2024 Quality Improvement & Health Equity (QIHE) Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification	Q1, 2024	Q2, 2024	Q3, 2024	Q4, 2024	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**	Y	**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)	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) drafted in collaboration with other departments. Finalized documents will be presented to QIHEC in April 2024.	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) were reviewed with the Alliance Board Chair and included as consent items to the Board in June 2024.	A high level summary of the QIHE Trilogy documents were presented to the Board by the CMO in July 2024. In addition, a presentation was given for all Trilogy documents (QIHE, UM, CM) at the HCS All Staff meeting in July 2024.	Planning was underway to initiate 2024 QIHE Trilogy documents in preparation for 2025.	All Sub-Committees and QIHEC	Q2 2024	Incorporated BH and SNF/LTC Quality Monitoring
Quality of Care													
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 2024**	N	**Continued**	Increase the HEDIS/MCAS measures below MPL in MY2023 to meet or exceed MPL by December 31, 2024	Measure below MPL in MY23 - Lead Screening (LSD), Follow-up after ED visit for Mental Illness (FUM) and Topical Fluoride for Children (TFL). Provided funding to CHCN network to purchase POC units for providers in the network. Educate providers on HEDIS specifications, Codes, Best Practices, and the process for QUEST pick-up services of specimen	Continue provider education. Collaborate with high volume, low performing providers to provide members with incentives for completing lead screening.	As of 9/5 LSD rates are at 65.36 above the 2023 MPL. Continue to educate providers on TFL measure. In partnership with Alameda County Dental office held educational webinar 9/20. Working on a partnership with Journey Health to conduct outreach calls for FUM measure.	As of 1/7/2025 MY2024 LSD rates are above the MPL at 66.69%. We are still missing data for FUM rates from the Alameda County and do not have complete data to conduct full analysis. TFL rates are at 11.34%, this measure is also pending DHCS data. Additionaly, DHCS provided guidance on coding, which will allow us to account for additional completed fluoride treatments.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2024	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 2024**	N	**Continued**	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.	CHCN record retrievals completed. Change Healthcare experienced a data breach in February which impacted measure trainings and completing abstractions and overreads; access to all Change Healthcare systems was cut off. Team is now working with Datavant for abstraction and overreads as of March. Measure training and overread process will begin in April.	Overreads completed, all records submitted to auditors	No updates	No updates	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	5/02/2024	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: Supervisor, Quality Performance Name: James Burke	**Pay For Performance (P4P) 2024**	N	**Continued**	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, 2024 - meet with at least 30% of Directs by January 30, 2025	Trainings in January completed for Direct providers on 01/11/24 and 01/24/24. Total Providers in Attendance of both sessions: 19	Program continuing to run. As Quality Improvement meets with Delegates and Direct Providers, updates are provided on their P4P performance rates.	Scheduling P4P Meetings with Delegates and Directs for MY25's program.	P4P Meetings for AHS, CFMG and CHCN have been completed. Directs have two webinar options scheduled in January of 2025.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2024	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: Supervisor, Quality Performance Name: James Burke	**Health Equity Incentive Pilot**	Y	**New**	Incentivizes providers to close care gaps on 3 measures (W15, CCS and CBP) with a focus on race/ethnicities that were 5% below the overall admin rate in 2022. - Facilitate webinars to discuss Health Equity Incentive Pilot - Share care gap reports - Support providers on meeting equity goals	Training provided to Delegates in December of 2024 and Directs in January of 2024.	Program continuing to run.	Program cotinuing to run.	Program cotinuing to run.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: Supervisor, Quality Performance Name: James Burke	**QI PDSA Cycle Training**	N	**Continued**	By December 31, 2024, offer two training opportunities for provider participation in learning and applying the PDSA methodology.	ABCs of QI Collaboration completed with CHCN in the month of February 2024: -02/13/24: 20 attendees -02/20/24: 11 attendees -02/27/24: 12 attendees	Planning for ABCs of QI series in July 2024, open to all providers and all Alliance employees.	Planning for ABCs of QI series in 2025: March and September.	Planning for March and September 2025 sessions in progress.	All Sub-Committees	6/30/2024	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 vehicle 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: Kale Asrat	**Priority PIP: Improve FUA/FUM - improve 30 day follow-up rate**	N	**Continued**	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	Baseline data submission due Sep 11, 2024. HSAG will conduct training in June 2024 to review submission requirements. New QIPS staff member Kalkidan (Kaleb) Asrat will co-lead work on PIP. Megan and Kalé will meet to complete causal/barrier analysis.	Attended training in June. HSAG released an updated intervention tracking sheet. Work on submission materials is ongoing. Submission due Sep 11	Non Clinical PIP worksheet was complete, steps 5 & 6 were updated and Step 7 with baseline data and Step 8 with quality improvement activities to date align with 2 separate intervention worksheets was completed and submitted to HSAG on August 30th.	HSAG provided feedback on the submission. There were 2 sections that were marked as "partially met". A Technical Assistance Request (TAR) was submitted to discuss the findings. Upon receipt of the TAR HSAG changed one of the sections from "partially met" to "met" and provided more clarity what was needed for the other section. The PIP was revised base on the findings and re-submitted to HSAG on November 24th.	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 II Name: Falmata Abatcha	**Equity PIP: Improve Well Child - W15 (6) for African American Children**	Y	**Continued**	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.	Analysis Alliance WCV population is done and ensure we have all the rates are accurately reflected for the State mandated PIP. Identified Black/African American. Identified the Exclusion and stratification of the population based on race and ethnicity. Decided not to use the Sound sampling for this PIP. Identified performance indicator for sampling will not be used.	Completed Barrier analysis and studies the results of the Member Experience survey conducted by F5 in March 2024. Created Driver diagram. Worked on Planning stage of the PDSA. Predicted outcome of the intervention and set goals for the transportation outreach. Identified 21 members for CFMG. Sent a list of the 21 members to First 5 to conduct an outreach. The outreach will inform of the transportation benefit offered by the Alliance and will also let Parents/guidance know to schedule Well-Child visit with their PCP.	