Needs Assessment Educati n	pic	Childh d Immunizati ns	Secti ns ab ve ta get
Status	In P g ess	Status	G al Met	
pic	CAHPS: H w Well D ct s C mmunicate	pic	Child en's D main SWO	
Status	In P g ess	Status	G al Met	
pic	Annual Access Plan	pic	Child and Ad lescent Well-Ca e Visits in Me ced C unt	
Status	In P g ess	Status	G al Met	
pic	P vide Ch ice: In-A ea Ma et Sha e	pic	Well-Child Visits in the Fi st 30 M nths f Life—Well-Child Visits in the Fi st 15 M nths—Six M o e Well-Child Visits (W30–6) measu e	
Status	In P g ess	Status	G al Met	
pic	CAHPS Su ve : Access Measu es	pic	F ll w-Up Afte Eme genc Depa tment Visit f Mental Illness—30-Da F ll w-Up—tal and F ll w-Up Afte Eme genc Depa tment Visit f Substance Use—30-Da F ll w-Up—T tal	
Status	In P g ess	Status	G al Met	
pic	P vide Satisfacti n	pic	Eating Dis de s	
Status	G al Met	Status	G al Pa tiall Met	
pic	Unde / Ove utilizati n	pic	G ievance and PQI Management	
Status	G al Met	Status	G al Pa tiall Met	
pic	Site f Ca e	pic	Facilit Site Review (FSR) Management	
Status	In P g ess	Status	G al Pa tiall Met	
pic	D ug Utilizati n Review (DUR)			
Status	In P g ess			
pic	Health Educati n and Disease Management			
Status	In P g ess			

Q3 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 Q3	**0**
Summary of Quarterly Activities Narrative	**Metric has been canceled and will not be measured moving forward**
Known Barriers/Root Cause(s) (as applicable)	**Adequate staff to perform activities**
Next Steps	**this metric will be rolled up into Organizational actions taken by all member voice.**

Topic	**Health Services Division Member Outreach & Engagement Campaigns**
Domain	**Member Experience** **Quality of Care** **Quality of Service**
Priority	**Core**
Committee	**QIHET-W, MSEC**
Goals	**Member outreach is critical to inform, foster dialogue, and support at risk Alliance members. Member outreach will consist of calling members impacted by the emergent issues, impact on access to care, and member voice assessments. Mobilize an internal team to identify members, develop scripting and information of appropriate resources and health education, and conduct telephonic outreach to high-risk, vulnerable members.** **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 Q3	**0.00%**
Summary of Quarterly Activities Narrative	**There were no ad-hoc member outreach campaigns completed in Q3 2023. The Health Services teams have focused staff efforts on preparation for Population Health Management implementation, new 2024 contract requirements and county expansion efforts.**
Known Barriers/Root Cause(s) (as applicable)	**Not applicable this quarter.**
Next Steps	**Teams are preparing for 2024 contract requirements and county expansion. If new member outreach campaigns are identified they will be reported accordingly.**

Topic	**Member Support - Call Center**
Domain	**Member Experience**
Priority	**Regulatory (DHCS)**
Committee	**MSEC**
Goals	**1. 95% of Calls to Member Services Answered Before Being Abandoned** **2. 80% of Calls to Member Services Answered Within 30 Seconds**
Opportunities for Improvement	**Identify additional barriers to being able to continuously meet this requirement.**
Results Q3	**1. 95% 2. 80%**
Summary of Quarterly Activities Narrative	**During Q3 2023 the Alliance Member Services' Call Center focused on sharing redetermination information with members and ensuring that their mailing address is up updated. We have also started to receive calls from expansion members and have been providing them with basic Alliance information.**
Known Barriers/Root Cause(s) (as applicable)	
Next Steps	**Keep eye on member walk-in volume**

