



SECTION 1: QUALITY PROGRAM STRUCTURE

ANNUAL EVALUATION (ANDREA SWAN)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Annual Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. To develop a comprehensive evaluation of all Quality Improvement activities for 2024.	1. Ensure all required sections of the workplan meet DHCS, and NCQA requirements. *Correction-This section notes the QI evaluation goals and objectives. 1. Ensure all data is tracked through the work plan each quarter as these updates will ensure completion of the evaluation timely.	1/1/2024-12/31/2024	Andrea Swan, Quality Improvement & Population Health Director	All workplan updates submitted quarterly with all information reviewed and approved by QIHEC. Evaluation on track to be written during QI 2025.	1: Barriers identified in data collection related to Grievance and Appeal data.	1. Reporting was created to accurately capture needed categories of grievance data moving forward.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Please add QI evaluation link
2.	2.		<input type="checkbox"/> Yes <input type="checkbox"/> No					
3.	3.		<input type="checkbox"/> Yes <input type="checkbox"/> No					
4.	4.		<input type="checkbox"/> Yes <input type="checkbox"/> No					

PROGRAM DESCRIPTION (ANDREA SWAN)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Annual Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Finalize 2024 Program Description for presentation to QI stakeholders.	1. Ensure all required sections of the workplan meet DHCS, and NCQA requirements.	1/31/2024-2/15/2024	Andrea Swan, Quality Improvement & Population Health Director	1 st update: Program description was finalized 5/15/2024. but has not been presented to QIHEW as it is currently being reviewed by NCQA team to ensure all elements have been met.	1: Program description completed in prior year were not sufficient to meet new DHCS and NCQA standards. Program description has been reviewed to meet all regulatory requirements.	1 Present finalized program description to QIHEW by the end of June 2024.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	2024 Workplan was completed and meets all NCQA and regulatory components. Delays were
2. Presentation of the Program Description to both the QIHEW, and QIHEC for approval by 3/31/2024	2. Submission of Program Description to QIHEW staff	2/1/2024-2/15/2024	Andrea Swan, Quality Improvement & Population Health Director				<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

3. Develop a comprehensive 2025 Quality improvement Program Description that outlines all required DHCS, and NCQA requirements.	3. Review all DHCS, and NCQA requirements to ensure all sections included are relevant and share the template with business owners to begin writing.	9/30/2024-12/31/2024	Andrea Swan, Quality Improvement & Population Health Director	2 nd update: 9/2024 workplan reviewed by NCQA team and has met all required elements.	2: Delay in approval of final PD as additional areas needed review to ensure program description met all required elements.	2: With all elements finalized, and system developed to ensure Business owner completion, and stakeholder review the QI program description going forward the program description for 2025 will be launched in December prior to the measurement year to ensure timely completion, and committee review and approval.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	encountered due to understanding of additional requirements needed to meet all area which led to the final program description not being presented at QIHEC however the QI workplan was used in its place to outline and report the QI program and al activities to stakeholders. 2025 workplan was launched late 2024 and is on track to be presented to QIHEC QI 2024.
4.	4.						<input type="checkbox"/> Yes <input type="checkbox"/> No	

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. To executes a QI program annual work plan that reflects ongoing activities throughout the year and addresses all required DHCS, and NCQA requirements	1. Create a workplan that captures yearly activities, time frame for each activity's completion, staff members responsible for each activity, monitoring of previously identified issues, and evaluation of QI program.	1/1/2024-2/15/2024	Andrea Swan, Quality Improvement & Population Health Director	Qtr. 1: Workplan successfully completed, and approved at QIHEW, and QIHEC in the 1 st quarter of 2024. 1 st quarter updates have been completed pending presentation to QIHEW and QIHEC.	1: Current workplan needed to be updated to meet DHCS and NCQA requirements which was successfully completed.	1: Continue to work with business owners for timely submission and ensuring work plan updates meet requirements and reflect progress towards goals.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Workplan updated to meet NCQA requirements with accurate timely reporting updates achieved.
2. Ensure all workplan elements are properly documented and reflect appropriate follow up by each business owner.	2. Regular quarterly check-ins to review workplan entries, with regular feedback provided to business owners when applicable.	3/31/2024,6/30/2024,9/30/2024,12/31/2024	Andrea Swan, Quality Improvement & Population Health Director	Qtr. 2 Quarter 1 updates presented and approved at QIHEW and QIHEC. Q2 updates completed pending update at QIHEW in August, and QIHEC in Sept.	2: With the presentation of workplan goals within the QIPH committee feedback included in the need to establish clear baselines, and timeframes. The workplan was updated, and presented with changes, and approved.		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
3. Review and approval of workplan quarterly by QIHEC	3. Review of all workplan entries prior to each committee to ensure appropriate documentation.	3/31/2024,6/30/2024,9/30/2024,12/31/2024	Andrea Swan, Quality Improvement & Population Health Director	Qtr. 3: Quarter 2 updates presented and approved at QIHEW and QIHEC. Q3 activities completed pending update at QIHEW in August, and QIHEC in Sept.	3: N/A	2. Continue to work with Business owner on timely accurate submissions of each area.	<input type="checkbox"/> Yes <input type="checkbox"/> No Yes	
4.	4.			Qtr. 4: Quarter 3 updates presented and approved at QIHEW and QIHEC. Q4 activities completed pending updates at Q1 2025 QIHEW and QIHEC.			<input type="checkbox"/> Yes <input type="checkbox"/> No	



SECTION 2: QUALITY OF CLINICAL CARE

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Establish and launch Provider Partnership program	1. Sign up 4 providers by 3.31.24. 2. Do onsite meetings and observations by 4.31.24. 3. Develop and implement interventions for 1-2 MCAS measures at each site by 6.30.24. 4. Monitor and adjust interventions and MCAS rates 9.30.24	1/1/24-3/31/24 3/31/24-4/31/24 4/1/24-6/30/24 7/1/24-9/30/24	Sarina King, Quality and Performance Improvement Manager	Five practices enrolled by April 2024. 2 Focused measures selected per site, with project charters completed. Monthly practice coaching sessions and quarterly data review meetings began in April 2024. Data as of Sept. 2024 shows upward trends in 9 of the 10 selected measures for the 5 sites.	Difficulty scheduling and meeting with providers, slow start to interventions.	Continue to support practice with Care Gap closure reports and funding for additional clinic time.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	The Alliance provider liaisons and leadership team were persistent in their support, education and outreach to our Provider Partners. This persistence resulted in regular coaching meetings with our sites and appropriate escalations and support with interventions. The result is improved performance across MCAS measures with 9 of 10 tracked measures showing year over year improvement and 4 of 10 reaching MPL.
2. Develop a comprehensive MCAS committee to capture, plan, and	1. Create project charter and project tracker.	1/1/2024-3/31/2024	Britta Vigurs, Quality Improvement Program Advisor	In Q1 2024 we drafted the MCAS Workgroup Meeting Charter and	The previous cross-departmental workgroup to	This meeting will reoccur monthly.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	This MCAS committee