First conducted Education on Well Child Screenings and Transportation Services benefit to target CFMG 0-15 months African American babies between July, 2024-August,2024. The outreach result was analyzed to complete outreach intervention worksheet. Submitted PIP Baseline report to HSAG on 9/11/24.	10/31/24HSAG has conducted its initial validation of AAH's 2024-25 Clinical initial PIP submission. While AAH met some of the evaluation elements, HSAG identified areas in need of clarification or revision. AHH sent back clarification feedback 11/15/2024.	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: Sangeeta Singh	**Workgroup: Women's Health**	N	**Continued**	By December 31, 2024, the Alliance will improve on women's health measures in the MCAS/P4P, by conducting improvement projects to increase the low performing measures to above the MPL and to further increase rates to meet the 90th percentile Women's Health Measures: CCS, BCS, PPC 1 and PPC 2 and CHL.	The Women's Health Workgroup completed: Review the previous year 2023 charter and goals. Updated the 2024 Project Charter and Driver Diagram. Reviewed the PPC measure and following the Prenatal Visits rate. Continuing use of mobile mammography and CCS birthday cards. Promotion of Pap-a-thon services to providers.	The Women's Health Workgroup continues to meet and have continued the promotion of mobile mammography services to all providers and usage of gap in care reports. Planning for updated CCS/BCS member faced flyers in collaboration with Health Education. Planning for upcoming community partner event for the Allen Temple Baptist Church Holistic Fair. Cancer Prevention webinar for providers targeting CCS/BCS. For CCS: member incentive birthday card mailers continued to outreach to members, however the non-incentive birthday cards ended in April. Pap-A-Thons have been discussed with our providers who are performing below the MPL. Exploring at Home HPV Testing. Promoting usage of gap in care lists. For PPC: Exploring the workflows and barriers with providers who are performing below the mpl and did not meet the measure in MY2023. Met with BACH to review the PPC workflow and chart reviews for missed opportunities. Preparing PPC Measure highlight for providers	The Women's Health Workgroup continues to meet every month to monitor the rates and give project updates. Health Equity team are interested in learning more on the ethnicity rates and targeting the community in future community events. The first Women's Health related community event took place on 7/13/2024 at the Allen Temple Baptist Church in Oakland. Team engaged with 55 people and 15 were AAH members. 1 Alliance member was connected to Mobile Mammography services and given a warm handoff to Lifelong medical, members appointment was confirmed. Upcoming SCI Breast Cancer and African Americans (BCAA) Conference on 8/24/2024. Mobile Mammography is continuing including 2 new providers, TVHC and BACH. TVHC started in July and BACH in August. We now have 4 Providers set up with Mobile Mammography with Sutter and working on connecting Alameda Health Systems. 8/5/2024 CCS outreach calls to Adult Expansion/Anthem members will start including a $25.00 member incentive for completing a CCS screening. PPC measure highlight is complete, BCS/CCS flyer is still in progress.	The Women's Health Workgroup continues to meet every month to monitor the rates. The Health Equity team is requesting data to find the correlation between non-compliance and BCS/CCS cancer diagnosis of the different ethnicities performing below the mpt. CCS outreach calls for Alliance directs are in progress to start by the end of October and As of August, CCS outreach calls for Adult Expansion and Anthem members are continuing. Upcoming Mobile Mammography event with Alnea is scheduled for October 16th in partnership with BayWell Health for Breast Cancer Awareness month. BCS flyer is complete and available for providers, and submitted for translation in Hindi, Punjabi, Farsi and Arabic. The CCS flyer is still in progress.	Internal Quality Improvement Committee	12/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist II Name: Falmata Abatcha Title: QI Project Specialist I Name: Patty Carrillo	**Workgroup: Well Child**	N	**Continued**	By December 31, 2024 the Alliance will improve on well-child measures in the MCAS, by conducting improvement projects to increase the rates from below the MPL and to further increase rates to meet the 90th percentile: Well Child Measures: W15, W30, WCV, CIS10, IMA, DEV, TFL	The Well-Child Workgroup completed: -Evaluate the '23 Project Charter -Updated the '24 Project Charter and Driver Diagram -Developed a plan for an Organization-wide Campaign on Well-Visits -Reviewed gaps in data on the CIS measure	The Well-Child Workgroup continues to meet monthly. All projects are in planning and implementation stages. The Org-wide Campaign on Well-Visits is planned to launch late August/early September 2024.	The Well-Child workgroup ownership is switched from Bob Hendrix to lead by Falmata Abatcha and Patty Carrillo. Continue to meet monthly to review rates and analyze gaps, brainstorm solutions.	The Well-Child Workgroup continues to meet every month to monitor the rates, share success and brainstorm solutions.	Internal Quality Improvement Committee	12/31/2024	
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	**Continued**	By December 31, 2024, Alameda Alliance for Health (AAH) will improve on chronic disease management measures in the MCAS/P4P to meet MPL and to further increase rates to meet the 90th percentile. Chronic Disease Measures: AMR, CBP, HBD 2, CRC	The Workgroup completed: - Evaluated the '23 Project Charter - Created diabetes gap in care and med adherence report - Began root cause analysis of AMR rate decline - Continuing to pursue collaboration with Exact Sciences and Let's Get Checked - Began planning for BP monitor outreach PDSA - Created DM and HTN comorbidity report	Created AMR claims analysis and continued to develop diabetes gap in care and medication adherence reports. Met with Analytics and Hallie Roth from CHCN to evaluate reports and work to streamline and update reports. Collaboration with Exact Sciences and Let's Get Checked still in progress, currently in contracting phase. BP monitor outreach project has started; so far 21/105 members requested a monitor, however an issue was identified where members had not recently been seen at Alameda Health so a prescription was not sent, working to contact last servicing providers to follow up	Continue to communicate with providers on reporting needs and refining reports. First cycle of BP monitor outreach is nearly complete, finalizing follow-ups from AHS and will begin planning for next cycle.	Project with AHS and Exact Sciences is underway. Planning a pharmacy education webinar with Roots. Encouraging providers to focus on chronic disease measures in final months of the year to get missing readings and monitor prescriptions for AMR.	Internal Quality Improvement Committee	12/31/2024	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.

