2023 Quality Improvement Health Equity Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiatve	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues (if applicable)
Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	N/A	**Annual QIHE Program Evaluation**		**New**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee (aka Member Advisory Committee)	The team is in the process of completing the 2022 Annual QI Program Evaluation. The QI 101 Quality Improvement and Health Equity (QIHE) policy was approved at HCQC in March 2023, and ultimately, steps will be taken to evolve the QI program to the QIHE Program in 2023.	Annual QI Program Evaluation was presented at the May 2023 HCQC meeting.	N/A	N/A	All Sub-Committees and HCQC	Q2 2023	AAH will insource BH 4/1/23

Quality of Care

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiatve		Continued or New?	Goal/Justification	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Manager Name: Farashta Zainal	**HEDIS Rates MY 2023**	**N**	**Continuation**	Increase the HEDIS/MCAS below MPL (W30 0-15, LSC, CCS, CBP, FUM) scores to meet or exceed MPL by December 31, 2023	2023 rates as of 5/5/2023 - CBP - 29.28% CCS - 44.48% FUM - 22.48% LSC - 53.0% W15 - 26.51%	2023 rates as of 8/5/2023: CBP - 36.16% CCS - 47.54% FUM - 28.39% LSC - 57.15% W15-38.47%	2023 rates as of 10/5/2023: CBP - 39.23 CCS - 49.60 FUM - 27.09 LSC - 58.20% W15 - 45.24%	2023 admin rates as of 01/05/2024: CBP - 46.65% CCS - 57.82% - above MPL FUM - 30.92% LSC - 60.67% W15 - 56.39%	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2023	Due to the pandemic AAH saw a decline in HEDIS measures with multiple years of service. Furthermore, state wide insufficient lead screening kits may be a factor in declining lead screening rates.
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Megan Hils	**HEDIS Retrieval and Overreads MY 2023**	**N**	**Continuation**	Alongside the analytics team, provide HEDIS support related to medical record retrieval, abstraction, and overreads. The goal is to overread 20% of the abstracted charts for the hybrid measures.	Completed record retrievals. Completed Change University training to conduct overreards; providing overread support for HBD measure only. 65% of overreads completed by May 1.	100% of overreads due by May 5. Rates were finalized in June. Project complete.	On Track	HEDIS team is in the process of preparing for HEDIS file retrieval. Weekly meetings with consultant is in progress and staff are preparing to complete exams for overreads.	Internal Quality Improvement Committee	5/02/2023	The quality analytics team benefits from QI partnership in completing their goal of 100% overreads to reduce errors in the HEDIS data submission
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Lead QI Project Specialist Name: James Burke	**Pay For Performance (P4P) 2023**	**N**	**Continuation**	Incentivizes providers to improve care on P4P measures with quarterly QI oversight. Facilitate webinars to discuss P4P updates, best practices and answer questions. - meet with 100% of the delegates by December 31, 2023 - meet with at least 30% of Directs by January 30, 2024	Hosted P4P provider webinars to discuss 2023 measures and program details. Disseminate program guides to providers and delegates.	Begin discussing 2024 P4P program, including payout measures.	QI and Anlytics team continue to meet and discuss measures for 2024. Leadership has approved additional funding for QI and as a result the P4P pool dollars will increase $5M Funding made into quality with additional 3.5M into P4P	MY24 P4P Webinars completed: - AHS: 12/04/23 - CHCN: 12/04/23 - CFMG: 12/11/23 MY24 P4P Webinars scheduled: - Directs: 01/11/24 & 01/24/24 Waiting for C&O to finalize and post the P4P Guides to the webpages.	Quality Improvement Health Equity Committee	12/2023	The P4P program has been a successful tool used to support providers improve HEDIS rates
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal 2024: Linda Ayala(?)	Title: Lead QI Project Specialist Name: James Burke	**Health Equity Incentive Pilot (P4P for 2024)**	**Y**	**New**		N/A	N/A	$5M Funding made into quality with 1.5M dedicated to provider incentives focused on health equity HEDIS metrics; ongoing d/w analytics re: program development	Promoting the Health Equity P4P in the P4P webinars listed above.	Quality Improvement Health Equity Committee	12/2023	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: Lead QI Project Specialist Name: James Burke	**QI PDSA Cycle Training**	**N**	**Continuation**	By December 31, 2023, provide support and training to all divisions to utilize the PDSA performance improvement model to develop and evaluate quality improvement projects	On Track	Offered ABCs of QI training to all staff in the Health Care Services division, with over 40 participants in attendance	No updates, will continue in MY24	Planing for MY24 sessions. Scheduled to conduct an ABCs of QI series with CHCN in February 2024: 02/13/24, 02/20/24, and 02/27/24.	All Sub-Committees	6/30/2023	As quality improvement (QI) projects spread throughout the Health Care Service team, it is essential that all staff have an understanding of the PDSA model for improvement. The model provides a vehical to drive QI projects
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Megan Hils	**Priority PIP: Improve FUA/FUM - improve 30 day follow-up rate**	**N**	**New**	Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within 30 days of emergency department (ED) by December 31, 2025	N/A	PIP submission submitted to HSAG/DHCS on 04/7/23. Received approval on 4/12/23. Attended HSAG PIP overview training 4/26/23.	Steps 1 - 6 submitted 9/7/2023 Aim statement: Does a visit feed based on claims increase the percentage of provider notifications that occur within seven days for member emergency department visits for mental illness and substance use disorder? Indicator: FUA/FUM 7 Day Provider Notification Rate.	Feedback on initial from State required changes to the aim statement to include the age of the population and remove reference to interventions. Resubmitted on Nov 27. Next submission due Sep 2024.	Internal Quality Improvement Committee	12/31/2025	This is a newly assigned PIP. PIP topic was assigned by the state based on low performance
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Bob Hendrix	**Equity PIP: Improve Well Child - W15 (6) for African American Children**	**Y**	**New**	To address the disparity that exists with Well Child visits, by December 31, 2025, increase the percentage of well-child visits (W30-6) amongst African American children between the ages of 0-15 months from 30.54% to MPL.	N/A	PIP submission submitted to HSAG/DHCS on 04/11/23. HSAG approved; DHCS's approval is in progress. Submission included MY22 W30-6 Population: Denominator: 167 Numerator: 51 Rate: 30.54%	Submission form due 9/8. First draft completed, revisions in progress	On 1/4/2024 HSAG conducted its validation of AAH's 2023–24 Clinical PIP resubmission. Per HSAG this is AAH's final 2023–24 PIP validation findings and no further action is required. HSAG suggested that AAH continue to actively work on the Clinical PIP (i.e., conducting barrier analyses, testing interventions, etc.	Internal Quality Improvement Committee	12/31/2025	This is a newly assigned PIP. PIP topic was assigned by the state based on low performance
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: Lead QI Project Specialist Name: James Burke	**SWOT - Improve Well Child W30-6 & W30-2 rates**	**N**	**New**	Increase well child visit rates: The first 30 months of life - 0-15 (6 or more visits The first 30 months of life 15-30 months (2 or more visits)	Strategy Submitted to DHCS on 01/30/23. Strategies: -Provider Training: P4P Directs Webinars, W30 Measure Highlight Webinar, and W30 Measure Highlight Cheat Sheet. -Member Education: Alliance sends mailers, and parter w/a Community Agency to provide member handouts. -Data Mining W30-6: Understand gaps in services and increase supplemental data.	Submitted update to DHCS in May. Continuing efforts initially established. Next update submission is due on 10/01/23.	Prepared update to DHCS for October 02, 2023 submission. Continuing efforts initially established. Scheduled Technical Assistance call with DHCS Nurse Consultants is on 10/12/23, where we will learn our next steps for this SWOT.	SWOT completed in October 2024.	Internal Quality Improvement Committee	09/30/2023	This is a SWOT assigned by DHCS based on MY21's peformance rates in these two measures.