<p>discuss quality improvement activities that will improve DHCS required MCAS measures, and NCQA HEDIS prioritized measures.</p> <p>Overall strategic goal is to improve Merced County Pediatric Measures by a 5 percentile increase over MY 22 each year through 2026. In addition to children's health measures sanctioned in Merced there were there are two women's health measures that also fell below the minimum performance level (MPL) held to the 50th percentile. Goal is to reach the following:</p> <ul style="list-style-type: none"> • Child and Adolescent Well-Care Visits (WCV) - 48.0% (45th percentile) • Childhood Immunizations - Combo 10 (CIS-10) - 24.5% (14th percentile). • Immunizations for Adolescents - Combo 2 (IMA-2) - 35.2% (50th percentile). • Lead Screening in Children (LSC) - 53.2% (25th percentile). • Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6)- (16th %ile) • Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits (W30-2) - 60.8% (28th %ile) • Breast Cancer Screening (BCS) - 52.6% (50th percentile). <p>Chlamydia Screening in Women (CHL-Tot) - 56.04% (50th percentile).</p>	<ol style="list-style-type: none"> 2. Establish regular monthly check-in with committee to monitor activities. 3. Evaluation current intervention strategies against finalized audited measurement year (MY) MY2023 MCAS measure rates. 4. Request direction of interventions from. 	<p>3/1/2024-6/30/2024</p> <p>6/17/23-8/31/2024</p> <p>4/1/24-12/31/2024</p>		<p>identified stakeholders across the Alliance to attend future meetings as core attendees or ad hoc. Topic tracker has been drafted to assist identifying standing agenda items and future topics based on priorities.</p> <p>MCAS Measurement Year (MY) 2023 rates (Report Year 2024) in Merced County show improvements in all measures but Immunizations for Adolescents (IMA-2). Child and Adolescent Well-Care Visits (WCV), Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6+), Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30-2+), and Breast Cancer Screening met 2023 Target Goals. WCV, W30-6+ and BCS are on track for 2024.</p> <p>In Q2 the MCAS Workgroup discussed tracking of all projects/initiatives that may impact MCAS measures. QIPH interviewed key stakeholders across the organization to assess impact, and track information for further discussion in the MCAS Workgroup.</p> <p>In Q3 the MCAS Workgroup discussed barriers and improvement activities for servicing Alliance members in rural communities to close gaps in care. Assessment for projects/initiatives for MCAS measures continues with stakeholders across the organization.</p>	<p>address MCAS measures during the pandemic was structured more for reporting out, rather than allowing active work within the meeting to identify and flag barriers in projects.</p> <p>In Q3 MCAS workgroup meetings were canceled due to competing hi-priority meetings and will work to see if meeting schedule should be modified for 2025.</p>			<p>meeting is structured to be an interdisciplinary workgroup to review and approve interventions, as well as serve as working sessions to problem solve barriers.</p> <p>There were a number of new quality improvement projects within the provider network last year in 2023, which would have helped drive improvements in targeted measures like BCS and W30-6+.</p>
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CARE-BASED INCENTIVE (CBI) (KRISTEN ROHLF)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
<ol style="list-style-type: none"> 1. Enhance Provider Portal reports to streamline access to reports and increase availability of functions and measures monthly. 	<ol style="list-style-type: none"> 1. Create business requirements for a roll-up function that allows multiple clinics sites to see a combined monthly rate for measures available monthly on the Provider Portal Quality Report. 2. Develop workflow to extract and generate additional columns that 	<p>1/1/2024-3/31/2024</p> <p>1/1/2024-6/30/2024</p>	<p>Alex Sanchez, Quality Improvement Program Advisor, Magdalena Kowalska, Quality Improvement Program Advisor, Shannon Fletcher, Quality Improvement Program Advisor, Annecy Majoros, Quality Improvement Program Advisor</p>	<ol style="list-style-type: none"> 1. Roll-up function has been deployed on the Provider Portal Quality Reports in Q1 2024. 2. Work for business requirements completed in Q2 2024. 	<p>Competing priorities for staff, and limited staffing available to build and test reports.</p> <p>Limited visual and report functionalities of the provider portal.</p>	<ol style="list-style-type: none"> 1. No further action required. 2. Awaiting ticket assignment, portal development, and testing. 	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Initial reports with target dates in Q1 were successfully completed with no issues after collaborating on the easiest technological</p>