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Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification	Q1, 2024	Q2, 2024	Q3, 2024	Q4, 2024	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**	**Y**	**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)	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) drafted in collaboration with other departments. Finalized documents will be presented to QIHEC in April 2024.	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) were reviewed with the Alliance Board Chair and included as consent items to the Board in June 2024.	A high level summary of the QIHE Trilogy documents were presented to the Board by the CMO in July 2024. In addition, a presentation was given for all Trilogy documents (QIHE, UM, CM) at the HCS All Staff meeting in July 2024.	Planning was underway to initiate 2024 QIHE Trilogy documents in preparation for 2025.	All Sub-Committees and QIHEC	Q2 2024	Incorporated BH and SNF/LTC Quality Monitoring
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist II Name: Kaiti Asrat	**Workgroup: Behavioral Health**	**N**	**New**	By December 31, 2024 Alameda Alliance for Health will improve on behavioral health measures in the MCAS to meet MPL and to further increase rates to reach the 75th percentile. Behavioral Health Measures: (FUA, FUM) Collaborate with BH Department in development of disease management for depression.	Continued exploration of providing FUA and FUM follow-up in-house Met with other health plans and providers to understand high performance on follow-up measures Reestablished regular meetings with ACBH Considered participation in DHCS/IHI Learning Collaborative but declined Explored FUA/FUM ED utilization New staff member Kalkidan (Kaiti) Asrat joined QI Performance team, transitioning to workgroup lead Began work to establish ED navigator program/partnerships	Started working with the Director of Housing & Community Services to partner with Journey Health who may be able to help us conduct the follow up using Community Health Workers The BH team is currently exploring working with Grow Therapy to conduct the follow ups Meeting with ACBH once a month to at our BH Quality work group to continue collaboration Provided an in depth data analysis to Alameda Health Systems, discovered that Substance Use Navigators (SUNs) in the ED are conducting visits that would count for follow ups but the visit is not being captured on claims, currently working with AHS to see if SUNs and CHWs at their EDs can use the CPT codes that would capture their work for the follow up	Journey Health will be conducting follow up for FUM for members assigned to CHCN, CFMG, and Direct Providers. Scripts have been created, SFTP has been set up for daily notification, and we're currently working on member facing material to send out about Journey Health and credentialing Journey Health's Nurse Practitioners. This project is expected to go live on November 1, 2024. There is currently a member incentive project with Axis Community Health Center to incentivize members to come in for a visit with a provider for a follow up for FUM. This stated in August 2024. Alameda Health Systems is working on creating codes to bill and get reimbursed for SUNs for FUA. This would allow the Alliance to capture the follow ups that are happening while the members are in the ED.	Journey Health already has CHWs deployed at Sutter Hospitals and will conduct follow ups before member leaves those EDs. However, the project to make outreach calls to members who have already been discharged from the ED is on hold, because Journey Health would like to use Pshy NPs and originally Alliance had wanted to use CHWs. We are currently in the process of cost analysis to see if we should move forward.	Internal Quality Improvement Committee	12/31/2024	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: Supervisor, Quality Performance Name: James Burke	**Engagement Outreach Program**	**N**	**New**	Annually, the Alliance QIHE Engagement Program will help close care gaps in the California Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures, and Health Equity gaps, by reaching or exceeding the MPLs through: •Engaging with members through outcalls and collaborating with provider and community partners on member focused campaigns. •Participate in quality improvement projects related to member engagement. •Participate and collaborate in QI Department initiatives.	In process of developing program description and onboarding program. Job Description were re-submitted to HR for grading, pending completion.	In process of recruiting two QI Engagement Program Coordinators. Estimated arrival of roles will be late August/early September 2024.	In September 2024, two QI Engagement Coordinators were hired. Currently they're working on an outcall campaign focusing on new Anthem and Adult Expansion members who need a BP and A1c check. Planning to conduct outcalls for CCS, and supporting PCPs with outreach requests for PCP assignments.	**Year to Date** **A1c/BP Outcomes** # of Calls: 2,899 % of Successful Contacts (w/Voicemail): 62.95% % of Successful Contacts (w/o Voicemail): 22.35% **CCS Outcomes** # of Calls: 254 % of Successful Contacts (w/Voicemail): 68.11% % of Successful Contacts (w/o Voicemail): 16.93% **WCV Outcomes** # of Calls: 181 % of Successful Contacts (w/Voicemail): 74.03% % of Successful Contacts (w/o Voicemail): 25.97%	Internal Quality Improvement Committee	12/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: Supervisor, Quality Performance Name: James Burke	**Provider Training on HEDIS measures**	**N**	**Continued**	By December 31, 2024, the QI Performance team will offer learning opportunities to the provider network on HEDIS measures, including measures specification and best and promising practices in and out of the Alameda Alliance network.	MY2024 Measure Highlight Webinar Series completed: -W30 on 02/07/24: 13 attendees -WCV on 03/13/24: 14 attendees	MY2024 Webinar Highlight Series completed: -Chronic Disease on 04/11/24: 14 attendees -Cancer Prevention on 05/01/24: 15 attendees -W30 on 05/15/24: 14 attendees Planning in process for a TFL-CH Webinar in September 2024. QI Virtual Town Hall is scheduled for 09/11/2024.	Planning sessions for MY2025.	Calendar of Webinars finalized for 2025.	Internal Quality Improvement Committee	12/31/2024	
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	**Non / 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 % to pediatric primary care services by 6/30/24	Worked with Xaqt to update script and tracking sheet. Calls began in March focusing on adults first. As of March 26 working with Xaqt to understand which call list is being used- there may have been a mix up between 2023 call list and the current year's list.	Outreach calls to adults completed with one attempt. Working on calls to children ages 13-19, next group is children ages 9-12. Received final tracking of calls to adults in late June, analysis will begin in July. Amended SOW through Dec 31 2024 in process for signature.	Results from all outreach calls have been received. Analysis of visits after successful contact complete for adults and children 6-under; will complete analysis for 9-12 and 13-19 in November. Presenting results at IQIC Oct 9.	Results were presented at IQIC. Final analysis for 9-12 and 13–19 still pending.	Internal Quality Improvement Committee	12/31/2024	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 increased ED use.