2023 Quality Improvement Health Equity Work Plan

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Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Sangeeta Singh	**PDSA - Improve Breast Cancer Rates**	**N**	**New**	Alameda Alliance for Health (AAH) will improve Breast Cancer Screening (BCS) rates for women (50-74 years from MY2021 53.02% to 55.00% by December 31, 2023.	Mobile Mammography has been schedule for three events in May. May 3rd: Lifelong, May 4th : West Oakland, May 5th: Fremont Directs (Ahuja,Narra, Mission Primary).	Finalizing final edits and ready to submit the PDSA on August 15th on time.	Completed 2 mobile mammography events for the PDSA. One with West Oakland which included Sutter and one with Life Long which included Alinea's portable units. PDSA is scheduled to be submitted on 11/15/2023	PDSA Completed on 11/15/2023 and reviewed with the nurse consultant on 11/30/2023	Internal Quality Improvement Committee	11/15/2023	This PDSA was assigned by DHCS based on MY21's BCS rates
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Sangeeta Singh	**Workgroup - Women's Health**	**N**	**New**	The Alliance will improve on women's health measures in the MCAS, by conducting improvement projects to increase the low performing measures to above the MPL and to maintain current rates, by December 31, 2023, as follows: Improve Cervical Cancer Screening rates from 51.70% to minimum performance level 57.64%, by December 31, 2023. Increase Breast Cancer Screening rate for African American Women from 48.22% to meet minimum performance level 51%, by December 31st, 2023	Established a charter and projects for the women's health workgroup. Cervical cancer screening measure proposed 3 new projects and breast cancer screening proposed 4 new projects.	Launched projects include: - CCS Xaqt Outreach calls: Targeting women ages 24-30, CHCN and Alliance Directs. Approx 7,090 members - CCS Birthday Cards expansion, now serving Axis Health, BACH, Lifelong, West Oakland Health Center for Incentive Birthday Cards, (10 directs for non-incentive birthday cards) - provider incentive / extended hours program, - BCS Mobile mammography (upcoming events include 9/29 with Lifelong and Alinea) Multiple events with Sutter at lifelong and West Oakland Health, -BCS African American Flyer Health Educational Flyer	Planning for 2024. Current projects include CCS Birthday cards, CCS Xaqt outreach calls, CCS/BCS Combo project with BACH, BCS flyer, BCS flyer outreach call with Xaqt, mobile mammography, West Oakland Pap a thon PPC focused project (given drop in rates and no current projects)	Projects continuing in 2024: CCS Birthday card until 6/2024, Mobile Mammography services with Sutter Completed Projects: Combo Project, Papathon, Papdrives, BCS Flyer outreach. CCS outreach calls will be ending as soon as the second attempts are completed. Target planning: Build contract with Sutter mobile services with proviers, Pap drives, workflow coaching, pregnancy program	Internal Quality Improvement Committee	12/31/2023	This workgroup supports the goal of creating a culture of quality improvement goals throughout the organization and increases alignment of quality improvement efforts across QI department teams.
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: Lead QI Project Specialist Name: James Burke	**Workgroup - Well Child**	**N**	**New**	The Alliance will improve on well-child measures in the MCAS, by conducting improvement projects to increase the rates from below the MPL to above the MPL and to maintain current rates, by December 31, 2023, as follows: WCV, from 49.24% to 59.34% '22 MPL: 48.93% LSC, from 57.47% to 67.47% (Admin Rate focus) '22 MPL: 63.99% W30-6+, from 46.56% to 56.57% '22 MPL: 55.72%	Established a charter & projects for drive improvement. Projects the workgroup identified: -Electronic Blood Lead Reporting (EBLR) System Provider Training (Measure Focus: LSC) -Newborn Letters for Pregnant Members (Measure Focus: W30-6) -Fluoride Varnish (FV) training for providers (Measure Focus: TFL-CH) -Virtual Town Halls (Measure Focus: W30-6, W30-2, WCV, CIS, IMA, DEV, TFL-CH, LSC)	Worked through planning phase of a few projects and continuing to develop content. New projects include: - Lead Screening Point of Care Testing Funds - HEDIS Crunch expansion for CFMG - Fluoride Varnish Video	Continued to develop a few more projects: -Lead Screening Incentives (9/1/23-12/31/23) -WCV Incentive for BACH targeting 3-17 y/o (10/9/23-12/31/23) -Starting to plan work for MY24	Planning for MY24: -Organization Wide Campaign -First 5 Member Equity Experience Survey -Newborn Flyer -Birthday Card Continuing incentives through 12/31/23: -Lead Screening -WCV w/BACH, Washington Township, and LifeLong W. Berkeley	Internal Quality Improvement Committee	12/31/2023	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Megan Hils	**Workgroup - Chronic Disease Management -**	**N**	**New**	Alameda Alliance for Health (AAH) will improve or maintain performance on chronic disease management measures in the Managed Care Accountability Set (MCAS) to meet the Minimum Performance Level (MPL), by conducting PDSA (Plan, Do, Study, Act) projects by December 31, 2023, as follows:□ - Asthma Medication Ratio (AMR), maintain at least 10% performance above MPL, by December 31, 2023. - Controlling High Blood Pressure (CBP), increase from 38.2% to 60.0%, by December 31, 2023. - Hemoglobin A1c Control for Patients with Diabetes, decrease from 42.2% to 39%, by December 31, 2023	Established a charter and projects to drive improvement. Projects the workgroup identified: Hypertension and diabetes management: partnering with vendor Gojji for remote monitoring support and care coordination. CHCN funding to support SMBP implementation. Hypertension education initiative in barbershops with Roots HC. Support access and awareness of health education programs. Increase colorectal cancer screening in partnership with Exact Sciences (Cologuard)	Group explored partnering with vendors for disease management. No contracts at this time, partnership still under exploration with Gojji. Working with Magellan to increase pharmacy knowledge of BP monitor covered benefit. Group began brainstorming BP management project ideas.	Health Education team is planning to launch asthma and cardiovascular disease management programs in Q3/Q4; group will provide support. Planning for joint BP control project between QI, Health Ed, Pharmacy, and case management underway	Workgroup has conducted brainstorming for projects related to A1c and blood pressure control. Exploration of vendors to support projects continues, including home A1c testing and CRC screening. Planning for projects around member outreach are underway; focus on increasing access to BP monitors and CRC test kits.	Internal Quality Improvement Committee	12/31/2023	This workgroup supports the goal of creating a culture of quality improvement goals throughout the organization and increases alignment of quality improvement efforts across QI department teams.