	<p>note members meeting continuous enrollment specifications to applicable monthly Provider Portal Quality reports.</p> <p>3. Create business requirements to add trending graphs to monthly quality reports.</p> <p>4. Create business requirements to add a Gaps in Care report.</p> <p>5. Create business requirements to generate email reminders for portal reports for providers.</p>	<p>6/30/2024-12/31/2024</p> <p>4/1/2024-12/31/2024</p> <p>4/1/2024-12/31/2024</p> <p>1/31/2024-3/31/2024</p>		<p>3. Business requirements completed and submitted to ITS in Q1 2023.</p> <p>4. Work to start in Q2 2024.</p> <p>5. Completed draft language in Q1 2024.</p>		<p>3. Awaiting ticket assignment, portal development, and testing.</p> <p>4. QA by QIPH and portal release.</p> <p>5. Continued discussions with staff from Provider Services and Quality Improvement and Population Health on portal feature development, then development and testing of the function</p>		<p>solution. Anticipate potential bandwidth challenges for the rest of the report enhancements due to regulatory and non-regulatory alliance projects for programming.</p>
<p>2. Increase access to introductory CBI program information for network providers.</p>	<p>1. Record a CBI 2024 introductory video.</p> <p>2. Create survey for feedback on training content.</p> <p>3. Published video on the Alliance Webinars and Training website.</p> <p>4. Advertise video to network providers, with additional targeting for newly added Mariposa and San Benito County providers.</p> <p>5. Create Data Submission Tool (DST) training video.</p> <p>6. Create and record coding training material for MCAS/CBI.</p>	<p>4/1/2024-5/30/2024.</p> <p>4/1/2024-5/30/2024.</p> <p>6/1/2024-6/30/2024</p> <p>7/1/2024-7/31/2024</p> <p>6/1/2024-8/31/2024</p> <p>6/1/24-8/31/24</p>	<p>Anecy Majoros, Quality Improvement Program Advisor, Juan Velarde, Quality Improvement Program Advisor, Britta Vigurs, Quality Improvement Program Advisor, Tera Mendoza, Coding Resource Specialist</p>	<p>Work completed for CBI Introduction video in Q2 2024.</p> <p>Coding Introduction video completed and posted to Alliance website in Q3.</p>	<p>Bandwidth of staff to complete the training videos in competition with regulatory and other project obligations.</p>		<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Planned activities were updated to combine the training videos for the CBI introduction, DST and provider portal reports into one training video for ease of use by provider clinics. Coding Introduction video will continue to be advertised in CBI forensics visits and at the CBI 2025 Workshop.</p>

BASIC POPULATION HEALTH MANAGEMENT (DESIRRE HERRERA)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Party	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
<p>1. On a quarterly basis, provide Health Education services and Member Health Rewards program presentations to Alliance internal department staff that interact with members to increase awareness of Health Education services and health rewards available for members.</p>	<p>1. The project team will reach out to internal departments that interact with members. Examples of teams:</p> <ul style="list-style-type: none"> a. Health Education team b. Member Services team c. Care Coordination team d. Community Engagement team <p>2. Schedule presentations</p> <p>3. Deliver Health Education and Member Health Rewards services presentation.</p> <p>4. Request input regarding presentation content and any</p>	<p>3/31/2024, 6/30/2024</p> <p>9/30/2024, 12/31/2024</p>	<p>Kevin Lopez, C&L Program Advisor</p> <p>Desirre Herrera, Quality and Health Programs Manager</p>	<p>A total of 5 presentations on Health Education services and Member Health Rewards were coordinated and completed in Quarter 4.</p> <p>Presentations were delivered to the following audiences:</p> <ul style="list-style-type: none"> • Alliance Community Grants Team • Merced County Office of Education • Merced Maternal Wellness Coalition 	<p>No issues to report in Q4.</p>	<p>The project team will continue to coordinate presentations for internal teams and external community partners in Q4.</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>This goal has been successful in increasing awareness among member facing teams and ensuring Alliance staff are informed of the services available for members.</p>

2. A minimum of 2 presentations will be conducted per quarter.	member needs that they have encountered regarding Health Education services.			<ul style="list-style-type: none"> A Community Counteracting Tobacco (ACCT) Coalition ECM Provider (ClinNEXUS) 				
3. On a quarterly basis, inform members of Health and Wellness programs and self-management tools available to them in 2024.	1. The project team will conduct outreach and education activities to inform members of services available to them via: <ol style="list-style-type: none"> Member outreach calls Member workshops Member mailings Member newsletter articles MSAG presentation 2. Request input from members regarding program and services. 3. Incorporate member feedback into bi-annual planning of health education activities.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Veronica Lozano, Quality and Health Programs Supervisor Health Educator team Desirre Herrera, Quality and Health Programs Manager	The following activities were completed in Q3 to inform members of Health and Wellness programs: <ul style="list-style-type: none"> <u>Member Newsletter</u>: The project team included 1 article in the December 2024 Member Newsletter informing members of health resources and self-management tools. <u>Member outreach calls</u>: The Health Education team completed 1,318 outgoing outreach calls in Q4 to offer members health and wellness programs. 	No issues to report in Q4.	The project team will continue to conduct member informing activities in 2025.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	The member newsletters result in higher calls to the Health Education Line regarding programs included in the newsletter. In Q4 the Health Education Line received 751 incoming calls from members, providers and the community regarding Quality and Health Programs services. Additionally, the Health Educators received 178 PCP referrals to health education services in Q4.
4. On a quarterly basis, collect member feedback from participants in chronic disease management and wellness programs to evaluate impact.	1. The project team will conduct satisfaction surveys with members to evaluate: <ol style="list-style-type: none"> Information about the overall program Usefulness of the information shared. Percentage of members indicating that the program helped them achieve health goals. 2. Request input from members regarding program and services. 3. Incorporate member feedback into bi-annual planning of health education activities.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Kevin Lopez, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager	Member feedback was collected regarding chronic disease management and wellness programs. <ul style="list-style-type: none"> Member Satisfaction Surveys: The project team completed a total of 60 surveys. 	No issues to report in Q4.	The project team will continue to proactively reach out to members via outreach calls to request member feedback via satisfaction surveys.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	According to the member feedback collected for chronic disease management programs: <p>92% of members reported they were satisfied with the HLP/chronic disease management program.</p> <p>96% reported they were satisfied with the staff that provided HLP.</p> <p>88% reported HLP helped them</p>

								<p>achieve health goals.</p> <p>96% reported the information received in HLP was useful.</p> <p>According to the member feedback collected for wellness programs: 100% of members reported the highest rating of satisfaction with the HWL/childhood obesity prevention program.</p> <p>100% reported they were satisfied with the staff that provided HWL.</p> <p>100% reported HWL helped them achieve health goals.</p> <p>100% reported the information received in HLP was useful.</p>
<p>4. On a quarterly basis increase the number of member workshops provided by the Health Education Team in comparison to 2023 baseline.</p> <p>In 2023 there were on average 2 workshops scheduled per quarter. In 2024 the team will double this number and offer at minimum 4 workshops per quarter.</p>	<p>1. The Health Educators will conduct a minimum of 4 member workshops per quarter.</p> <p>2. Health Educators will lead recruitment and outreach efforts to members to enroll in the programs.</p> <p>3. Health Educators will lead.</p>	<p>3/31/2024, 6/30/2024, 9/30/2024, 12/31/2024</p>	<p>Veronica Lozano, Quality and Health Programs Supervisor</p> <p>Health Educator team</p> <p>Desirre Herrera, Quality and Health Programs Manager</p>	<p>A total of 8 member workshops were coordinated in Q4. The following workshop modalities and languages were provided:</p> <ul style="list-style-type: none"> • 1 virtual Healthier Living Program (HLP) group in English. • 2 virtual Live Better with Diabetes (LBD) group, 1 English, 1 Spanish. • 2 virtual Healthy Weight for Life (HWL) groups, 1 English, 1 Spanish. • 3 telephonic Healthier Living Program (HLP) groups, 1 Spanish, 2 English. 	<p>No issues to report in Q4.</p>	<p>The project team will continue to schedule workshops in 2025.</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>The project team continues to experience high interest in member workshops.</p>