Topic	**Cultural and Linguistics (C&L) Services & Population Needs Assessment Education**
Domain	**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 Q3	**55.50%**
Summary of Quarterly Activities Narrative	**In Q3 2023 there was a 55.5% total increase compared to Q3 of 2022 of providers utilizing face-to-face (in-person) interpreting services.** **County specific data for face-to-face interpreting services was as follows:** **Merced County had 193% increase in Q3 2023 compared to Q3 2022** **Santa Cruz County had 78.2% increase in Q3 2023 compared to Q3 2022** **Monterey County had 14.2% increase in Q3 2023 compared to Q3 2022** **For telephonic interpreting services the data is not broken down by county.** **In Q3 2023 there was a 22.9% increase of providers and staff utilizing telephonic interpreting services compared to Q3 2022.**
Known Barriers/Root Cause(s) (as applicable)	**In Q3 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 Santa Cruz County utilization. The C&L team will continue to monitor utilization rates to ensure member access**
Next Steps	**In Q3, the C&L team worked on county expansion efforts with vendors to ensure access to interpreting services in the new counties starting in 2024. Most vendors have confirmed capacity within the new expansion counties. In Q4, the C&L team will continue to work closely with our interpreting vendors to address any language access gaps that may arise.**

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 Q3	**Results anticipated in 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. Results from survey expected in Q4 2023.**
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 Q3	**The committee continued work to develop additional criteria to prioritize recruitment, and in Q3 metrics based on grievances and potential delays in care were discussed. These metrics will be finalized and thresholds defined.**
Summary of Quarterly Activities Narrative	**Working w/ NDSC attendees to develop criteria to assist in ensuring appropriate prioritization of access plan focus areas.**
Known Barriers/Root Cause(s) (as applicable)	**TBD**
Next Steps	

Topic	**Provider Choice: In-Area Market Share**
Domain	Member Experience · Quality of Service
Priority	**Regulatory, Core**
Committee	**NDSC**
Goals	**1. 80% Market Share (PCP and Specialist) target with 75% lower threshold 2. Market Share stability with a no more than 5% decrease annually.**
Opportunities for Improvement	**1. Credential non-credentialed providers practicing at contracted locations. 2. Engage providers who have historically declined to contract.**
Results Q3	**Monterey County Access gaps for Nephrology (adult and pediatric) and Psychiatry (adult) were closed in Q3 further to successful contracting with providers identified in Q2. The Psychiatry (pediatric) gap is anticipated to be closed in Q423 due to Carelon data improvements as Abdellatif Aichouri, MD was added to the pediatric Psychiatry network.**
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 Q3	**Results anticipated in Q4 2023/Q1 2024**
Summary of Quarterly Activities Narrative	**Sample Frames for the 2023 Adult and Child CG CAHPS survey will be submitted in Q3. Field surveys anticipated to begin in Q4**
Known Barriers/Root Cause(s) (as applicable)	**Sample frames for 2023 Adult and Child CG CAHPS submitted in September 2023.Surveys will begin in Q4.**
Next Steps	**Review the finalized analysis by the vendor for 2023 survey results in Q4 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 Q3	**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 Q3	**Assessment: Q3 UMWP data reflects the following Claims activity, with percentages measured against Claims activity in prior quarter (Q2 2023). ACE at 12,162 claims, a 9.5% increase over prior quarter (n=11,105). Breast Cancer Screening at 5,035 claims, a 4.7% decrease over prior quarter (n=5,273). Colorectal Cancer Screening at 4,882 claims, a 2.4% increase over prior quarter (n=4,768). EMG at 256 claims, a 32% increase over prior quarter (n=195). Initial Health Assessment at 64,692 claims, a 11% increase over prior quarter (n=58,191). Lead Screening in Children at 4,765 claims, a 2% decrease over prior quarter (n=4,856). Depression screening remains unchanged from prior quarter and likely reflects incomplete capture of screening activity with new metric, consistently noting fewer than 50 claims/quarter.**
Summary of Quarterly Activities Narrative	**Report finalized in Q1 and metrics updated for 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 Q3	**100%**
Summary of Quarterly Activities Narrative	**Q3: We focused on completing the Site of Care transition for the members who were identified in Q2. There were two members from Q2 who had accepted transition to Site of Care but were pending provider decision at the time of our last summary. Of those members one will be starting home infusion in January 2024 and the other one will not be transitioning to home infusion because the provider could not be reached. We also chose new target drugs based on the remaining medications that our local home-infusion provider has access to; □ustekinumab (Stelara), pegloticase (Krystexxa), □alpha-1-proteinase Inhibitor (Glassia), and □alpha-1-proteinase Inhibitor (Zemaira). Unfortunately, none of the members on these medications were eligible for our Site of Care program so no outreach was conducted in Q3. We have completed training for this program for of all pharmacy technicians and all 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 Q3	**78**
Summary of Quarterly Activities Narrative	**Q3:** **Drug utilization review was performed to identify high risk members who received buprenorphine MAT and full opioid agonist concurrently during April 2022 through March 2023. The goal was to identify concerning prescribing patterns such as co-prescribing of buprenorphine and opioids for more than 7 days. We discovered that 33 clinicians co-prescribed opioid and buprenorphine to a total of 66 members (only 14 were co-prescribed Naloxone). Additional goal was to identify high risk members who received opioids from a prescriber different than the one issuing buprenorphine. We identified 63 members that received a full opioid agonist prescription from prescriber different than the one who issued buprenorphine (only 19 of these were co-prescribed naloxone). Targeted outreach will be conducted to encourage providers reevaluate necessity of buprenorphine and opioid concurrent therapy, to monitor Controlled Substance Utilization Review and Evaluation System (CURES) and to encourage co-prescribing of naloxone.** **Drug utilization review was performed on Alliance members who were less than or equal to 18 years of age and had a prescription for a controlled substance in the drug classes sedative or antianxiety in 2022. The goal was to determine any inappropriate prescribing patterns and/or potential fraud, waste, and abuse (FWA). We concluded that there were no concerns for inappropriate prescribing patterns or for fraud waste and abuse. We will continue to monitor this DUR topic annually.** **Drug utilization review was performed to evaluate naloxone prescribing to high-risk members. Our primary goal was to assess whether naloxone was co-prescribed to members who received Emergency Department or inpatient treatment for nonfatal opioid overdose during 2022. We discovered that only 87 out of 405 members were co-prescribed naloxone after discharge. Results of the analysis were shared and discussed with Alliance Behavior Health, Enhanced Care Management and Quality improvement teams to increase awareness and collaboration.** **Over 100 member profiles were reviewed by the pharmacy department for those who received sedative/hypnotics during the year 2022 for potential fraud, waste, and abuse. The goal was reviewing prescribing patterns by the providers, early fills, multiple provider visits and multiple pharmacies fills by the members and early fills and overrides by the pharmacy providers. No concerns were found. A provider bulletin on 'Managing insomnia' will be published soon to educate providers on a recent update on managing insomnia in primary care setting.**
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	**Q3: We will be connecting with Analytics team to improve process efficiency during data analysis. This will help in reducing the time spent by pharmacists on analyses and more time performing interventions.**