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: Supervisor, Quality Performance Name: James Burke	**IHI/DHCS Equity Learning Collaborative - Children's Health**	**Y**	**New**	Roots Community Health Center: By December 2024, Roots Community Health Center, in partnership with Alameda Alliance for Health, will increase completed well-child visit rates for: Black/African Americans Medi-Cal Patients: -4-6 years old, from 27.27% to 48.07%. -9-14 years old, from 25.00% to 48.07%. Hispanic Medi-Cal Patients: -4-6 years old, from 40.00% to 48.07%. -9-14 years old, from 38.46% to 48.07%. LifeLong LeNoir Health Center: By December 2024, LifeLong LeNoir Health Center, in partnership with Alameda Alliance for Health, will increase completed well-child visit rates for: Black/African Americans Medi-Cal Patients: - 4-6 years old, from 56.10% to 61.15%. -9-12 years old, from 57.47% to 61.15%. Hispanic Medi-Cal Patients: -4-6 years old, from 77.78% to 100.00%. -9-12 years old, from 52.63% to 55.08%.	DHCS assigned this in March 2024. Participating Providers: Roots Community Health Center and LifeLong LeNoir Health Center	Completed Tasks: Reviewed data w/participating clinics, established an AIM statement for each clinic (see column G), started conducting gift card incentive PDSAs, and started conducting provider and member interviews.	Completed provider and member surveys to help identify PDSA projects with Roots and LeNoir. Roots will test transportation assessment to support patient access. LeNoir will test text reminders to support patient engagement.	**PDSA's focuses**: Roots: Access to Care via Transportation LeNoir: Member Engagement via Text Reminders Next intervention is Character Mapping to align and collaborate with Community Based Organizations (CBOs).	N/A	March 2025	
Population Health Management													
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 Needs Assessment**	**Y**	**New**	Define meaningful participation in Alameda County and City of Berkeley CHA/CHIP processes in coordination with Kaiser by August 1, 2024. Establish project plans with Alameda County and City of Berkeley by September 30, 2024.	Conducted monthly meetings with ACPH, City of Berkeley, and Kaiser to discuss shared goals and opportunities for meaningful participation.	Shared objective developed with City of Berkeley. Shared objective developed with ACPHD. Continued monthly meetings with ACPHD and City of Berkeley.	Developed DHCS PNA deliverable worksheets and collaborated on responses with ACPHD and City of Berkeley. Continued meetings with LHJs to align CHA/CHIP efforts, funding, and data requests.	Reported CHA/CHIP collaboration progress to DHCS through the DHCS PHM Deliverable. Continued monthly meetings with LHJs to align CHA/CHIP efforts, funding, and data requests.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	9/30/2024	
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 Monitoring**	**Y**	**Continued**	Expand PHM monitoring and evaluation processes to include further analysis for understanding KPIs, Quality Measures, PHM Strategy goals, and identifying barriers and opportunities for action by the end of 2024.	Collaborated with the PHM workgroup to develop the PHM Evaluation of the 2023 PHM Strategy. Provided feedback to DHCS re: KPI specifications.	Worked with NCQA consultants to ensure compliance with NCQA requirements. Submitted PHM Evaluation to QIHEC 5/2024.	Completed quarterly PHM strategy goal updates and review. Continued monitoring of PHM KPIs. Onboarding PHM consultant to refine and identify PHM monitoring process improvements.	Completed midpoint PHM strategy goal updates and review. Continued monitoring of PHM KPIs. Reviewed quality measures and NCQA Health Equity measures.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	9/30/2024	
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**	**Y**	**Continued**	Develop the Alliance 2024 PHM Strategy to address priority gaps in care and disparities in compliance with DHCS and NCQA requirements.	Completed the annual PHM assessment to identify gaps in care and disparities. Collaborated with the PHM workgroup to update strategies, activities and resources in the 2024 PHM strategy.	Developed and updated the 2024 PHM strategy in compliance with NCQA requirements. Submitted to QIHEC for approval 5/2024.	Developed and completed perinatal population-based analyses and meetings that will help inform the 2025 strategy.	DHCS PHM deliverable submitted and approved.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	5/30/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: Manager of Quality Improvement Name: Farashta Zainal	**QIP #4: Increase Initial Health Appointment rates**	**N**	**Continued**	By 12/31/2024 Improve IHA completion rates from MY2023 to MY2024 by 3%.	Continue to share IHA reports with providers for outreach and connection to care. Continue to conduct IVR calls to remind new members to schedule an appointment with their provider. Develop and share a Measure Highlight tool outlining IHA requirements, codes, and best practices. Close CAP with DHCS.	Include IHA Measure Highlight tool in the provider communication.	IHA chart audit completed. Added IHA as part of the 2025 P4P program. In collaboration with the Claims Department, researched appropriate codes to capture outreach attempts to obtain IHA.	Continued to monitor IHA rates, as of 1/4/2025 MY2024 IHA rates are at 41.5% an increase of 3.6 over MY2023	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2024	State issued CAP for IHA
Safety of Care													

2024 Quality Improvement & Health Equity (QIHE) Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification	Q1, 2024	Q2, 2024	Q3, 2024	Q4, 2024	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**	Y	**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)	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) drafted in collaboration with other departments. Finalized documents will be presented to QIHEC in April 2024.	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) were reviewed with the Alliance Board Chair and included as consent items to the Board in June 2024.	A high level summary of the QIHE Trilogy documents were presented to the Board by the CMO in July 2024. In addition, a presentation was given for all Trilogy documents (QIHE, UM, CM) at the HCS All Staff meeting in July 2024.	Planning was underway to initiate 2024 QIHE Trilogy documents in preparation for 2025.	All Sub-Committees and QIHEC	Q2 2024	Incorporated BH and SNF/LTC Quality Monitoring
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**	N	**Continued**	Goal 1: By 12/31/24, educate chronic opioid users on health habits, management of chronic pain, and alternative therapy and care (>120 MME) daily). Goal 2: By 12/31/24, educate opioid users at risk of becoming chronic users (i.e., 50 to 119 MME/day).	Automated mailing list set for 6/7/24 from analytics.	Educational mailings for providers and members updated. Communication and SLT approved with updates. Mailings to send out on 7/23/24	Next automated mailing list set for 12/7 from analytics	Member letter was updated due to CMO change. This letter is pending approval from state. Mailing is aimed for end of January.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/24	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**	N	**Continued**	Goal 3: By 12/31/24, 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.	Automated mailing list set for 6/7/24 from analytics.	Educational mailings for providers and members updated. Communication and SLT approved with updates. Mailings to send out on 7/23/24	Next automated mailing list set for 12/7 from analytics	C&O would like to mail both provider and member letter at the same time. With the recent CMO change, state approval was required for member letter. Mailing is aimed for end of January.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/24	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**	N	**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.	PQI case closures above 95% threshold	PQI case closures above 95% threshold	PQI case closures above 95% threshold	PQI case closures above 95% threshold	Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	Q1 2025	