SECTION 3: SAFETY OF CLINICAL CARE

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 80% of existing primary care provider sites with an FSR/MRR due this quarter are completed within three years of their last FSR date.	<ol style="list-style-type: none"> Enhance provider scheduling support by onboarding three additional QI RNs dedicated to conducting facility site reviews. Implement proactive planning by reviewing all upcoming site reviews one quarter in advance. Streamline scheduling by offering provider sites a selection of review dates two months before the review due date. Maintain continuous communication with provider sites until a review date is confirmed. 	10/01/2024-12/31/2024	Joana Castaneda, Quality Improvement Program Advisor, Tisha Criswell Senior Quality Improvement Nurse	<ol style="list-style-type: none"> Achieved goal with a result of 5 out of 6 reviews completed (83%). Recruitment is underway for three FSR positions. Q1 reviews were proactively assessed during Q4 for planning. Initial communications have been sent to providers regarding Q1 reviews. 	To ensure adequate staffing levels, the organization has approved two new positions, and one backfill position for an FSR nurse who resigned in Q3 2024.	<ol style="list-style-type: none"> Ongoing collaboration with HR to recruit three QI RN positions for FSR. Maintain communication with providers with site reviews due in Q1 2025, ensuring follow-up on date selection until each review date is confirmed. 	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Two new hires began in January 2025, and an additional new hire is currently in process with HR approval and an offer pending, with a potential start date in February.
2. 100% of practices with Corrective Action Plans (CAPs) arising from FSR/MRR submit a plan to address the CAP within regulatory timeframes.	<ol style="list-style-type: none"> Enhance CAP management support by onboarding three additional QI RNs for facility site reviews. Send email reminders to provider sites regarding upcoming CAP due dates. Directly contact non-responsive providers via phone, involving PRRs as necessary. 	10/01/2024-12/31/2024	Tisha Criswell Senior Quality Improvement Nurse	<ol style="list-style-type: none"> Achieved goal results of 6 out of 6, or 100%. Currently in the recruitment phase for three FSR positions. Reminders regarding upcoming due dates have been sent to providers with CAPs. 	To ensure adequate staffing levels, the organization has approved two new positions, and one backfill position for an FSR nurse who resigned in Q3 2024.	<ol style="list-style-type: none"> Ongoing collaboration with HR to recruit three QI RN positions for FSR. Maintain consistent communication with providers regarding CAP due dates. Follow up with non-responsive providers through direct phone calls involving PRRs as needed. 	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Two new hires began in January 2025, and an additional new hire is currently in process with HR approval and an offer pending, with a potential start date in February.

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 100% of member grievances received by QI concerning potential medical quality of care issues are resolved within the regulatory timeframes for Member Grievances.	2. Establish due dates in SharePoint for PQIs that allow sufficient time for investigation, translation needs (if applicable), and for the Grievance Coordinator to resolve the case. 3. Promptly request medical records necessary for the PQI investigation upon case assignment to the QI RN. 4. Ensure timely coordination of discussions if the case requires MD guidance or potential P2/P3 recommendations.	10/01/2024-12/31/2024	Emily Kaufman, Clinical Safety Supervisor, Eleni Pappazisis, Quality Improvement Program Advisor, Naomi Kawabata, Senior Quality Improvement Nurse, Katie Lutz, Senior Quality Improvement Nurse, Sandy Clay Senior Quality Improvement Nurse, Bethany Fung, Quality Improvement Nurse, and Karen De Leon, Quality Improvement Nurse	1. Achieved goal results of 100%, with all 112 cases closed on time. 2. Due dates have been established in SharePoint to facilitate the closure of regulatory PQIs. 3. The QI RN requested medical records promptly for PQI investigations. 4. Timely discussions were conducted with MDs regarding P2/P3 cases.	1. Ensure staffing levels are adequate to balance regulatory PQIs, internal PQI referrals, CAP management, collaborative efforts, and quality studies to enhance the quality of care for members.	1. Continue establishing due dates in SharePoint to prioritize promptly closing regulatory-based PQIs. 2. Maintain the practice of requesting medical records as needed for investigations to ensure timely case closures. 3. Conduct weekly MD meetings to discuss potential P2/P3 cases requiring guidance, ensuring that these discussions do not hinder timely case resolution.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Regulatory PQI work is on track, with current initiatives meeting established timelines and quality standards. Efforts in this area continue to progress as planned, ensuring that regulatory requirements are consistently met.
1. 80% of non-grievance related PQIs are completed within 90 calendar days.	2. Triage and prioritize incoming internal referrals for the following case types: <ol style="list-style-type: none"> Known provider to tracking and trending. Provider on a CAP or involved in an open Quality Study LTSS member 	10/01/2024 – 12/31/2024	Eleni Pappazisis, Quality Improvement Program Advisor, Naomi Kawabata, Senior Quality Improvement Nurse, Emily Kaufman, Senior Quality Improvement Nurse, Katie Lutz, Senior Quality Improvement Nurse, Sandy Clay Senior Quality Improvement Nurse, Bethany Fung, Quality Improvement Nurse, and Karen De Leon, Quality Improvement Nurse	1. Achieved goal results of 73%, with 24 out of 33 cases closed on time. 2. The team effectively triaged and prioritized incoming internal referrals for the following case types: <ul style="list-style-type: none"> Known providers for tracking and trending. Providers on a CAP or involved in an open Quality Study. LTSS members. 	1. Ensure staffing levels are adequate to balance regulatory PQIs, internal PQI referrals, collaborative efforts, and quality studies to enhance the quality of care for members.	2. Triage incoming 90-day referrals promptly. 3. Temporarily decline collaborative work and be selective about participating in Quality Studies until the team can achieve 100% compliance in closing regulatory and internal referral PQIs.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	PQI observed a 2% improvement in closing internal referrals within 90 days from Q3 to Q4 2024. In December 2024, Policy 401-1301 (“Potential Quality Issues”) was updated to extend the turnaround goal from 90 to 120 days, effective Q1 2025. This operational change is expected to further enhance performance on this key metric. However, the team continues to face challenges with managing non-regulatory PQI referrals, timely CAP management, quality studies, and collaborative work to enhance the quality of care for members. In Q1 2025,