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 Q3	100%
Summary of Quarterly Activities Narrative	In Q3 the Quality and Health Programs team completed 1 Healthier Living Program workshops series. The workshop was offered in English in the telephonic modality.
Known Barriers/Root Cause(s) (as applicable)	There were no barriers to delivering this workshop series.
Next Steps	The QHP team started a virtual and an in-person HLP series in late Q3 that will be completed in Q4. There will be an additional telephonic HLP series that will start and end in Q4.

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 Q3	1. Goal not met - pharmacy hypertension program has not yet been initiated. 2. Goal not met - Santa Cruz County Clinics decided against participating in the new PLAD Hypertension program. Instead, requesting a one-time clinician focused training around the latest hypertension guidelines. 3. Goal met - Santa Cruz County Clincs Q2 2023 CBI CBP measured in Q3 2023 = 66.527%
Summary of Quarterly Activities Narrative	1. Project placed on hold until June while continuing to track BP recheck rates monthly. 2. Per check-in with provider over the summer, they are not interested/able in a full PLAD project. At this time, project identified as closed. 3. Project identified as closed.
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 Q3	1. Goal met - New clinics outreached to: Gettysburg Medical Clinic, Dr. Thao, Soledad Medical Clinic. Also, reconnected with Mee Memorial Clinics. 2. Goal me: Completed PLAD DM program: CSVS on 6/8/23; Start date pending: DoD, Gettysburg, Dr. Thao. On-hold: Mee Memorial, Soledad Medical Clinic.
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 Q3	I. All providers participating in the CB QIP have completed their Letter of Agreement and received their initial (80%) and second (10%) payment, with their final payment (10%) to be received after participation in the second cohort meeting completed on October 24, 2023. II. Performance Improvement Projects (PIP) have begun, and the following actions have taken place: - Chlamydia Screening, we identified a gap in care for members 16-17 years of age due female members receiving prescription for contraceptives to control their menses. Staff shared CDC's and American Academy of Pediatrics (AAP) best practice for screening all female members at well-visits for chlamydia, with the option to opt out with Merced Faculty Associate (MFA) North and Apex Medical Group. III. Completed delivery of Black member mailing to Merced providers of non-compliant members eligible for breast cancer screening.
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.