2023 Quality Improvement Health Equity Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiatve	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues (if applicable)
Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	N/A	**Annual QIHE Program Evaluation**		**New**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee (aka Member Advisory Committee)	The team is in the process of completing the 2022 Annual QI Program Evaluation. The QI 101 Quality Improvement and Health Equity (QIHE) policy was approved at HCQC in March 2023, and ultimately, steps will be taken to evolve the QI program to the QIHE Program in 2023.	Annual QI Program Evaluation was presented at the May 2023 HCQC meeting.	N/A	N/A	All Sub-Committees and HCQC	Q2 2023	AAH will insource BH 4/1/23
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Megan Hils	**Workgroup - Behavioral Health**	**N**	**New**	Alameda Alliance for Health will improve on behavioral health measures in the Managed Care Accountability Set that are held to the Minimum Performance Level (MPL), by conducting PDSA (Plan, Do, Study, Act) projects to increase the rates to meet or exceed the MPL by December 31st, 2023 as follows: •FUM: Maintain 5% or greater performance above MPL (54.51%) •FUA: Maintain 7% or greater performance above MPL (21.24%)	Established a charter and projects to drive improvement. Projects the workgroup identified: Increase provider education of the FUA and FUM measures through webinars and measure highlight documents. Increase provider notifications of member ED visits through use of the ADT report. Monitor rates for the following measures: DSF, DRR, PND, PDS	FUA/FUM webinars delivered to providers and measure highlights distributed. Group continued brainstorming ideas to increase FUM rates.	Group working to develop vendor partnership to conduct FUM follow up. Health Education is planning to launch maternal mental health program; group will provide support.	Continuing to explore vendor partners to conduct FUM follow up. Workgroup is considering education session for providers around opioid use disorder and pharmacotherapy management in partnership with Pharmacy dept.	Internal Quality Improvement Committee	12/31/2023	This workgroup supports the goal of creating a culture of quality improvement goals throughout the organization and increases alignment of quality improvement efforts across QI department teams.
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: Lead QI Project Specialist Name: James Burke	**Provider Training on HEDIS measures**	**N**	**New**	Provide multiple forms of QI education to the AAH provider network by December 31, 2023	Three education session: <u>P4P for Directs</u> Dates: 1/18/23 & 1/25/23 # Signed Up: 47 # Attended: 49 <u>W30 Measure Highlight</u> Date: 3/8/23 # Signed Up: 18 # Attended: 19 <u>FUA & FUM Measure Highlight</u> <u>Date: 3/15/23</u> <u># Signed Up: 18</u> <u># Attended: 16</u>	Planning a QI Virtual Townhall for Fall 2023	QI Virtual Town Hall Date: 09/13/2023 # Signed Up: 35 # Attended: 36	2024 Schedule: - Well-Child, 0-30 months: 02/07/24 - Well-Child, 3-21 years: 03/13/24 - Chronic Disease: 04/04/24 - Cancer Prevention: 05/01/24 - Children 0-30 months: 05/15/24	Internal Quality Improvement Committee	12/31/2023	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Megan Hils	**Under Utilization Outreach**	**N**	**Continued**	Member outreach to at least 20% of non-utilizers over the age of fifty, and connect 2% to primary care services; outreach to 20% of non-utilizers ages six and under, connect 2% to pediatric primary care services by 6/30/23	Provided Xaqt with gap list and outreach script. Completed "train the trainer" session with Xaqt staff. Established regular meetings to discuss campaign logistics.	Campaign calls began May 2. Target population: Adults 50+ with ER visit, children under 6.	Contract was renewed through Jun 30 2024. Non-utilizer outreach paused, CCS gap in care outreach currently taking place. Final results of first non-utilizer campaign received and being analyzed. Results will be reported at DHCS conference and IQIC in November	Final results reporting: 44% of calls resulted in a voicemail. 41% of members could not be reached due to incorrect/disconnected phone number, no option to leave voicemail or no phone number on file. 102 (2.25%) adults and 97 (1.26%) children had a PCP visit following a successful contact Due to time constraints within the contract period and the decision to focus on contacting children first, 29% (3334) of children under 6 years old were contacted but only 12% (4353) of adults over age 50 were contacted.	Internal Quality Improvement Committee	12/31/2023	More than half of members have not seen a PCP, which contributes to low IHA rates and may contribute to low performance in other indicators, including iincreased ED use.

Population Health Management

Sponsor	Business Owner		Topic			Goal	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Projected Due Date	Monitoring of Previously Identified Issues
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Population Health Management DHCS Readiness**		**New**	5.1 - Develop a robust CalAIM PHM strategy to support population health equity by October 2023.	5.1 - Developed policies and procedures re: PHM APLs.	5.1 - Provided feedback on PNA and PHM Concept paper. Preparation for LHD integration in progress.	5.1 - Ongoing planning meetings with HCSA and City of Berkeley.	5.1 - October DHCS PHM Strategy deliverable submitted and approved.	Internal Quality Improvement Committee	9/30/2023	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Health Equity NCQA Readiness**		**New**	5.3 - Develop a strategic framework and roadmap for NCQA HEQ Accreditation by the end of 2023.	5.3 - Starting in Q4 2023.	5.3 - Strategic framework draft in socialization.	5.3 - Preseted PHM framework to IQIC.	5.3 - Defined requirements for population health and equity roadmap to engage consultant support.	Internal Quality Improvement Committee	12/31/2023	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**PHM Monitoring of KPIs**		**New**	5.2 - Implement PHM monitoring processes and roadmap by September 2023.	5.2 - Developed PHM 2023 strategic goals and objectives to monitor.	5.2 - Coordinating PHM monitoring response by Aug 15.	5.3 - Submitted DHCS KPI Monitoring report.	5.2 - Resubmitted August DHCS KPI data and submitted November report. Continuing to work on KPI data accuracy.	Internal Quality Improvement Committee	9/30/2023	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Population Health Management - PHM Strategy Document**		**Continued**	4.3 - Maintain and conduct yearly update an cohesive plan of action that addresses the Alliance member/population needs across the continuum of care.	4.3 - Developed plan of action (strategy) to address population health needs.	4.3 - Identifying and consolidating lessons learned and process improvements.	4.3 - Updated PHM strategy and reviewed with NCQA consultants.	4.3 - Submitted updated PHM Strategy with October DHCS PHM Strategy deliverable (see 5.1).	Internal Quality Improvement Committee	5/30/2023	