									processes will be examined and areas for process improvement pinpointed.
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GRIEVANCE & APPEALS REVIEW (SARAH SANDERS)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. On a quarterly basis, provide grievance updates to interdisciplinary groups including SGRC and QIHEW.	a. Monitor and process concerns within regulatory timeframes. b. Provide internal communications on appeal and grievances trends and outcomes. c. Track and trend grievance data by demographics including language to analyze disparities. d. Identify actionable opportunities for improvement	04/01/2024-6/30/2024 3/31/2024,6/30/2024 9/30/2024,12/31/2024	Sarah Sanders, Grievance and Quality Manager	Q4: June staffing deficiency	Q3: Staffing deficiency impacted regulatory timeframes.	Continue monitoring regulatory compliance and trends. Active staffing recruitment planned for Q3-24 to ensure appropriate staffing to support regulatory compliance.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Close monitoring, communications and tracking of AG occurred
2. Support Members by resolving issues of dissatisfaction with the Alliance.	a. Ensure that where appropriate, corrective action is implemented and effective in improving identified problems. b. Track grievance and appeals for access/QOC trends, system issues, and identify actionable corrections needed.	04/01/2024 – 06/30/2024 3/31/2024,6/30/2024 9/30/2024,12/31/2024	Sarah Sanders, Grievance and Quality Manager	Q4: System testing continued to resolve identified issues for new CMSR system (Jiva). While training and familiarity helped to close the gap with learning curves, regulatory performance still below targets.		QI action and monitoring for responsiveness	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
3. Quality Data: External Report requirements are met 100% of the time.	a. Monitor timely data and state submissions to ensure completeness. b. Evaluate and identify opportunities to improve the data accuracy of AG information.	04/01/2024 – 06/30/2024 3/31/2024,6/30/2024 9/30/2024,12/31/2024	Sarah Sanders, Grievance and Quality Manager	Q3: Category reconciliations.	Q3: n/a	Monitor for data to ensure new benefit types pulled for required MCPD reporting.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	New benefits added to the tableau reporting suite.
4. Ongoing monitoring of AG results to support that appropriate action is taken when occurrences of poor performance are identified. Identify and track allegations of discrimination.	a. Identify and, when appropriate, act on substantiated issues in a timely manner. Monitor and report findings bi-monthly. Complete audits for allegations of discrimination to monitor, prevent and identify any discriminatory practices.	04/01/2024 – 06/30/2024 3/31/2024,6/30/2024 9/30/2024,12/31/2024	Sarah Sanders, Grievance and Quality Manager	Q4: Grievance trends with provider availability (access), provider and plan attitude, and appeal trends with medically tailored meals.	Q3: n/a	Monitor outliers	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Results Achieved.

COC OF MEDICAL & BEHAVIORAL HEALTH (REBECCA MCMULLEN)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Party	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Increase Utilization of BH benefit overall by 2.5% within the Behavioral health network in Merced County, from a baseline of 4.07% by	-At minimum, annual BH team member attendance at PAG and QIHEC meetings to discuss BH services	By 10/31/2024	- Rebecca McMullen, BH Manager and/or Shae Redwine, BH Analyst	Q4 update: -BH Manager presented on BH benefits to MSAG and WCM advisory committee.	-Lack of accessible in person appointments within 10 business days for many BH providers/members not	-BH services will be insourced in 7/2025 with goal to increase utilization and member and provider experience, ensuring	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	The reason why goal was not met is due to several factors related to lack of education of BH benefit to members and

<p>12/31/2024, by increasing provider and member education about BH benefits offered.</p>	<p>-At minimum, annual BH team member attendance at MSAG or other similar member forums to discuss BH services such as WCM advisory committee</p> <p>-increase in provider outreach and education via provider newsletters</p> <p>-Promotion of BH services at outreach activities (at least 3) in Merced County annually.</p> <p>-Meet with Delegate (Carelon) monthly and MHPs at minimum quarterly to track and discuss appropriate referrals and transitions to the NSMHS benefit.</p> <p>Outreach and engage local Merced Eds in collaboration on referrals to BH care.</p>	<p>Attended by 2/8/2024</p> <p>Ongoing, started 5/1/2024</p> <p>By 12/31/2024</p> <p>Ongoing, started in 5/1/2024</p> <p>Ongoing, started 1/1/2024</p> <p>By 12/31/2024</p>	<p>- Communications department manager, Provider Services Manager, Member Services Manager</p>	<p>-BH Manager and QI team presented at PAG in 5/2024 on current BH measures, including discussion from providers related to BH benefit.</p> <p>-BH Managers invited to several of the hospital JOC meetings, where psychiatric hospitalizations (FUA FUM measure) were discussed.</p> <p>-Weekly meetings with Carelon to review data on BHT referrals and linkage to care, specifically.</p> <p>- BH Managers met with Monterey group of pediatricians, along with other Carelon staff on 7/2025 and 9/2024 to discuss BH services and referral process and barriers.</p> <p>-Outreach events attended by BH manager in our 2 new counties.</p> <p>-Workgroup started with Merced BHRS in 6/2024 on high utilizers and ED visits and in person collaborative occurred with Merced BHRS to discuss interventions.</p> <p>-BH Manager attended 2 outreach events in Merced County in 2024.</p> <p>-Engagement with BH providers by the plan in preparation for insourcing 7/1/25 began in Q3/Q4.</p> <p>-Carelon to provide the BH service until 6/30/25.</p>	<p>having initial appointment occur within 10 business days</p> <p>- Discovery of pending BHT referrals through Carelon not linked to services in a timely manner</p> <p>-BH team informed by BH providers of difficulty with credentialing timelines and referral questions</p> <p>-Local Eds lacking engagement and awareness of most appropriate referral options for BH care.</p> <p>-From Q4 2023 to Q3 2024, Merced County Membership for CCAH reduced by 2000 members.</p> <p>-Local Ed having turnover in leadership.</p>	<p>appropriate representation of providers in the Merced County area.</p> <p>-Annual communication to members and providers via a "NSMHS outreach and education plan" draft completed and will be posted on external website for members and providers by DHCS.</p> <p>-BH Manager to continue ongoing monthly collaboration with Merced BHRS to discuss BH interventions at local ED.</p> <p>-BH team will present at on BH benefits and/or BH coordination of care at QIHEC and PAG Q1 2025, and MSAG in Q2 2025.</p> <p>-BH Manager to meet monthly with Merced BHRS team to discuss Coordination of care for ED members and engage with local ED on outreach and referrals for BH care.</p> <p>-BH team doing a presentation to providers at "Lunch and Learn" in May 2025.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>providers, lack of available providers in the BH space, difficulty referring members to the BH benefit and lack of follow through on referrals submitted incorrectly or with insufficient information.</p>
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SECTION 4: MEMBER EXPERIENCE