	For Q3 QIPH provided member recall rosters for Apex Medical Group and MFA North showing members due for chlamydia screening and well-visits. Worked with GVHC to identify barriers within organization to implement member recall rosters in coordination with QI and Care Management teams. Worked with QI department to review member recall roster for potential exclusions to upload to the Alliance's Data Submission Tool for compliance.
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. For Q3 staffing heavily impacted all interventions due to staff on leave or loss of staff. MFA was assigned a CAP from FSR team and focused efforts on addressing CAP before working on intervention project. GVHC departments work in silo; QI comes up with interventions and then has challenges getting the necessary staff to implement intervention. GVHC has also taken on a lot of projects and is over stretched.
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. For Q3 QIPH will continue to meet with clinics and address barriers, and provide updated member recall lists as needed.

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 Q3	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 Q3

Goal 1 (1A-1C): Member Outreach project completed in Q2-2023. Goal 2, (2A): Infant Wellness Map (IWM) dissemination in progress in Merced County (see narrative). Goal 2, (2B): Pediatric Best Practices Webinar completed by Merced County pediatrician Dr. Carmela Sosa with support from QI PH staff September 2023. Goal 3, (3A): As of October 2023, Healthcare Technology grant applications are currently under review, and if approved will go to Board for approval in Q4-2023. Goal 3, (3B): Several CBI Forensic visits with Provider Portal training/edu. have been conducted by QI staff and more visits are scheduled for Q4-2023

Summary of Quarterly Activities Narrative

SWOT 1 Actions A-C: The Member Barrier outreach project was successful because we gained insight as to:
- What the top barriers to accessing care were for this member sample.
- The type of education QI PH needs to provide to parents/guardians to increase their understanding of the importance of regular well-child visits and timely immunizations.
- Best practices when contacting members and sharing information regarding a potential or actual healthcare deficiency.
These lessons learned will be taken into consideration for future outreach efforts made by QI PH staff.

SWOT 2 Action A: Promoting the distribution and use of the Alliance's Infant Wellness Map (IWM) to Merced County CBOs, clinics, and members.
This project was a success because QI PH staff successfully disseminated the tool in collaboration with the Merced County office of Education – Head Start Program and Merced County Public Health.
Head Start received 200 copies of the IWM June 2023 (75 Spanish, 100 English and 25 Hmong) and are actively distributing the tool to their Alliance insured members. CCAH staff will check in with Head Start to offer support and more copies in Q4-23.
Additionally, staff have collaborated with Merced County Public Health, First Five of California, and Golden Valley Health Centers to host a Health Fair for the Merced community.
The Health Fair will occur on 10/8/2023 and will include:
- An Alliance informational booth to pass out IWM.
- Flu vaccinations, blood glucose checks, blood pressure checks, eye exams and more.1
- 35+ exhibitors with informational booths.
- 'Passport' cards completed by visiting and learning about each exhibitor.
- Completed cards can be entered into a raffle for prizes and a bonus raffle ticket is given to those that receive a flu vaccine at the fair.
- Live radio broadcasting from a local Merced Spanish radio station.

The flu vaccine has been a highlight for this Health Fair to raise awareness for the Merced community on the importance of flu vaccinations.

SWOT 2 Action B: Pediatric Best Practices Webinar:
This project was a success because we met our goal of conducting a live-session Pediatric Best Practices Webinar in Q3 of 2023 and exceeded the webinar attendance goal. 38 out of 69 (55%) external registrants attended from 35 different entities and clinics (including 19 from Merced County).
The Pediatric Best Practices webinar was hosted by Dr. Carmela Sosa, a prominent and high-performing Merced County Pediatrician, with assistance from CCAH staff.
The webinar recording will be posted on our provider webpage by Q4-2023 as a resource for providers and office staff.
The webinar content included:
• AAP Periodicity Schedule
• Early Childhood & Adolescent Well Visits
• Immunizations
• Lead Screening
• Fluoride Application
• ACEs Screenings
• Alliance Resources

SWOT 3 Action A: Promote Healthcare Technology grants to Merced County physicians.
This effort was a success because there were 3 entities from Merced County that applied for the Healthcare Technology Program grant; one application was approved, and two are pending.
A grant of $50,000 was awarded to Golden Valley Health Centers, who serves approximately 65,000 Alliance members within the county, to apply towards Epic Welcome & Tonic Health tablets for patient registration, scheduling, and health surveys and questionnaires.
As of September 2023, there are 2 pending applications from Merced County providers that will be internally reviewed and, if recommended, go to the Board for approval in October.