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**	N	**Continued**	Ensure clinical monitoring of Exempt Grievances for Quality of Care, Service, Access and Language issues per P&P QI-104 through bi-annual review of 100 randomly selected Exempt Grievances.	Presented at IQIC on 1/17/24-next audit due Q3 2024 (audit period Q4 2023 & Q1 2024)	Presented at IQIC on 7/10/24-next audit due Q1 2025 (audit period Q2-3 2024)	Presented at IQIC on 7/10/24-next audit due Q1 2025 (audit period Q2-3 2024)	Presented at IQIC on 1/15/25	Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	IQIC 3/19/25	
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**	N	**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 quality of care grievances	Annual training provided to HCS Dept in January. Plan to offer training to MSD and LTC in April	Annual training was added for LTC and MSD in April and will be done again at next annual training in January 2025 with HCS.	Annual training was added for LTC and MSD in April and will be done again at next annual training in January 2025 with HCS.	Annual training planned for Feb 2025 at HCS all staff meeting and MSD team meetings	Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	2/20/2025	
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	**PQI ModivCare Focus**	N	**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.	Missed rides to Dialysis continue to be a focus of investigation and collaboration with Modivcare along with AAH CM dept	Missed rides to Dialysis continue to be a focus of investigation and collaboration with Modivcare along with AAH CM dept; meetings occur to review PQIs 2-4x/month and as needed	Missed rides to Dialysis continue to be a focus of investigation and collaboration with Modivcare along with AAH CM dept; meetings occur to review PQIs 2-4x/month and as needed	Missed rides to Dialysis continue to be a focus of investigation and collaboration with Modivcare along with AAH CM dept; meetings occur to review PQIs 2-4x/month and as needed	Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	IQIC 3/19/2025	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Coordinator Name: Jamisha Jefferson	**IHA Audit**	N	**New**	IHA audit now performed bi-annually per change in audit cadence in 2024 from annual to bi-annual.	Previously performed by QI Manager	IHA chart audit planning process initiated	Audit performed in September 2024/ next due in January 2025 to establish a Jan/Jul audit cycle going forward; results to be presented at A&A to show compliance with DHCS findings	Due to competing priorities with the DHCS and DMHC audits, the 2025 IHA cycle was changed to April/November 2025	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	4/1/2025	
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**	N	**Continued**	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. CAP closure do not exceed 120 days from FSR/MRR Report.	8 CAPs (80%) received within 30 days, 10 CAPs (100%) closed within 90 days.	11 CAPs (85%) received within 30 days, 13 CAPs (100%) closed within 90 days. There are 2 open CAPs active and pending closure as of 6/30/24.	17 CAPs (94%) received within 30 days, 15 CAPs (100%) closed within 90 days. There are 5 open CAPs active and pending closure as of 9/30/24.	20 CAPs (100%) received within 30 days, 19 CAPs (100%) closed within 90 days. There are 10 open CAPs active and pending closure as of 12/31/24.	Access to Care Sub-Committee Quality Improvement Health Equity 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 Rattray	**Inter-rater Reliability (IRR) Continuation-Annual**	N	**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 completed in February 2024 with passing scores for RN and MD reviewers. Next IRR planned for Q1 2025	IRR was completed in February 2024 with passing scores for RN and MD reviewers. Next IRR planned for Q1 2025	IRR was completed in February 2024 with passing scores for RN and MD reviewers. Next IRR planned for Q1 2025	IRR was completed in February 2024 with passing scores for RN and MD reviewers. Next IRR planned for Q1 2025	Internal Quality Improvement Committee	Q1 2025	
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**	N	**New**	Develop quality monitoring tools for SNF/LTC to meet APL 23-004 SNF/LTC Benefit Standardization: 1) Obtain 100% of the SNF attestation by7/1/24. 2) Develop site audit tool for SNF and SubAcute and visit low performing sites (as needed) by 9/1/2024. 3) Monitor quality measures (i.e. HEDIS/MCAS) once programmed by Analytics by June 30, 2024.	As of 3/18/2024, 52 (52%) attestations were received out of 100 SNF sites.	As of 6/26/2024, 53 (56%) attestations were received out of 95 SNF sites. Ongoing monitoring of CDPH Cal Health database for deficiencies and complaints. Ongoing monitoring of CMS star ratings.	As of 9/30/2024, 64% attestations were received out of 104 SNF sites. We will continue to closely monitor and update the ratings of skilled nursing facilities each month, ensuring that all contracted locations meet high-quality standards. In addition to tracking census data, we collect and verify QAPI attestations to support continuous improvement in patient care across facilities.	As of 12/31/2024, 57% attestations were received out of 105 SNF sites.We will continue to closely monitor and update the ratings of skilled nursing facilities each month, ensuring that all contracted locations meet high-quality standards. In addition to tracking census data, we collect and verify QAPI attestations to support continuous improvement in patient care across facilities.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2024	
Member Experience													
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)**	N	**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. The compliance threshold goal for Call Return Time and Time to Answer Call remains 70% (with a stretch goal of 80%). In Office Wait Time goal remains 80% for 2024. Starting Q2 2024, CG-CAHPS will includes BH providers.	**Call Return Time** 4th Quarter 2023 Numerator: 1,145 Denominator: 1,522 Compliance Rate: 75.2% Goal Met: Y Gap to goal: 0% **In Office Wait Time** 4th Quarter 2023 Numerator: 2,920 Denominator: 3,172 Compliance Rate: 92% Goal Met: Y Gap to goal: 0% **Time to Answer Call** 4th Quarter 2023 Numerator: 1,781 Denominator: 2,468 Compliance Rate: 72.2% Goal Met: Y Gap to goal: 0%	**Call Return Time** 1st Quarter 2024 Numerator: 1,229 Denominator: 1,659 Compliance Rate: 74.1% Goal Met: Y Gap to goal: 0% **In Office Wait Time** 1st Quarter 2024 Numerator: 3,026 Denominator: 3,297 Compliance Rate: 91.8% Goal Met: Y Gap to goal: 0% **Time to Answer Call** 1st Quarter 2024 Numerator: 1,745 Denominator: 2,440 Compliance Rate: 71.5% Goal Met: Y Gap to goal: 0%	2nd Quarter 2024 Call Return Time (PCP) Numerator: 1,130 Denominator: 1,569 Compliance Rate: 72.0% Goal Met: Y In-Office Wait Time (PCP) Numerator: 1,906 Denominator: 2,078 Compliance Rate: 91.7% Goal Met: Y Time to Answer Call (PCP) Numerator: 1,300 Denominator: 1,708 Compliance Rate: 76.1% Goal Met: Y Call Return Time (BH) Numerator: 211 Denominator: 293 Compliance Rate: 72.0% Goal Met: Y In-Office Wait Time (BH) Numerator: 388 Denominator: 411 Compliance Rate: 94.4% Goal Met: Y Time to Answer Call (BH) Numerator: 241 Denominator: 302 Compliance Rate: 80% Goal Met: Y	3rd Quarter 2024 Call Return Time (PCP) Numerator: 1,303 Denominator: 1,772 Compliance Rate: 73.5% Goal Met: Y In-Office Wait Time (PCP) Numerator: 2,254 Denominator: 2,401 Compliance Rate: 93.9% Goal Met: Y Time to Answer Call (PCP) Numerator: 1,475 Denominator: 1,926 Compliance Rate: 76.6% Goal Met: Y Call Return Time (BH) Numerator: 117 Denominator: 189 Compliance Rate: 61.9% Goal Met: N Gap to Goal: 8.1% In-Office Wait Time (BH) Numerator: 256 Denominator: 283 Compliance Rate: 90.5% Goal Met: Y Time to Answer Call (BH) Numerator: 152 Denominator: 190 Compliance Rate: 80% Goal Met: Y		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)**	N	**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 Sep - November 2023.