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start& end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. CAHPS survey fielded timely, and results reported out to internal stakeholders within 8 weeks of receiving results	1. CAHPS workflows, processes, and timelines documented and reviewed in Q1 2024, and steps are taken to begin MY2023 surveys.	2/8/24 – 12/31/24	Sarina King, Quality and Performance Improvement Manager	In Q4 CG CAHPS fielding occurred. We also received MY2023 Quality Benchmark data as well as breakdowns by county. Confirmed sample frames and supplemental questions for MY24 Medi-Cal CAHPS so that fielding could be done timely in 2025.	Previously fielding was not always completed in a timely manner which led to delayed results.	<ul style="list-style-type: none"> Review and analyze CG CAHPS results Ensure MY24 Medi-Cal CAHPS are fielded timely Update workflows and processes to reflect any changes to work. 	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Creating the workflows and timelines and coordinating with all involved parties led to do timely fielding of the Medi-Cal and CG CAHPS surveys.
2. Increase organizational awareness of what CAHPS is and current what current rates are	2. Present MY 2022 CAHPS rates to targeted and appropriate stakeholders Begin outreach to chiefs/admins to present CAHPS overview and high-level rates to organization at all-staff or division meetings.	3/1/2024 – 12/31/24 3/1/2024 – 12/31/24	Sarina King, Quality Performance Improvement Manager	In Q4 2024, we analyzed MY23 and created a presentation to share with the organization in Q12025. We will present to both QIHEW in Ops Committee to share results and get input on interventions and goals for 2025. A CAHPS article for the January employee newsletter was created and set to be published. Attended Member Services Advisory Group on 11/7/2024 to get feedback on CAHPs results.	Current issues that we are working through involve getting organizational involvement and alignment on CAHPS interventions based on previous MY results.	Develop CAHPS goals and interventions for 2025.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	We have continued to lay the groundwork for organizational support and alignment to focus on CAHPS interventions. Now that we have MY23 results, we will be sharing the results out organizationally and within QIHEW to develop goals and interventions.



SECTION 4: QUALITY OF SERVICE

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Semi-Annual Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Comply with DMHC Timely Access Survey Requirements	<ol style="list-style-type: none"> Ensure 90% of After-hours triage compliance in Timely Access Survey. (Provider Appointment Availability Survey [PAAS]). Ensure 75% Urgent and routine appointment access compliance, as well as next available follow up appointment for non-physician mental health care, within required time frames. PAAS work begins in the summer with vendor engagement and finalization of the project plan and contact lists. The survey is launched from August to November/December. Results are available in Q1 of the subsequent year. 	7/1/2024-12/31/2024	Jessie Dybdahl, Provider Service Director	Q4: complete PAAS survey and report outcomes once available.	none	Receive results from Vendor (Mid-March 2025) and compile data to report out.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	PAAS vendor survey is complete- awaiting results.
2. Quarterly review of provider to member ratios for PCPs and High-volume/high-impact Specialties. To ensure all ratios meet regulatory requirements.	<ol style="list-style-type: none"> Ensure provider to member ratios are w/in compliance and mitigate if out of compliance on a quarterly basis. Tableau report is monitored no less than quarterly to ensure provider to member ratios are met for each required provider type. 	7/1/2024 - 12/31/2024	Jessie Dybdahl, Provider Service Director	<p>Q4: Review ratios and any outcomes.</p> <p>Based on the policy standards, are well within compliance for provider to member ratios for all provider types, minus two. Those that we are not within compliance with, we will continue to monitor quarterly and work with necessary departments to address.</p>	none	<ul style="list-style-type: none"> Inform Grants of specialties where we aren't in compliance. Inform Network Develop Team of necessary new specialties for recruitment. 	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Current metrics are in line with requirements, except Allergy & Immunology and Internal Medicine.

							- Continue monitoring quarterly for compliance.		
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GEO ACCESS (TIMELY ACCESS) (JESSIE DYBDAHL)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Semi-Annual Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Comply with Time or Distance Standards set forth by DHCS	<ol style="list-style-type: none"> Ensure the network meets time or distance standards in compliance with DHCS requirements when a provider is available. Monitor areas where no provider is available and ensure alternative access requests are in place on a quarterly basis. Evaluate the non-contracted provider network to determine if recruitment might remedy access gaps. Launch recruitment efforts as applicable. 	<p>7/1/2024 - 12/31/2024</p> <p>7/1/2024 - 12/31/2024</p>	Jessie Dybdahl, Provider Service Director	Q4: The Alliance has submitted the Network Certification Report to DHCS and DHCS is reviewing and will provide outcomes.	none	Continue to monitor any gaps as they arise with in network and recruit as feasible.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Completed submission of the reports. Awaiting DHCS.
2.	2.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.	3.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	4.						<input type="checkbox"/> Yes <input type="checkbox"/> No	