SWOT 3 Action B:
As of 9/29/2023, staff has conducted Care Based Incentive (CBI) Forensic visits with 9 clinics from Merced Co. and anticipate further visits this year. In these visits, Alliance staff share our resources such as member incentives and provider portal reports to support clinics in accessing, understanding, and using their data for performance improvement. Additionally, QI PH will host a live-session 2024 CBI overview October 2023.

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.
- Post virtual Pediatric Best Practices Webinar on Provider website.
- Continue to promote internal and external tech grands/funding to Merced County providers.

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 Q3	N/A- Project Complete; Goal Met in Q2
Summary of Quarterly Activities Narrative	Our final rate for the WCV PIP was 62.61%; 14.05% above our goal rate for this project. Module 4 was submitted to DHCS on April 21, 2023. DHCS provided validation findings on June 2, 2023. We met all requirements and given a High confidence level rating for this PIP. No further actions need to be taken; this PIP cycle is officially closed.
Known Barriers/Root Cause(s) (as applicable)	No barriers identified
Next Steps	None.

Topic	Well-Child Visits in the First 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 Q3	On 9/7/23 the 2023-2026 DHCS W30-6 PIP form was submitted to HSAG and DHCS.
Summary of Quarterly Activities Narrative	2023-2026 DHCS W30-6 PIP submission was completed. Analysis performed to identify Merced providers with highest potential for impact. No further requirements from HSAG.
Known Barriers/Root Cause(s) (as applicable)	TBD
Next Steps	Pull baseline data for 2023 after year-end and allowing for claim lag (likely May 2024). Determine provider to work with on PIP.

Topic	Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total and Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total
Domain	Quality of Care
Priority	Statewide Department of Healthcare Services (DHCS) Non-Clinical Performance Improvement Project (PIP) 2023-2026
Committee	QIHET-W
Goals	By quarter 3 2023, complete first modules for DHCS PIP.
Opportunities for Improvement	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 Q3	On 9/8/23 the nonclinical PIP submission was sent to DHCS and HSAG.
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. Resubmission in Q4 for validation findings from HSAG.

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 Q3	**PI Project Charter and Kickoff complete, including cross organizational group. Provider Payment Workgroup topic and sub-group EDO focused established.**
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 Q3	**1.152/152 (100%) PQIs were closed within timeframe this quarter. 30/30 (100%) of internally referred PQIs were completed within 90 calendar days or less; and 122/122 (100%) of Member Grievance PQIs were completed within 30 calendar days or less; and 2. 30 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 Q3	**1. 100% (17 of 17) 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% (3 of 3) of practices where Critical Elements Corrective Action Plans (CE CAPs) arising from FSRs are resolved within 10 business days.** **3. 86% (12 of 14) of practices with a Corrective Action Plans (CAPs) arising from FSR submit a plan to address the CAP within 45 calendar days.** **4. 79% (11 of 14) 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) to continue education, align continued implementation of FSR tools and standards, and share resources.;** **2. Collaborate with Alliance Application Services to create and test interface for MSRP to effectively meet DHCS reporting requirements;** **3. Collaborate with Anthem DHCS Certified Master Trainer to ensure a smooth expansion to San Benito and Mariposa counties;** **4. Attend Inter Rater Reliability IRR for Certified Master Trainer recertification.**
Known Barriers/Root Cause(s) (as applicable)	**1. Site review team is short staffed.** **2. MSRP delays at the state level. Will have second round of testing soon.** **3. 1 out of 2 FSR RNs were able to attend IRR.**
Next Steps	**1. Moved PQI RN to FSR for coverage for an FSR RN on LOA.** **2. Continue to update resources in the current Corrective Action Plan template to ensure that providers are supported in implementing improvements.** **3. Volunteered to beta test for next round of MSRP interface upload testing.** **4. The FSR RN who was unable to attend IRR will need to recertify as CSR once she returns from LOA.**