** Goal: 88.3% (2% increase from MY 2022)	Results received Feb, 2024. Overall Satisfaction Plan Rating for MY2023 is 78.4% down by 7.9% points from MY2022 - 86.3%. Met or significantly higher scores compared to PG Commercial and Aggregated BoB. Results shared with COO/CEO for review and evaluation of next steps. Meeting with PG to discuss survey results on April18, 2024	Met with PG on April 18, 2024, unable to discuss about survey results as representative for the survey was out. PG will send out meeting invite to discuss on Survey Results. Provider Services will be presenting data at the Q3 2024 A&A Sub-Committee.	Survey results presented at the Q3 2024 A&A Sub-Committee on 09/04/2024.	On Track	Access to Care Sub-Committee Quality Improvement Health Equity Committee	01/30/2024	

2024 Quality Improvement & Health Equity (QIHE) Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification	Q1, 2024	Q2, 2024	Q3, 2024	Q4, 2024	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**	**Y**	**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)	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) drafted in collaboration with other departments. Finalized documents will be presented to QIHEC in April 2024.	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) were reviewed with the Alliance Board Chair and included as consent items to the Board in June 2024.	A high level summary of the QIHE Trilogy documents were presented to the Board by the CMO in July 2024. In addition, a presentation was given for all Trilogy documents (QIHE, UM, CM) at the HCS All Staff meeting in July 2024.	Planning was underway to initiate 2024 QIHE Trilogy documents in preparation for 2025.	All Sub-Committees and QIHEC	Q2 2024	Incorporated BH and SNF/LTC Quality Monitoring
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 Quan	**CAHPS 5.1 (Member Satisfaction Survey) Continuation (Annual)**	**N**	**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 2024.** Goal TBD.	MY2023 Survey Results still in pending from PG	From PG JOM on 04.18.24. Survey is currently in fielding. Feb - May 2024	Survey results presented at the Q3 2024 A&A Sub-Committee on 09/04/2024. **Medi-Cal Child:** Urgent Appointment: 80.5% Non-Urgent Appointment: 76.1%+ Getting Care, Test, Or Treatment: 84.9% Getting Specialist Appointment: 67.7%- **Medi-Cal Adult:** Urgent Appointment: 76.8% Non-Urgent Appointment: 73.0% Getting Care, Test, or Treatment: 83.3% Getting Specialist Appointment: 63.8% **Commerical Adult** Urgent Appointment: 76.8% Non-Urgent Appointment: 53.2% Getting Care, Test, or Treatment: 69.6% Getting Specialist Appointment: 72.5%	On Track: MY2024 CAHPS Survey Sample Frame will be submitted next quarter	Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/30/2024	
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	**After Hours Care Continuation (Annual)**	**N**	**Continued**	Audits provide after-hours protocols (Emergency 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 September 2023.	**Primary Care Providers** Numerator: 68 Denominator: 69 Compliance Rate: 98.6% Goal Met: Y Goal: 80% **Specialists** Numerator: 166 Denominator: 178 Compliance Rate: 93.3% Goal Met: Y Goal: 80% **Behavioral Health** Numerator: 65 Denominator: 78 Compliance Rate: 83.3% Goal Met: Y Goal: 80%	On Track: According to the PG JOM on April, 2024.	On Track: According to the PG JOM on August, 2024.	Results received from SPH in November. A&A to conduct analysis and reassessment of fail providers	Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/30/2024	
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: Fiona Quan	**Initial Pre-Natal Visits Continuation (Annual)**	**N**	**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. 2023** **HEDIS Prenatal visits: 85.36 baseline to 85.40 admin (MPL) - increase by 3%**	MY2023 Survey Results were presented at the March 6, 2024 A&A Sub Committee Numerator: 63 Denominator: 83 Compliance Rate: 75.9% 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.	On Track	On Track for fielding in Q4, 2024	Non-PAAS for First Pre-Natal Visits is currently in fielding progress.	Access to Care Sub-Committee Quality Improvement Health Equity Committee	3/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Specialist Name: Fiona Quan	**PAAS (Provider Appt Availability Survey) Continuation (Annual)**	**N**	**Continued**	To ensure that the annual survey aligns with DMHC requirements to assess appointment availability 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. 2023	MY2023 Survey Result pending from QMetrics	MY 2023 were presented at the A&A Sub-Committee meeting on May 1, 2024.	On Track: Kick-Off with QMetric on June 5, 2024. First year outsourcing PAAS.	PAAS is currently in fielding progress.	Access to Care Sub-Committee Quality Improvement Health Equity Committee	End of Q4	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Specialist Name: Fiona Quan	**Provider Visits and Training**	**N**	**New**	Conduct at least 2 site visits per quarter to provider offices/clinics and provide training on timely access standards through the end of 2024.	**1/12/24 - Training:** Robert Phillips (WOHC), Amit Pabla (AXIS), Shanna Cruz (Lifelong), Mayra Castrejon and Tania Martinez (La Clinica) **1/19/24 - Training:** Zenaida Aguilera (La Clinica), Danae Rodrigues (Lifelong), Isela Diaz and Ivonne Spedalieri (TVHC) **3/19/24** - Onsite Visit: AmCare Medical Group	4/11/24 - Virtual Visit: La Clinica 5/20/24 - Virtual Visit: BACH 5/23/24 - Virtual Visit: CHCN 5/31/24 - Virtual Visit: La Clinica	7/02/24 - Virtual Visit: John Muir 7/08/24 - Virtual Visit: Tiburcio Vasquez 7/15/24 - Virtual Visit: Mindpath 7/24/24 - Virtual Visit: Davis Street Primary Care 8/07/24 - Virtual Visit: Mission Primary Care 9/13/24 - Virtual Visit: AHS - MS Dept 9/20/24 - Virtual Visit: Davis Street Primary Care 9/23/24 - OnSite: BACH 9/27/24 - Virtual Visit: CA Cardiovascular Consultant	10/15/24 - Virtual Visit: Washington Township 10/16/24 - Virtual Visit: CFMG 11/07/24 - Virtual Visit: Epic Care 11/07/24 - OnSite:TVHC 11/14/24 - Virtual: TVHC 11/20/24: Virtual: CHCN 12/04/24: Onsite: Misra Sourjya, MD 12/31/24 - Virtual Visit: Asian Health Services	Access to Care Sub-Committee Quality Improvement Health Equity Committee	End of Q5	
Health Education													