PROVIDER SATISFACTION SURVEY (JESSIE DYBDAHL)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Semi-Annual Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Provider Satisfaction Survey	<ol style="list-style-type: none"> Monitor Provider Satisfaction annually. Ensure no less than 5% decrease in overall satisfaction with the plan from prior year. The Provider Satisfaction Survey (PSS) is launched in the summer with vendor engagement in spring. Contact lists are sent for primary care, specialty care, and non-physician mental health care. The survey is launched from July to August. Results are available in quarter 4. 	7/1/2024 - 12/31/2024	Jessie Dybdahl, Provider Service Director	<p>Overall satisfaction by Provider type has increased to 89%, previously 88%.</p> <p>Satisfaction by county:</p> <ul style="list-style-type: none"> - Merced- 90% - Monterey- 90% - Santa Cruz- 85% <p>Behavioral Health (NPMH) provider satisfaction- 79%, previously 72%</p>	none	Discuss county specific results	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	none
2.	2.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.	3.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	4.						<input type="checkbox"/> Yes <input type="checkbox"/> No	

TELEPHONE ACCESS (VERONICA OLIVARRIA)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
<p>1. 80% of calls to Member Services answered within 30 seconds.</p>	<p>1. The Call Center is continuously monitoring this metric as it is also included on the Operational Dashboard.</p> <p>Improvement efforts slated for 2024:</p> <ul style="list-style-type: none"> ○ The adoption of a Workforce Management Tool to assist with call forecasting and representative scheduling, ensuring we have appropriate levels of staff supporting the queues at any given time/day. ○ Call Audit Optimization: We are developing formal call audit guidelines and defined audit methodology to ensure staff is adhering to Alliance updates and processes. ○ Developing additional call circles (queues) to: ○ Optimize resource availability. ○ Improve speed to answer. ○ Reduce representative training time. ○ Increase member satisfaction. ○ Computer Telephone Enhance HSP/Finesse by adding a screen pop up of member's demographics when a member calls into the call center. This will reduce time on phone for the MSR and will make each call more efficient. Integration: <p>2. Assess staffing needs due to increase in membership</p>	<p>3/31/2024,6/30/2024 9/30/2024,12/31/2024</p>	<p>Veronica Olivarría, MS Call Center Manager Lilia Chagolla, Member Services Director</p>	<p>Goal not met (63%). The call center has hired additional staff to support the calls and member walk-in volume.</p> <p>Coordinate lunch and break schedules to maximize the peak/busy times.</p> <p>Assign staff to support offices to assist member walk-ins.</p> <p>Eliminate unnecessary meetings and focus meetings/training on business needs.</p> <p>Call Center Supervisors review Queue data throughout the day to determine if changes need to be made for the day - such as schedules.</p> <p>Trainings coordinated in small teams to maximize service level.</p>	<p>Q1 is the busiest time of the year in the Call center, the company was also in a Common Spirit negotiation that impacted 7600 members and the Call center was short staffed.</p> <p>Q2- we hired an additional 5 MSR's that helped maximize coverage and increase service level to 90% and higher monthly.</p> <p>Q3- We hired 2 Call Center Supervisors, 2 FTE's and onboarded 2 Temps Reps to back fill for staff who recently promoted to other departments.</p> <p>Q4- Additional temp were hired to back fill for 2 staff promotions out of the department and 3 MSR's out on LOA.</p>	<p>The Call Center team will continue to ensure we are fully staffed by continuing to review the needs of our callers and ensure our staff have the most current resources and/or trainings.</p>	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>This goal has been successful in increasing every month by ensuring we are fully staffed to meet the needs of our membership and ensuring Alliance staff are informed and trained about the services available to members.</p> <p>We are currently in the process of reviewing a new phone system and a Workforce management tool.</p> <p>Call center Supervisors are focused on coaching real time, ensuring resources are available and HSP updates are current to allow staff to focus on the needs of the caller.</p>

2. Call abandonment rate will not exceed 5% of calls to Member Services answered before being abandoned.	2. The Call Center is continuously monitoring this metric as it is also included on the Operational Dashboard. (Same as above)	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Veronica Olivarria, MS Call Center Manager Lilia Chagolla, Member Services Director	<p>Goal not met (63%)</p> <p>The call center has hired additional staff to support the calls and member walk-in volume.</p> <p>Coordinate lunch and break schedules to maximize the peak/busy times.</p> <p>Assign staff to support offices to assist member walk-ins.</p> <p>Eliminate unnecessary meetings and focus meetings/training on business needs.</p> <p>Call Center Supervisors review Queue data throughout the day to determine if changes need to be made for the day - such as schedules.</p> <p>Trainings coordinated in small teams to maximize service level.</p>	<p>Q1 is the busiest time of the year in the Call center, the company was also in a Common Spirit negotiation that impacted 7600 members and the Call center was short staffed.</p> <p>Q2- we hired an additional 5 MSR's that helped maximize coverage and increase service level to 90% and higher monthly.</p> <p>Q3- Onboarded 2 Call Center Supervisors, 2 FTE's and 2 Temps Reps to back fill for staff who recently promoted to other departments.</p> <p>Q4 - The call center focused on ensuring the queue was covered to meet the needs of our callers. We did experience multiple staff out on leave and several staff promoted out of the department. However, we successfully met all call center metrics.</p>	Working on additional FTEs and moving call quality auditing to MS Ops team, WFM tool to be implemented with new phone system.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<p>This goal has been successful in increasing every month by ensuring we are fully staffed to meet the needs of our membership and ensuring Alliance staff are informed and trained about the services available to members.</p> <p>We are currently in the process of reviewing a new phone system and a Workforce management tool.</p> <p>Call center Supervisors are focused on coaching real time, ensuring resources are available and HSP updates are current to allow staff to focus on the needs of the caller.</p>
3.	3.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	4.						<input type="checkbox"/> Yes <input type="checkbox"/> No	

