2025 Quality Improvement & Health Equity (QIHE) Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Health Equity Focus (1/16) Include Reducation Biofs	Continued or New?	Goal/Justification *(Update this column)	Q1, 2025	Q2, 2025	Q3, 2025	Q4, 2025	Subcommittee	Project Due Date	Met (Y/N)?	Monitoring of Previously Identified Issues (if applicable)
Title: Sr. QI Director Name: Michelle N. Stull	Title: Sr. QI Director Name: Michelle N. Stull	N/A	**Annual QIHE Program Evaluation**	Y	**Continued**	Conduct an annual written evaluation of the QIHE program that includes: 1. Review of the overall effectiveness of the QIHE program in improving the 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	The QIHE Program Evaluation was updated and approved in IQEC, with final approval by QIHEC on May 8, 2025.	The QIHE Trilogy document was approved at the July 11, 2025 Board meeting.	The 2026 QIHE Program Description was updated to reflect DSRIP requirements.	The 2026 QIHE Program Description was approved in QIHEC on 11	All Sub-Committees and QIHEC	12/31/26		Incorporated RH and BH/LTC Quality Monitoring
Title: Senior Director, Quality Improvement Name: Michelle Stull	Title: Manager, Quality Improvement Name: Fawatha Zeinal	Title: Manager, Quality Improvement Name: Fawatha Zeinal	**HEDIS Rates/MY 2025**	N	**Continued**	Increase the HEDIS/MCAS measures below MPL in MY2026 to meet or exceed MPL by December 31, 2026.	Measure rates MPL, AMR, CBP, TRL. Continue work protocols below MPL for these measures to identify gaps in care and barriers to care. Continue to support through incentive, provider specific reports and educate staff on measure specification and coding.	Continue to work with providers to close care gaps for members with hypertension and Asthma. Utilize detailed reports created in coordination with Pharmacy to identify members for outreach and medication management. Ensure PQHC providers are coding accurately to account for 1PL measure.	Continue to educate providers and encourage members of receiving IBP. Provider education on AMR and share best practices. Identify members with one completed TRL and outreach members for a 2nd TRL.	Implement outreach calls to members missing a well-child visit and who also need a second fluoride treatment. Conducted outreach calls to members with asthma who were out of compliance with their medication ratio. Members were educated about controller vs rescue and ensure they were using their controller medication. The Asthma pilot also started with CHN organizations to reach members who are not in the Medicaid Asthma Program and encouraged them to schedule a visit with their provider.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/26		Due to the pandemic AAH saw a decline in HEDIS measures with multiple years of service. Furthermore, state wide transitions of care, quality scores impacted by decreasing HMO membership.
Title: Senior Director, Quality Improvement Name: Michelle Stull	Title: Manager, Quality Improvement Name: Fawatha Zeinal	Quality Performance Team	**Pay For Performance (P4P) Program**	N	**Continued**	By 12/31/2025, the Quality Performance Team will help clinics meet or exceed their established P4P goals (90th or 75th Percentile). This will be accomplished by providing performance updates to clinics, sharing best practices, and offering project support during their established Quality Meetings.	Continued to meet with providers/delegates to share rates, educate on measure specification, share best practices and support on QI projects. Offered 3 webinars on MY2025 HEDIS measures to educate provider staff on measure specification and share best practices.	Continued to meet with providers/delegates to share rates, educate on measure specification, share best practices, and support on QI projects. P4P committee has continued planning for MY2026. P4P committee has started planning for MY2026.	Continued to meet with providers/delegates to share rates, educate on measure specification, share best practices, and support on QI projects. P4P committee has continued planning for MY2026. Meetings with delegates/clinics have been scheduled in December and January to introduce MY2026's program.	Met with providers and delegates to discuss 2024 P4P results and introduced 2026 P4P.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/26		