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Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	N/A	**Annual QIHE Program Evaluation**		**New**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee (aka Member Advisory Committee)	The team is in the process of completing the 2022 Annual QI Program Evaluation. The QI 101 Quality Improvement and Health Equity (QIHE) policy was approved at HCQC in March 2023, and ultimately, steps will be taken to evolve the QI program to the QIHE Program in 2023.	Annual QI Program Evaluation was presented at the May 2023 HCQC meeting.	N/A	N/A	All Sub-Committees and HCQC	Q2 2023	AAH will insource BH 4/1/23
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Population Health Management - PHM Evaluation Document**		**Continued**	4.2 - Conduct yearly impact analysis of the PHM Strategy according to NCQA (Group Care and Meedi-Cal) and DHCS (Medi-Cal) guidelines and implement activities to address findings.	4.4 - Finalized impact evaluation of 2022 PHM Strategy.	4.2 - Implementing activities and monitoring.	4.2 - Developing tools to support leads in reporting and monitoring.	4.2 - Conducted and presented a midpoint review of 2023 PHM Strategy goals to PHM Committee.	Internal Quality Improvement Committee	5/30/2023	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Population Health Management - Population Assessment**		**Continued**	4.1 - Conduct annual population health asssessment according to NCQA (Group Care and Medi-Cal) and DHCS (Medi-Cal) guidelines including a gap analysis.	4.1 - Conducted member health assessment and developed gap analysis.	4.3 - Identifying and consolidating lessons learned and process improvements.	4.3 - Refining and understanding NCQA requirements.	4.1 - Planned assessment process for 2024. Decided on shared goal and objective with City of Berkeley. Proposed areas for collaborative goals and objectives to HCSA.	Internal Quality Improvement Committee	5/30/2023	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Linda Ayala	**Population Health Management - DEI Strategic Framework**		**New**	6.1 - Collaborate with the Chief of Health Equity to incorporate the Alliance's Population Health Management strategy into the organization's DEI strategic framework.	6.1 - Socialized Health Ed and PHM programs with CHEO.	6.1 - Developed HEQ/PHM deliverables. Supported CHEO onboarding consultants to support work.	6.1 - Bimonthly coordination meetings held QI/PHM and Chief Health Equity Officer. DEI consultant onboarded by CHEO. First PHM meeting with DEI Consultant held.	6.1 - Ongoing collaboration with CHEO and QI. Leveraging DEI consultants for equity lens review of NCQA assessment analysis.	Internal Quality Improvement Committee	12/31/2023	

Quality of Service

Sponsor	Business Owner		Topic			Goal	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Projected Due Date	Monitoring of Previously Identified Issues
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	TBD	**QIP #4: Increase Initial Health Appointment rates**			By 12/31/2023 Improve IHA completion rates from MY2022 37.2% to 45% by December 31, 2023	Implemented IVR outreach calls April 2023 First quarter rates - 43.67%	In progress - rates pending claims data	Chart review process underway by QI RNs, results are forthcoming.	Audit results: 20 charts - age 27-55, average case percentage 65% 11 charts - ages 2 mo - 6 yr - average case percentage - 41% 3 charts - 9-14 yrs - average case percentage 33% IHA rates as of 12/7/2023 34.9%	Internal Quality Improvement Committee	12/31/2023	State issued CAP for IHA

Safety of Care

Sponsor	Business Owner		Topic			Goal	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Projected Due Date	Monitoring of Previously Identified Issues
Title: Sr. Director, Pharmacy Services Name: Helen Lee Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Clinical Pharmacist Name: Ramon Tran Tang	N/A	**QIP #5: Opioid / SUD - Continuation**		**Continued**	Goal 1: By 12/31/23, educate chronic opioid users on health habits, management of chronic pain, and alternative therapy and care (>120 MME) daily). Goal 2: By 12/31/23, educate opioid users at risk of becoming chronic users (i.e., 50 to 119 MME/day).	Analytics was working on automating the mailing list for member education.	Analytics completed chronic and rising risk member mailing list. C&O request was also submitted to work in tanget with analytics request. C&O requested we update the letter language and send to the state for approval.	As of 8/14/23, DHCS approved both member letters. C&O is now proceeding with member translation. C&O mailed member education at end of August	Check to see if mailing was effective by checking member opioid claims.	Internal Quality Improvement Committee	12/31/2023	Staff bandwidth and staffing transition
Title: Sr. Director, Pharmacy Services Name: Helen Lee Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Clinical Pharmacist Name: Ramon Tran Tang	N/A	**QIP #5: Opioid / SUD - Continuation**		**Continued**	Goal 3: By 12/31/23, educate providers who are assigned members that utilize high dose opioids (>120MME) and who are presenting to the Emergency Department with opioid and / or benzodiazepine overdose.	Analytics was working on automating the mailing list for provider education.	Analytics completed provider mailing list. Pharmacy will mail both member and provider letters at the same time.	C&O mailed provider education at end of August	Check to see if mailing was effective by checking member opioid claims.	Internal Quality Improvement Committee Health Care Quality Committee	12/31/2023	Staff bandwidth and staffing transition
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Supervisor Name: Christine Rattray	**Potential Quality Issues (PQIs) Continuation- Quarterly**		**Continued**	Monitor, evaluate, and take effective action with >/= 95% PQI closure within 120 days to address any needed improvements in the quality of care delivered by all providers rendering services on behalf of the Alliance in any setting along with internal data validation.	As of 3/27/23, 2.23% of PQIs exceeded the 5% 120 day TAT benchmark of 120 days.	As of 6/26/23, 1.01% of PQIs exceeded the 5% 120 day TAT benchmark of 120 days.	As of 9/30/23, 1.48% of PQIs exceeded the TAT of 120 days which is well within our stated benchmark of 95%.	As of 12/31/23, 2.65% of PQIs exceeded the TAT of 120 days which falls within the benchmark of 95%.	Internal Quality Improvement Committee Access to Care Sub-Committee Health Care Quality Committee	12/31/2023	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Supervisor Name: Christine Rattray	**Exempt Grievances Auditing- Biannual**		**Continued**	Ensure clinical monitoring of Exempt Grievences for Quality of Care, Service, Access and Language issues per P&P QI-104 through bi-annual review of 100 randomly selected Exempt Grievances.	This report is performed bi-annually-last done in Jan 2023 with a passing score of 100% and is due in June 2023	N/A	Audit lookback Q4 2022-Q1 2023-passing score of 99.5%	N/A	Internal Quality Improvement Committee Access to Care Sub-Committee Health Care Quality Committee	12/31/2023	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Supervisor Name: Christine Rattray	**Potential Quality Issues (PQIs) Annual Training**		**Continued**	Plan provides documented evidence of ongoing annual training on PQIs by clinical staff for both new and seasoned customer service staff who serve as the front-line entry for the intake of all potential qualtiy of care grievances	Annual training was last performed companywide including MSD in Nov/Dec 2022 and is due in Nov/Dec 2023	Annual training was last performed companywide including MSD in Nov/Dec 2022 and is due in Nov/Dec 2023	Annual training was last performed companywide including MSD in Nov/Dec 2022 and is due in Nov/Dec 2023	Per Dr O'Brien, annual training will be done for HCS Dept only, rather than company wide. To be done in Jan 2024.	Internal Quality Improvement Committee Access to Care Sub-Committee Health Care Quality Committee	End of Q4	