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**	**N**	**Continued**	1.1 - Maintain a 95% fulfillment rate for health education material requests and referrals within 10 business days for threshold languages and within 15 business days for translated materials through the end of 2024. 1.3 - Support coordination and logistics of Community Advisory Committee meetings, monthly and quarterly team meetings through the end of 2024.	89.7% fulfillment rate 105 out of 117 materials requests fulfilled within 10 business days. Average fulfillment of 6.1 days. Hired new HED coordinator to support CAC meetings.	Q2: 98.3% of 121 materials requests fulfilled within 10 calendar days. Average fulfillment of 3.7 days. Completed CAC logistics and coordination training for 6/13/2024.	Q3: 100% fulfillment rate 95 out of 95 materials requests fulfilled within 10 business days Average fulfillment of 2.5 days. Supported successful coordination of CAC meeting on 9/19/2024.	Q4: 100% fulfillment rate 114 out of 114 materials requests fulfilled within 10 business days Average fulfillment of 2.5 days. Supported coordination of CAC meeting on 12/5/2024 which was disrupted by a natural disaster warning. Supported coordination of a special CAC meeting on 12/16/2024 for the fulfillment of previous meeting objectives.	Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	12/31/2024	
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**	**N**	**Continued**	2.1 - Implement the Health Education Intake form and enable reporting on Health Education activities by Q2 of 2024.	Not started	Draft developed. Refining with stakeholders. In progress.	Socializing final draft of Health Education Intake Form.	The Health Education Request Form has been finalized and is now fully operational. The form has been uploaded to our internal website and integrated with a Smartsheet for tracking and management.	Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	6/30/2024	
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**	**N**	**New**	2.2 - Develop one new health education initiative by the end of 2024.	Reviewed health education programming and contracts with Compliance. Identified gaps in contractual relationships. Developed research into maternal mental health peer support coaching and inequities to support program development.	Scoping maternal mental health peer supports; exploring potential for CHW reimbursement and tie to disease management equity efforts. Met with 18 reasons to explore offerings. Exploring proposal to develop a tailored Black Diabetes Prevention Program curriculum and program.	Developing CHW SOW for perinatal peer supports.	Our Roots CHW provider contract executed and onboarded. Finalizing SOW and workflows.	Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	6/30/2024	

2024 Quality Improvement & Health Equity (QIHE) Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification	Q1, 2024	Q2, 2024	Q3, 2024	Q4, 2024	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**	**Y**	**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)	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) drafted in collaboration with other departments. Finalized documents will be presented to QIHEC in April 2024.	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) were reviewed with the Alliance Board Chair and included as consent items to the Board in June 2024.	A high level summary of the QIHE Trilogy documents were presented to the Board by the CMO in July 2024. In addition, a presentation was given for all Trilogy documents (QIHE, UM, CM) at the HCS All Staff meeting in July 2024.	Planning was underway to initiate 2024 QIHE Trilogy documents in preparation for 2025.	All Sub-Committees and QIHEC	Q2 2024	Incorporated BH and SNF/LTC Quality Monitoring
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**	**Y**	**New**	2.3 - Support CBOs in the training (eligibility and PAVE enrollment) of community Doulas who will contract with the Alliance to expand our provider network by 125% by Q3 2024. 2.4 - Develop and implement a maternal and child health equity program utilizing Doulas by the end of 2024.	Completed stakeholder engagement listening session with Doula CBOs and ACPHD. Developed Doula RFQ. Developed Doula initial and ongoing training.	Interviewed Doula RFQ finalists and selected a CBO. Contract development in progress. Doula utilization report. Presentation at Alameda County Doula Forum.	Twelve (12) Alliance contracted doulas in-network. Developed and released five (5) communication pieces re: doula benefit to providers and members, standing recommendation, and recommendation for additional services. Doula CBO consultants reviewing training and Doula Scholarship Program. Reviewed maternal and child health equity doula program roadmap utilizing doulas with CBO consultant. Completed a series of meeting on perinatal services and supports to identify opportunities for improvement and collaboration.	Sixten (16) contracted doulas with the Alliance. **Goal exceeded.** Maternal and Infant Health Equity Program milestones: Updated Doula Benefit Overview for providers, doulas, and members. New doula flyer to include in the Baby Steps packets. High touch outreach to contracted doulas to document their experience, barriers, concerns. Reviewed processes and materials with consultant - report of recommendations expected Q1 2025. Health outcome measures for doula utilization and health equity identified.	Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	12/31/2024	
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**	**Y**	**New**	3.1 - Collaboratively develop a strategy to support Disease Management populations with closing care gaps and addressing inequities by the end of 2024.	Reviewing disease management disparities data and building a disease management health equity data index. Refining current reports to include information on vulnerable populations (e.g. risk criteria for perinatal population).	Continuing to review disease management disparities data and incorporating feedback from QI and chronic disease management workgroups. Identifying a target population of members missing care gaps. Supporting QI blood pressure PDSA.	Developed Diabetes and Cardiovascular Disease disparities analysis and developing plan for targeted outreach to address disparities, including health coaching and connection to resources.	Created a targeted outreach campaign for members experiencing disparities in blood pressure and blood glucose readings. Conducted outreach and provided health coaching and community and Alliance referrals for members. Created a targeted outreach campaign for Group Care members to increase member engagement. Developed a scope of work for vendor to offer peer coaching and CHW support to high-risk perinatal members. Developed DM Program Evaluation Plans to monitor successes, identify areas for opportunities for improvement, and identify potential disparities or inequities.	Utilization Management/Quality Improvement and Health Equity Committee	12/31/2024	
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**	**N**	**New**	3.2 - Develop a comprehensive Disease Management dashboard that can track all applicable measures. Each DM program will utilize the dashboard to find and analyze 75% of the data they will require for reporting by the end of 2024.	Submitted disease management population dashboard request. Working with CM and analytics to refine data requests and develop a comprehensive dashboard that can be utilized across departments.	Disease management population dashboard went live 6/2024. Reviewing dashboard, refining data visualizations, and report outs.	Developed disease management program goals and evaluation plans with identified measures from DM dashboard.	DM Program Evaluations utilized 100% of the data from our DM Dashboard. DM Dashboard used to identify priority population for vendor to offer peer coaching and CHW support to high-risk perinatal members.		12/31/2024	
Cultural and Linguistic Services													
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.	1. CLS needs assessed at 01/24/2024 CLSS Meeting.	1. CLS needs assessed at 04/24/2024 CLSS Meeting.	1. CLS needs assessed at 08/28/2024 CLSS Meeting.	1. CLS needs assessed at 12/03/2024 CLSS Meeting.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2024	