CULTURE & LINGUISTICS (DESIRRE HERRERA)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. On a quarterly basis, provide at least 1 C&L services presentations to Alliance internal department staff that interact with members to increase awareness of C&L services available for members.	1. The C&L team will reach out to internal departments that interact with members. Examples: <ol style="list-style-type: none"> a. QIPH new hire orientation b. Member Services team c. Care Coordination team d. Community Engagement team 2. Schedule C&L services presentation 3. Deliver C&L services presentation. 4. Request input regarding presentation content and any	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Osiris Ramon, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager	A total of 2 presentations on C&L services were coordinated and completed in Quarter 4 . Presentations were delivered to the following audiences: <ul style="list-style-type: none"> • Alliance Community Grants teams • Clinica de Salud del Valle de Salinas (CSVS) 	No issues to report in Q4.	The project team will continue to coordinate presentations for internal departments and external partners in Q1 2025.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	This goal has been successful in increasing awareness among member facing teams and ensuring Alliance staff are informed of the services available for members. Increased awareness of C&L

	member needs that they have encountered regarding C&L services.							Services allows Alliance staff to share information on a broader scale with members they are working with in day-to-day operations.
2. On a quarterly basis, inform members of C&L Services available to them in 2024 utilizing at least 1 member informing modality.	<ol style="list-style-type: none"> 1. The C&L team will conduct outreach and education activities to inform members of services available to them via: <ol style="list-style-type: none"> a. Member newsletter articles b. MSAG presentation 2. Request input from members regarding program and services. 3. Incorporate member feedback into bi-annual planning of health education activities. 	3/31/2024,6/30/2024 9/30/2024,12/31/2024	<p>Osiris Ramon, C&L Program Advisor</p> <p>Ivonne Munoz, Quality and Health Programs Supervisor</p>	<p>The following activities were completed in Q4 to inform members of C&L Services:</p> <p>December Member Newsletter article– the article in the newsletter informed members of their rights to have written information in alternative formats (Alternative Format Selection/AFS).</p>	No issues to report in Q4.	The project team will continue to coordinate presentations for internal departments and external partners in Q1 2025.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<p>This goal has been successful in increasing awareness among member facing teams and ensuring Alliance staff are informed of the services available for members.</p> <p>Increased awareness of C&L Services allows Alliance staff to share information on a broader scale with members they are working with in day-to-day operations.</p>
3. On a quarterly basis, collect member feedback on their experience with language assistance services in a clinical setting.	<ol style="list-style-type: none"> 1. The project team will conduct satisfaction surveys with members to evaluate: <ol style="list-style-type: none"> a. Individual ratings of access to language services. b. Overall rating of interpretation services. c. Access to language services at a health care encounter. d. Gather individual experiences with the services. 2. Request input from members regarding program and services. 3. Incorporate member feedback into bi-annual planning of health education activities. 	3/31/2024,6/30/2024 9/30/2024,12/31/2024	<p>Osiris Ramon, C&L Program Advisor</p> <p>Desirre Herrera, Quality and Health Programs Manager</p>	<p>The following activities were completed in Q4 to collect member feedback regarding language assistance services in a clinical setting.</p> <ul style="list-style-type: none"> • Member Satisfaction Surveys: The project team completed a total of 26-member experience surveys. 	No issues to report in Q4.	The project team will continue to proactively reach out to members via outreach calls to request member feedback via satisfaction surveys.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<p>According to the member feedback collected for language assistance services in a clinical setting:</p> <ol style="list-style-type: none"> 1. Over 96% of members reported the highest rating of satisfaction with the interpreter at their doctor visit. 2. 100% reported they would use the interpreting services again. 3. When asked for recommendations to improve the experience 96% of members reported no improvements needed. 4% shared recommendations such as training all

								<p>interpreters to provide the same quality of service as high performing interpreters.</p> <p>The C&L team will take this input and share feedback with the interpreting services vendors to work on these recommendations.</p>
<p>4. Increase provider utilization of language assistance services quarterly by a minimum of 5% in comparison to 2023 baseline utilization data.</p>	<p>1. The project team will track utilization for the following services:</p> <ul style="list-style-type: none"> • Phone interpreting services. • Face-to-Face (F2F) interpreting services. <p>2. Use quarterly utilization data to identify potential need to training of provider network on language assistance services.</p>	<p>3/31/2024 6/30/2024 9/30/2024 12/31/2024</p>	<p>Osiris Ramon, C&L Program Advisor</p> <p>Ivonne Munoz, Quality and Health Programs Supervisor</p>	<p>Provider Utilization for Q4 was as follows:</p> <p>Phone interpreting services: There was a total of 6,815 total calls in Q4 by provider sites. This reflects an increase of 38% compared to Q4 in 2023.</p> <p>Face-to-Face (F2F) interpreting services: There was a total of 1,764 requests in all service counties for F2F in Q4. This reflects an increase of 35% compared to Q4 in 2023.</p> <ul style="list-style-type: none"> • Santa Cruz County had 710 requests in Q4. This was an 8.2% increase compared to Q4 2023. • Merced County had 470 requests in Q4. This was a 20.2% increase compared to Q4 2023. • Monterey County had 580 requests in Q4. This was a 123.9% increase compared to Q4 of 2023. • San Benito County had 4 requests in Q4. This is a new service county and there was no comparison for 2023. • Mariposa County had 0 requests in Q4. This is a new service county and there was no comparison for 2023. 	<p>No issues to report in Q4.</p>	<p>The utilization data from Q1-Q4 reflects very low to no utilization of in-person/F2F interpreting services in the new expansion counties. The C&L team will reach out to the Provider Relations team to share this information and inquire how to best support the providers in the expansion counties with language assistance services access.</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>There continues to be increases in utilization of language assistance services by providers in 2024 compared to 2023.</p>

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Ensure all activities delegated on behalf CCAH and the QIPH department meet all DHCS, DMHC, and NCQA regulations.	1. Quarterly review of delegate reports to ensure compliance, and identification of any issues.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	DeAnna Leamon, Clinical Safety Quality Manager. Kristen Rohlf, Quality Improvement & Population Health. Desirre Herrera, Quality Health Programs Manager. Andrea Swan, Quality Improvement & Population Health Director	1. All delegate reports for the 1 st quarter were received and reviewed with no gaps identified.	No previous issues identified	Continue with quarterly review	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	All areas delegated within QI were received, reviewed, and reported timely.
2. Ensure oversight of all delegated activities by governing board.	2. Present quarterly updates of all reviewed activities with identification of any issues to the governing board for review, and feedback.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	DeAnna Leamon, Clinical Safety Quality Manager. Kristen Rohlf, Quality Improvement & Population Health. Desirre Herrera, Quality Health Programs Manager. Andrea Swan, Quality Improvement & Population Health Director	3. All delegate reports for the 2 nd quarter were received and reviewed with no gaps identified. 4. No issues with delegate reports. QIPH is working with Compliance to ensure all delegate reports meet NCQA requirements. 5. No issues with delegate reports as well close out Q4.	No previous issues identified	Continue with quarterly review	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	In 2024, no identified issues with QI Delegated entities.
3.	3.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	4.						<input type="checkbox"/> Yes <input type="checkbox"/> No	