2023 Quality Improvement Health Equity Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiatve	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues (if applicable)
Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	N/A	**Annual QIHE Program Evaluation**		**New**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee (aka Member Advisory Committee)	The team is in the process of completing the 2022 Annual QI Program Evaluation. The QI 101 Quality Improvement and Health Equity (QIHE) policy was approved at HCQC in March 2023, and ultimately, steps will be taken to evolve the QI program to the QIHE Program in 2023.	Annual QI Program Evaluation was presented at the May 2023 HCQC meeting.	N/A	N/A	All Sub-Committees and HCQC	Q2 2023	AAH will insource BH 4/1/23
		Title: QI Supervisor Name: Christine Rattray	**PQI ModivCare Focus**	**No**	**New**	On tracking and trending of PQI cases as well as a review of grievances, we note a substantial number of C1 / C2 cases and member complaints related to missed rides.	All ModivCare cases include a review of MRs to understand member clinical concern. These cases are leveled as a C1 / C2, brought to the joint meeting between QI and ModivCare and also presented at the JOMs.	On review of PQI cases, certain cases were billed for though rides were not provided. This information was shared and will continue to be shared with compliance focused on FWA.	Data obtained to identify members who are high risk (ongoing CA treatment, ongoing HD, etc); this data was shared with ModivCare to promote VIP list involvement. On a weekly basis, VM meets with ModivCare to identify members who missed rides and ensure appropriate f/u. After much discussion, ModivCare brought up YellowCab given large number of PQIs / grievances. ModivCare indiciated likely ending contract.	Compliance is now reviewing regular reports and working with Modivcare to identify possible FWA in regard to rides billed for but not fulfilled. As a result, reimbursement is being realized for these claims. QI Supervisor continues to meet biweekly to present cases to identify high risk members and to achieve resolution to prevent issues with member's medical care related to missed rides and the potential for ED/IP encounters. VM, CMDM are also involved with this collaborative effort.	Internal Quality Improvement Committee Access to Care Sub-Committee Health Care Quality Committee	End of Q4	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title: Sr. QI Nurse Specialist Name:Kathy Ebido	**Facility Site Review (FSR) Continuation**		**New**	100% of corrective action plans for periodic (full-scope) site reviews (FSR/MRR) are received within 30 days and closed within 90 days of FSR/MRR Report.	7 CAPs, closed within 30 days*, closed within 90 days *providers were given a grace period of 45 days to comply with APL 22-017 4/12 CAPs (33%) received within 30 days, 5/12 CAPs (42%) closed within 90 days. **Full scope reviews completed in Q1** FSR: 10 MRR: 7 **Additional reviews (non Full-scope) in Q1** Interim Monitoring: 11 Focused reviews: 4 (2 CAPs issued)	0/3 CAPs (0%), received within 30 days, 2/3 CAPs (67%) closed within 90 days. CAP letter include CAP due dates and APL 22-017 language on new membership hold. Providers are called and/or sent reminder email/fax to return CAP on or before the CAP due date around 20th day from review. FSR team follow escalation process. New membership assignment is placed on hold if CAP is not closed timely. **Full scope reviews completed in Q2** FSR: 0 MRR: 3 **Additional reviews (non Full-scope) in Q2** Interim Monitoring: 27 Focused reviews: 6 (6 CAPs issued)	3/3 CAP (100%), received within 30 days, 3/3 CAP (100%) closed within 90 days. **Full scope reviews completed in Q3** FSR: 2 PCP, 2 Urgent Care, 4 Dialysis MRR: 1 **Additional reviews (non Full-scope) in Q3** Interim Monitoring: 20 Focused reviews: 8 (5 CAPs issued)	6/9 CAP (67%), received within 30 days, 8/9 CAP (89%) closed within 90 days. **Full scope reviews completed in Q4** FSR: 8 MRR: 3 **Additional reviews (non Full-scope) in Q4** Interim Monitoring: 11 (1 CAP issued) Focused reviews: 4 (2 CAPs issued)	Access to Care Sub-Committee Health Care Quality Committee	End of Q4	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Supervisor Name: Christine Ratt:	**Inter-rater Reliability (IRR) Continuation-Annual**		**Continued**	IRR is performed annually to ensure >/=90% IRR consistency and accuracy of review criteria applied by all clinical reviewers - physicians and non-physicians - who are responsible for conducting clinical reviews and to act on improvement opportunities identified through this monitoring.	IRR was last performed in Feb 2023 (passing score for all participants) and due again in Feb 2024	N/A	PQI IRR scheduled Feb, 2024 UM / BH / G&A IRR scheduled for Q4, 2023	N/A	Internal Quality Improvement Commite	12/31/2023	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. Qi Nurse Name: Kathy Ebido	**Skilled Nursing Facility/Long Term Care (SNF/LTC) Quality Monitoring**		**New**	Develop quality monitoring process for SNF/LTC to meet APL 23-004 SNF/LTC Benefit Standardization: CMS SNF QAPI Program, quality and HEDIS measures, and track/trend monitoring for facilities.	An attestation was drafted to distribute to SNFs to attest and/or acknowledge CMS SNF QAPI requirements. Incorporated quality monitoring in the SNF/LTC TownHall training scheduled in Q2.	A SNF/LTC tracker was developed that incorporated monitoring of CHDP site reviews, Quality Stars, and PQI. Attestations will be distributed following SNF/LTC roster is completed	Fax blast sent to providers to complete SNF attestation. Team is collecting CDPH site review data for review.	Received 36 QAPI Attestations. Ongoing outreach regarding attestations. Ongoing monitoring of CDPH inspectin report and Star ratings.	SNF/LTC Project Health Care Quality Committee	12/31/2023	

Member Experience

Sponsor	Business Owner		Topic			Goal	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Projected Due Date	Monitoring of Previously Identified Issues