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.	1. Q1- 97% fulfillment rate for all modalities.	1. Q2- 98% fulfillment rate for all modalities.	1. Q3-98% fulfillment rate for all modalities.	1. Q4-98% fulfillment rate for all modalities.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2024	
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**	**New**	Ensure tracking of interpreter services utilization for behavioral health services.	1. Met with vendor to discuss options for tracking behavioral health services provided via on-demand telephonic and in-person interpreter services.	1. Reviewed options presented by vendor to track behavioral health services and utilization of interpreter services. Awaiting for vendor confirmation on portal/reporting capabilities to update the category/type of appointment field.	1. Received sample report from vendor. 2. Reviewed vendor sample report. 3. Discussed streamline category update implementation with vendor.	1. Based on streamline categories, the vendor is unable to indicate if a call involves behavioral health (BH) without the initial prompt indication by the caller. 2. The Alliance will continue to work with the vendor on the call prompts to see if a BH call could be flagged at any given time during the call.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2024	
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.	1. Q4 2023-Adult: 86%; Child: 95.7% (Metric Met). 2. Q1 2024-Planned implementation Q2.	1. Planned implementation Q2.	1. Q1 2024-Adult: 84%; Child: 91.4% (Metric Met for adults and Not Met for child) 2. Q2 2024-Adult: 86.6%; Child: 94% (Metric Met)	1. Q3 2024-Adult: 90%; Child: 93% (Metric Met). 2. Q4 2024-Planned implementation for Q1 2025.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2024	
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**	Based on the Timely Access Requirement (TAR) Survey results, develop and implement action steps, as needed, to address 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.	1. Planned implementation Q2.	1. Mail Drop to Alliance members on 04/01/2024. 2. Data Collection ended on 04/19/2024. 3. Received raw data files on 04/24/2024. 4. Scrubbed raw data files and developed final report. 5. Submitted the Adult TAR Survey Report to DMHC via Regulatory Affairs on 04/30/2024. 6. Mail Drop to Alliance Child members on 05/13/2024 7. Data Collection for Child TAR Survey ended on 06/24/2024	1. Received final Child TAR Survey Report from DMHC on 08/01/2024. 2. Reviewed results and identified areas to increase member satisfaction with vendor.	1. 2024 results were reviewed by SMEs at the vendor on 08/01/2024. 2. Based on 2024 results, no additional action are needed. The Alliance will continue to share identified quality concerns with interpreter services vendors at Joint Operations Meeting.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	6/30/2024	Monitoring plan for 2025: Meet or exceed first year survey results for both adult and child.
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 and Race and/or Ethnicity (Provider Network)**	**Y**	**Continued**	Complete NCQA NET 1 An Analysis of Capacity of Alliance Provider Network to meet Cultural and Linguistic needs of members.	1. Submitted a new analytics report to pull provider race/ethnicity from credentialing process for active providers in 2023. 2. Started to pull data and reports.	1. Completed gathering of data and reports. 2. Started on draft Net 1 A Report. 3. Submitted to NCQA consultants and received feedback. 4. Assessed feedback and gap in reporting. 5. Updated report to fill gap in reporting/data. 6. Presented/shared Net 1 A Report at QIHEC and received approval. 7. Resubmitted Net 1 A Report to NCQA for review with updated reporting/data.	1. Received consultant feedback. 2. Assessed consultant feedback and updated information on religion section in the report. 3. Resubmitted Net 1 A Report to NCQA consultant for another review.	1. Received and reviewed consultant feedback. 2. Net 1A Report met all standards. 3. Presented updates at the Quality Improvement & Health Equity Committee (QIHEC) on 11/15/2024 and Cultural and Linguistic Services Subcommittee on 12/03/2024 with feedback to differentiate between substantial vs. non-substantial discrimination cases. 4. Met with Compliance to review the discrimination case report for inclusion of substantial vs. non-substantial cases.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	4/1/2024	
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	**Community Engagement: Community Advisory Committee (CAC)**	**Y**	**Continued**	Ensure implementation of DHCS 2024 Contract updates to CAC and community engagement.	1. Developed CAC Selection Committee proposal. 2. Started planning for CAC Selection Committee recruitment. 3. Completed CAC Demographic Survey.	1. CAC Selection Committee Proposal approved. 2. Started recruitment for CAC Selection Committee through targeted outreach (i.e., flyer in provider communication and specific contacts to meet required representation). 3. Updated CAC Charter to include CAC Selection Committee as a Committee. 5. Developed CAC Selection Committee and presented to the BOG for review/approval. 6. Finalized CAC Selection members and started planning for initial meeting.	1. Held first CAC Selection Committee meeting on 09/30/2024. 2. Started planning for CAC member recruitment based on CAC Demographic Survey results and feedback from CAC Selection Committee members to meet 60-day vacancy fulfillment requirement.	1. Connected and presented information about the CAC as part of membership recruitment efforts: • Father-Friendly Provider Network Members (FFPN): 11/15/2024. • Healthy Relationships Learning Community (HRLC): 11/21/2024. • Health and Human Resource Education Center (HHREC). • Alameda County Public Health Fatherhood Initiative. 2. Held a CAC Selection Committee meeting on 12/17/2024.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	6/30/2024	

2024 Quality Improvement & Health Equity (QIHE) Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification	Q1, 2024	Q2, 2024	Q3, 2024	Q4, 2024	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**	**Y**	**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)	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) drafted in collaboration with other departments. Finalized documents will be presented to QIHEC in April 2024.	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) were reviewed with the Alliance Board Chair and included as consent items to the Board in June 2024.	A high level summary of the QIHE Trilogy documents were presented to the Board by the CMO in July 2024. In addition, a presentation was given for all Trilogy documents (QIHE, UM, CM) at the HCS All Staff meeting in July 2024.	Planning was underway to initiate 2024 QIHE Trilogy documents in preparation for 2025.	All Sub-Committees and QIHEC	Q2 2024	Incorporated BH and SNF/LTC Quality Monitoring
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	**Potential Quality Issues-Quality of Language (PQI-QOL)**	**Y**	**New**	Monitor, evaluate, and conduct appropriate interventions for PQI-QOLs with a closure rate of 95% or more within 60 business days.	1. Q1-96% closure rate.	1. Q2-86% closure rate. (Metric Not Met)	1. Q3-95% closure rate.	1. Q4-93% closure rate. (Metric Not Met)	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	6/30/2024	Challenges: -Increased volume of scheduling. -Difficulty reaching provider offices due to no answer. Sucesses: -All QOL-PQI cases closed within 120 business days. -No provider CAPs issued.