2023 Quality Improvement Health Equity Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiatve	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues (if applicable)
Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	N/A	**Annual QIHE Program Evaluation**		**New**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee (aka Member Advisory Committee)	The team is in the process of completing the 2022 Annual QI Program Evaluation. The QI 101 Quality Improvement and Health Equity (QIHE) policy was approved at HCQC in March 2023, and ultimately, steps will be taken to evolve the QI program to the QIHE Program in 2023.	Annual QI Program Evaluation was presented at the May 2023 HCQC meeting.	N/A	N/A	All Sub-Committees and HCQC	Q2 2023	AAH will insource BH 4/1/23
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title:QI Specialist Name: Tanisha Shepard	**CG-CAHPS Survey Continuation (Quarterly)**		**Continued**	Ensure that quarterly survey questions align with DMHC timely access and language requirements to evaluate member clinical & group satisfaction/experience with Timely Access Standards - Office Wait Time, Call Return Time, Time to Answer Call. To ensure that the survey results are actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. *Starting Q3 2022, the compliance threshold goal was changed from 80% to 70% (with a stretch goal of 80%) for Call Return Time and Time to Answer Call. In Office Wait Time goal remains 80% for 2023.	**Call Return Time 4th Quarter 2022** Numerator: 925 Denominator: 1225 Compliance Rate: 75.5% Goal Met: Y Gap to goal: 0% **In office Wait Time** 4th Quarter 2022 Numerator: 2168 Denominator: 2380 Compliance Rate: 91.1% Goal Met: Y Gap to goal: 0% **Time to Answer Call** 4th Quarter 2022 Numerator: 1383 Denominator: 1897 Compliance Rate: 72.9% Goal Met: Y Gap to goal: 0%	**Call Return Time 1st Quarter 2023** Numerator: 1,204 Denominator: 1,619 Compliance Rate: 74.3% Goal Met: Y Gap to goal: 0% **In office Wait Time** 1st Quarter 2023 Numerator: 2,885 Denominator: 3,135 Compliance Rate: 92% Goal Met: Y Gap to goal: 0% **Time to Answer Call** 1st Quarter 2023 Numerator: 1716 Denominator: 2450 Compliance Rate: 70.0% Goal Met: Y Gap to goal: 0%	**Call Return Time** 2nd Quarter 2023 Numerator: 1,022 Denominator: 1,372 Compliance Rate: 74.5% Goal Met: Y Gap to goal: 0% **In office Wait Time** 2nd Quarter 2023 Numerator: 2,168 Denominator: 2,380 Compliance Rate: 91.1% Goal Met: Y Gap to goal: 0% **Time to Answer Call** 2nd Quarter 2023 Numerator: 1,383 Denominator: 1,1897 Compliance Rate: 72.9% Goal Met: Y Gap to goal: 0%	**Call Return Time** 3rd Quarter 2023 Numerator: 815 Denominator: 1,075 Compliance Rate: 75.8% Goal Met: Y Gap to goal: 0% **In office Wait Time** 3rd Quarter 2023 Numerator: 1,997 Denominator: 2,122 Compliance Rate: 94% Goal Met: Y Gap to goal: 0% **Time to Answer Call** 3rd Quarter 2023 Numerator: 1,164 Denominator: 1,546 Compliance Rate: 75.3% Goal Met: Y Gap to goal: 0%	Access to Care Sub-Committee Health Care Quality Committee	3/31/2024	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title:QI Specialist Name: Tanisha Shepard	**Provider Satisfaction Survey Continuation (Annual)**		**Continued**	Annually, timely completion of measures for provider and staff satisfaction/experience with the health plan and department services. To ensure that the survey meets NCQA requirements and is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. **Fielding Oct - December 2022.** Goal: 88.3% (2% increase from MY 2022)	Results received Feb, 2023. Overall Satisfaction Plan Rating 86.3% up by 9% points from 2021 -73.3%. Met or significantly higher scores compared to SPH Comm. and Aggregate BoB. Results shared with COO/CEO for review and evaluation of next steps. Provider Services and QI collaborates on the Provider Did you know campaign to increase satisfaction scores. Will share results at May 3, 2023 A&A Sub-committee meeting	C. Gomez from Provider Services presented the MY2022 Provider Satisfaction Survey results at the A&A Sub-Committee Meeting on May 3, 2023. Results will then be presented at the next HCQC on August 18, 2023.	MY2022 results were presented at the HCQC on August 18, 2023. MY2023 On Track	On Track	Access to Care Sub-Committee Health Care Quality Committee	12/31/2023	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title:QI Specialist Name: Fiona Qian	**CAHPS 5.1 (Member Satisfaction Survey) Continuation (Annual)**		**Continued**	Measures member experience with health plan and affiliated providers. To ensure that the annual survey aligns with NCQA standards and is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities for member experience. **Fielding: Feb. - May of 2023.** Goal TBD.	MY 2022 Results Highest and Lowest measures for all LOB identified. Met with internal SME to review data to further discuss opportunity for improvement	Survey fielding process with SPH	MY2022 Final report received from SPH. A&A team to review and analyze data to report at Q4 A&A Sub-Committee meeting. Met with internal SME to review data.	CAHPS 5.1 results were presented at the 11.01.23 A&A Sub-Committee Meeting	Access to Care Sub-Committee Health Care Quality Committee	8/31/2023	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title: QI Specialist Name: Tanisha Shepard	**After Hours Care Continuation (Annual)**		**Continued**	Audits provide after hours protocols (Emegency Instructions/Access to Provider) and availability according to DMHC/NCQA methodology/standards for PCP, Spec. and BH providers. To ensure that the survey is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. Maintains 80% compliance rate for After Hour Survey. **Fielding Oct - Nov 2022**	**Primary Care Providers** Numerator: 71 Denominator: 73 Compliance Rate: 97.3% Goal Met: Y Goal: 80%% **Specialists** Numerator: 192 Denominator: 207 Compliance Rate: 92.8% Goal Met: Y Goal: 80% **Behavioral Health** Numerator: 102 Denominator: 113 Compliance Rate: 90.3% Goal Met: Y Goal: 80%	On Track: According to the SPH JOM on July 20, 2023. The 2023 After Hours Survey is in Engaged through end 9/7/2023 in Amendment 20 and contract pending approval Amendment 22.	On Track	Results received from SPH in November. A&A to conduct analysis and reassessment of fail providers	Access to Care Sub-Committee Health Care Quality Committee	12/31/2023	

2023 Quality Improvement Health Equity Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiatve	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues (if applicable)
Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	N/A	**Annual QIHE Program Evaluation**		**New**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee (aka Member Advisory Committee)	The team is in the process of completing the 2022 Annual QI Program Evaluation. The QI 101 Quality Improvement and Health Equity (QIHE) policy was approved at HCQC in March 2023, and ultimately, steps will be taken to evolve the QI program to the QIHE Program in 2023.	Annual QI Program Evaluation was presented at the May 2023 HCQC meeting.	N/A	N/A	All Sub-Committees and HCQC	Q2 2023	AAH will insource BH 4/1/23
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title:QI Specialist Name: Fiona Qian	**Initial Pre-Natal Visits Continuation (Annual)**		**Continued**	To ensure that the survey aligns with DHCS requirements and is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities related to OB/GYN appts offered according to Timely Access Standards. Reach or exceed 75% compliance rate for First Prenatal appointment. **Fielding Sep - Nov. 2022** **HEDIS Prenatal visits: 85.36 baseline to 85.40 admin (MPL) - increase by 3%**	On Track	Numerator: 20 Denominator: 36 Compliance Rate: 55.6% Goal: 75% Goal Met: N Gap to Goal: 19.4% Establish a workgroup in collaboration with Provider Relations and Data Analytics to conduct a PDSA for the following: 1.Non-Responding providers/delegates: Provider education regarding the First Pre-Natal Visit survey and regulatory requirements. A&A will issue corrective action plans (CAPs) to non-responding providers beginning Q2 2023. 2.Ineligible providers: The list of ineligible providers will be shared with Provider Services and the Data Analytics department with the intent of ensuring optimal provider database integrity to generate a reliable provider sample. 3.Non-Compliant Providers / delegates / groups: Provider education regarding the First Pre-Natal Visit survey and regulatory requirements. A&A will issue corrective action plans (CAPs) to non-compliant providers beginning Q2 2023. 4.Track and trend OB/GYN QOA PQI reports to identify non-compliant providers for education and ongoing compliance.	Non-PAAS for First Pre-Natal Visits is currently in fielding progress.	Numerator: 63 Denominator: 83 Compliance Rate: 75% Goal: 75% Goal Met: Yes Establish a workgroup in collaboration with Provider Relations and Data Analytics to conduct a PDSA for the following: 1.Non-Responding providers/delegates: Provider education regarding the First Pre-Natal Visit survey and regulatory requirements. A&A have issued corrective action plans (CAPs) to non-responding providers. 2.Ineligible providers: The list of ineligible providers will be shared with Provider Services and the Data Analytics department with the intent of ensuring optimal provider database integrity to generate a reliable provider sample. 3.Non-Compliant Providers / delegates / groups: Provider education regarding the First Pre-Natal Visit survey and regulatory requirements. A&A have issue corrective action plans (CAPs) to non-compliant providers. 4.Track and trend OB/GYN QOA PQI reports to identify non-compliant providers for education and ongoing compliance.	Access to Care Sub-Committee Health Care Quality Committee	12/31/2023	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title: QI Specialist Name: Fiona Qian	**Oncology Survey Continuation (Annual)**		**Continued**	To ensure that the survey aligns with DHCS requirements and is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities related to timeliness of Oncology routine and urgent care appointments. Maintains a 75% compliance rate for urgent & non-urgent appointment. **Fielding Sep - Nov.**	On Track	**Urgent Appts** Numerator: 18 Denominator: 35 Compliance Rate: 51.4% Goal: 75% Goal Met: N **Non-Urgent** Numerator: 29 Denominator: 35 Compliance Rate: 82.9% Goal: 75% Goal Met: Y establish a workgroup in collaboration with Provider Relations and Data Analytics to conduct a PDSA for the following: 1.Non-Responding providers/delegates: Provider education regarding the Oncology Visit survey and regulatory requirements. A&A will issue corrective action plans (CAPs) to non-responding providers beginning Q2 2023. 2.Ineligible providers: The list of ineligible providers will be shared with Provider Services and the Data Analytics department with the intent of ensuring optimal provider database integrity to generate a reliable provider sample. 3.Non-Compliant Providers / delegates / groups: Provider education regarding the Oncology Visit survey and regulatory requirements. A&A will issue corrective action plans (CAPs) to non-compliant providers beginning Q2 2023. 4.These providers will receive a letter regarding the timely access requirements and a CAP. These CAPs will be issued during Q2 2023.	PAAS for Oncology is currently in fielding progress.	Continuation of PAAS Oncology fielding progress.	Access to Care Sub-Committee Health Care Quality Committee	12/31/2023	

2023 Quality Improvement Health Equity Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiatve	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues (if applicable)
Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	N/A	**Annual QIHE Program Evaluation**		**New**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee (aka Member Advisory Committee)	The team is in the process of completing the 2022 Annual QI Program Evaluation. The QI 101 Quality Improvement and Health Equity (QIHE) policy was approved at HCQC in March 2023, and ultimately, steps will be taken to evolve the QI program to the QIHE Program in 2023.	Annual QI Program Evaluation was presented at the May 2023 HCQC meeting.	N/A	N/A	All Sub-Committees and HCQC	Q2 2023	AAH will insource BH 4/1/23
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title:QI Specialist Name: Fiona Qian	**PAAS (Provider Appt Availability Survey) Continuation (Annual)**		**Continued**	To ensure that the annual survey aligns with DMHC requirements to assess appointment availabilty is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. Maintains a 75% compliance rate for urgent and non-urgent appointment. **Fielding Aug - Dec. 2022**	MY 2022 Results undergoing analysis and report development	MY 2022 Results undergoing analysis and report development. Results will be presented at the next A&A Sub-Committee meeting on August 2, 2023.	PAAS fielding is in progress.	Continuation of PAAS fielding progress.	Access to Care Sub-Committee Health Care Quality Committee	12/31/2023	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title:QI Specialist Name: Fiona Qian	**Provider Visits and Training**		**New**		A&A team reaching out to providers to schdule onsite/virtual visits	Alvarado Medical Center John Muir Physician Network UCSF Medical Group Epic Care La Loma Medical Group Davis Street Primary Care	Tiburcio Vasquez Health Center Lifelong Medical Care Bay Area Community Health Axis Asian Health Services LaClinica Health Center	Fremont OB/GYN (Padmaja Sharma, MD) Dr. Okoronkwo Office (PCP)	Access to Care Sub-Committee Health Care Quality Committee	12/31/2023	

Health Education

Sponsor	Business Owner		QI Activity/Initiatve			Goal/Justification	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Health Education Operations**		Continued	1.1 - Maintain a 95% fulfillment rate for health education material requests and referrals within 10 days through the end of 2023. 1.2 - Sustain member wellness libraries and materials by updating and adhering to the 5 year review cycle. 1.3 - Support coordination and logistics of Member Advisory Committee meetings, monthly and quarterly team meetings through the end of 2023.	1.1 - 97.73% Service Level Target for Fuilfillment Rate goal. 1.2 - Carebook updated pending approval by Dr. O'Brien. 1.3 - Supported successful March MAC.	1.1 - 98.33% Service Level Target for Fuilfillment Rate goal. 1.2 - Health Ed offerings refresh project started in July. 1.4 - Supported successful June MAC meeting.	1.1 - 85% service level achieved for 10- day fulfillment on materials. 1.2 - Reviewed/approved 11x educational materials. 1.3 - Coordinator supported successful Q3 MAC.	1.1 - 91% for new 12-day fulfillment on materials; 100% for 15-day fulfillment on materials (bi-monthly) 1.3 - Supported successful Q4 CAC and Special Year-End CAC	Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	12/31/2023	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Health Education Programs**		Continued	2.1 - Develop and implement health education program evaluations to drive process and program improvements by Q3 2023.	2.1 - Program evaluation planning begins in July 2023.	2.1 - Completed program evaluations and program audits.	2.1 - Transitioned Diabetes Prevention Program network provider and terminated Weight Watchers.	2.1 HabitNu and Yumlish DPP went live. Developed communications and evaluation plans to monitor/implement program.	Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	12/31/2023	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Health Education Programs**		New	2.2 - Launch Maternal Mental Health Program by July 2023.	2.2 - Developed PHM program objectives.	2.2 - Kicked off Maternal Mental Health planning June. In progress; program deliverables.	2.2 - Submitted DMHC narrative. Developed screening guidelines.	2.2 Drafted provider guidelines. Continued meeting regularly with workgroup to define workflows, resources, and program outreach strategy.	Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	6/30/2023	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Health Education Programs**		New	2.3 - Submit Health Education Program Descriptions to DHCS for approval by the end of Q3 2023.	2.3 - Starting in July 2023.	2.3 - Planned kick off first of Q3.	2.3 - Developing program descriptions for submission to DHCS.	2.3 Met with Reg Affairs to align on program description guidelines. Submitted narratives for class letters.	Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	12/31/2023	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Disease Management: Asthma**		New	3.1 - Implement the launch of expanded Ashtma Disease Management health education and coaching campaigns in Q2 2023. 3.2 - Implement the expansion of Asthma Remediation services to adults in Q3 2023.	3.1 - Updated workflows and streamlining reporting. 3.2 - Starting in July 2023.	3.1 - Asthma and DM expansion in progress. Updated target date to September 2023.	3.1 - Preparing for launch of DM programs in November/December of 2023. 3.2 - Adult Asthma Remediation expansion pushed out to 2024.	3.1 - Launched asthma letter campaign for low risk population. 3.2 - Partnered with CS-Asthma Remediation provider to support the expansion of this program for adults. Program description updates and outreach letter are undergoing review. Adult program will be available Q1 2024.	Utilization Management/Quality Imrpovement and Health Equity Committee	6/30/2023 9/30/2023	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Disease Management: Diabetes**		New	3.3 - Implement the launch of Diabetes Disease Management health education and coaching campaigns in Q3 2023.	3.3 - Starting in April 2023.	3.4 - Planning in progress. Target go-live in September of 2023.	3.4 - Planning in progress. Target go-live pushed out to Q4 of 2023.	3.4 - Launched diabetes letter campaign and continue to offer diabetes health coaching. Refined data collection to ensure easy data extraction.	Utilization Management/Quality Imrpovement and Health Equity Committee	9/30/2023	
Title: Sr. QI Director Name: (Michelle Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Disease Management: CVD and Depression**		New	3.4 - Implement the launch of Cardiovascular Disease and Depression Disease Managemetn programs in Q4 2023.	3.4 - Starting in Q3 2023.	3.5 - Kickoff held in July. Target go-live in Dec 2023. Planning in progress.	3.5 - Target go-live in January 2024. Planning in progress.	3.5 - Submitted CVD letter and Depression flyer to DHCS. Prepared layout for program. Continuing to refine workflow. Added programs to CM/DM referral form. Outreach campaign to launch Q1 2024.	Utilization Management/Quality Imrpovement and Health Equity Committee	12/31/2023	

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Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	N/A	**Annual QIHE Program Evaluation**		**New**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee (aka Member Advisory Committee)	The team is in the process of completing the 2022 Annual QI Program Evaluation. The QI 101 Quality Improvement and Health Equity (QIHE) policy was approved at HCQC in March 2023, and ultimately, steps will be taken to evolve the QI program to the QIHE Program in 2023.	Annual QI Program Evaluation was presented at the May 2023 HCQC meeting.	N/A	N/A	All Sub-Committees and HCQC	Q2 2023	AAH will insource BH 4/1/23

Cultural and Linguistic Servcies

Sponsor	Business Owner		QI Activity/Initiatve			Goal/Justification	Q1, 2023	Q2, 2023	Q3, 2023	Q4, 2023	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Member Cultural and Linguistic Assessment**	**Y**	Continued	Assess the cultural and linguistic needs of plan enrollees.	CLS Needs assessed at 1/23/2023 CLS Committee.	1. CLS needs assessed at 05/02/2023 CLS Committee.	1. CLS needs assessed at 07/26/2023 CLS Committee.	1. CLS needs assessed at 10/25/2023 CLS Committee.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	1/31/2023	Success: CLS was able to assess the cultural and linguistic needs of members each quarter through existing analytics reports.
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Language Assistance Services**	**Y**	Continued	Reach or exceed an average fulfillment rate of ninety-five percent (95%) or more for in-person, video, and telephonic interpreter services.	Q1 - 99.97% Fill rate for all modalities of services.	1. Q2- 96% fill rate for all modalities of services.	1. Q3- 95% fill rate for all modalities of services.	1. Q4- 95% fill rate for all modalities of services.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	4/31/2023	Success: Fulfillment rate was at 95% or above for each quarter. Considerations: CLS will monitor the unfulfillment rate for both on-demand telephonic and prescheduled interpreter services and address with vendor areas of improvements/develop action steps to improve fulfillment rate.
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Provider Language Capacity (Member Satisfaction)**	**Y**	Continued	Based on the Member CG-CAHPS Survey 81% of adult members and 92% of child members who need interpreter services will report receiving a non-family qualified interpreter through their doctor's office or health plan.	Planned implementation Q2	1. Q4 2022-Adult: 83.7%; Child: 91.5% (Metric Met) 2. Q1 2023-Adult: 84.4%; Child: 95.9% (Metric Met)	Planned implementation Q3	1. Q2 2022-Adult: 87.1%; Child: 94.3% (Metric Met) 2. Q3 2023-Adult: 81.8%; Child: 96.1% (Metric Met)	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	7/31/2023	Success: Met benchmark for both adult and child each quarter. Barrier/Consideration: Decrease in response rate for both adult and child. CLS will work with A&A to review the member sample by language and make considerations to increase response rate.
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Provider Language Capacity (Provider Network)**	**Y**	Continued	Complete NCQA NET 1 A Analysis of Capacity of Alliance Provider Network to meet Cultural and Linguistic needs of members.	Planned implementation Q2	1. NCQA Net 1 A Report was completed and presented at the CLS Committee on 05/02/2023.	1. NCQA Net 1 A Report was completed and presented at the CLS Committee on 05/02/2023.	1. NCQA Net 1 A Report was completed and presented at the CLS Committee on 05/02/2023.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	10/31/2023	Success: CLS completed the Net 1A Report. Considerations: For 2024 Net 1A Report, CLS will include the race/ethnicity make-up of providers. In addition, create action steps to address gaps/challenges.
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Cultural Sensitivity Training - Participation**	**Y**	Continued	96% of Alliance staff will participate in the annual Cultural Sensitivity training.	Planned implementation Q3 - Q4	1. Planned implementation in Q3-Q4. 2. Put together workgroup to review current training topics and staff input/feedback.	1. CST rolled out on 09/09/2023 to all staff as part of the annual compliance trainings.	1. 100% completion rate for all Alliance staff.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	3/31/2023	Successes: Successfully launched the CST to Alliance staff. Completion rate should have increased since Q4 as Compliance follow-ups with each staff member to ensure completion.
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Cultural Sensitivity Training - Enhancements**	**Y**	New	Facilitate collaborative process to update Cultural Sensitivity Training (s) to meet DHCS 2024 requirements.	Updated P&Ps relevant to DHCS 2024 Contract.	1. Completed analysis of DHCS 2024 Contract requirements, including draft DEI APL. 2. Scheduled meeting with impacted departments to identify department scope/ownership of work. 3. Met with CST workgroup to review staff feedback/input, finalize 2023 training content/outline, and identify speakers.	1. Completed final CST recording. 2. Submitted final CST recording to Compliance for review.	1. CST enhancements completed in Q3 2023.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	6/30/2023	Success: CST enhancements were integrated successfully.

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Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Member Advisory Committee**	**Y**	New	Ensure implementation of DHCS 2024 Contract updates to Member Advisory Committee and community engagement.	Updated P&Ps relevant to DHCS 2024 Contract.	1. Planned timeline for analysis by Q3 2023 and planned implementation by Q2 2024.	1. Completed analysis of DHCS 2024 Contract requirements. 2. Outreached to Compliance for clarification on 2024 Contract requirements.	1. Submitted IPD request for assistance as part of the Single Plan Operational Readiness. 2. Scheduled weekly meetings with IPD and internal stakeholders to discuss tasks and action plan to implement new requirements. 3. Updated charter and created resolution for a CAC Selection Subcommittee. Both presented and approved by CAC members at a CAC Special Meeting held on 12/28/2023.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	9/30/2023	Success: Planning of activities to meet 2024 Contract requirements and receiving assistance from IPD.
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Language Assistance Services (Member Satisfaction)**	**Y**	New	Complete Timely Access Requirement (TAR) Survey to assess member's satisfaction with: a)scheduling appointments with an interpreter; b)availability of interpreters who speak member's preferred spoken language; c)knowledge, skill, and quality of interpreters.	Final ruling for timely access requirement received.	1. Kick-off meeting with survey vendor. 2. Engaged with internal stakeholders for additional clarification on survey requirements. 3. Worked with Vendor Management on addendum to existing contract with survey vendor.	1. Reviewed SOW with suvey vendor and Vendor Management. 2. Reviewed survey cover letter and survey. 3. Submitted C&O Request to review survey cover letter and survey.	1. Finalized and signed SOW with vendor. 2. Received draft mock-up of survey mailing packet. 3. Submitted a draft mock-up for survey mailing packet to C&O for final review/approval and submission for state approval. 4. Scheduled kick-off meeting with survey vendor project manager.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2023	Successes: SOW finalized and signed. Draft mock-up was received with branding. Considerations: Set a timeline to allow for back and forth communication and reviews, both internally and with survey vendor.