Title: Senior Director, Quality Improvement Name: Michelle Stull	Title: Manager, Quality Improvement Name: Fawatha Zeinal	Title: Supervisor, Quality Improvement Name: James Burke	**Learning Academy**	N	**Continued**	By December 31, 2025, the Quality Performance Team will: **Provider Education:** Provide quarterly educational opportunities for providers to learn and apply the PDSA (Plan-Do-Study-Act) methodology, with at least 70% of registered providers attending each session. **MCAS Trainings:** Offer four learning opportunities to the provider network on MCAS measures. These sessions will cover measure specifications and best and promising practices. **Member Education:** Will develop and deliver, in collaboration with Health Education and Health Equity, at least one member education session on the importance of preventive care. This session will be presented to a minimum of one Community-Based Organization (CBO) identified by the team.	Completed webinars for Measure Highlight Webinars on the following topics: Initial Health Assessments (IHAs) and Childhood Dorsum), and a three-part series for ARCs of QI. Continuing planning for other Measure Highlight Webinars for Behavioral Health, Chronic Disease, Cancer Prevention, and Reproductive Health.	Completed Measure Highlight Webinars on topics: Behavioral Health and Chronic Disease. Planning is continuing for Cancer Prevention and Reproductive Health.	Completed ARCs of QI series with providers and health care services in attendance. Starting to plan for MY2026's webinars.	Preparing webinar content for Q1 2026	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/26		An quality improvement (QI) project spread throughout the Health Care Service team. It is essential that all staff members understand the PDSA model for improvement. The model provides a vehicle to drive QI projects.
Title: Senior Director, Quality Improvement Name: Michelle Stull	Title: Manager, Quality Improvement Name: Fawatha Zeinal	Title: QI Project Specialist II Name: Kalli Ikeuli	**Priority PIP: Improve FUA/FUM - improve 30 day follow-up rate**	N	**Continued**	By December 31, 2026, Alameda Alliance will improve the 7-day provider notifications rate by 2% for members visiting the ED with SUD/SMH diagnoses.	In MY 2024, the Alliance was providing a report of members visiting the ED with SUD/SMH diagnoses due to ANSI, CHCN, Reach, and weekly to CFMG. Beginning 07/2025, the Alliance has started providing the same type of report weekly to 11 direct primary care providers to improve the 7-day provider notification rate.	ANSI, CHCN, CFMG and 11 direct primary care providers continue to get notification of members who have been to the ED for FUA or FUM as soon as the Alliance gets claims for it. Data was pulled from MY 2024 and the 7-day notification rate for FUA was 12.10% and FUM was 11.85%. This is an increase from MY 2023. 5.85% and	The FUA and FUM PIP was submitted was submitted to HSAG. ANSI, CHCN, CFMG and 11 direct primary care providers continue to get notification of members who have been to the ED for FUA or FUM as soon as the Alliance gets claims for it.	By December 31, 2026, Alameda Alliance will a goal to improve the 7-day provider notification rate by 2% for members with SUD/SMH diagnoses following an ED visit. This goal has been achieved and exceeded. In MY 2024, the notification rate was 12.10% for FUA and 11.85% for FUM. These rates have since increased in MY 2025, 13.98% for FUA and 19.63% for FUM. This	Internal Quality Improvement Committee	12/31/26		This is a continued PIP topic that was assigned by the state based on low performance.
Title: Senior Director, Quality Improvement Name: Michelle Stull	Title: Manager, Quality Improvement Name: Fawatha Zeinal	Title: QI Project Specialist II Name: Kalli Ikeuli	**Equity PIP: Improve Well Child - W15/30 for African American Children**	Y	**Continued**	To address the disparity that exists with Well Child visits, by December 31, 2026, increase the percentage of well-child visits (W30/d) amongst African American children between the ages of 0-15 months from 30.56% to 68%.	Telephonic Outreach for Well-Care Visits. Through 1st Third Quarter of 2026, each month QI Engagement Coordination conducted two rounds of telephonic outreach to African American members who are missing a well-child visit. These calls aim to: Remind member to complete their well-care visits. Educate on the importance of well-care visits. Provide navigation support to connect with their primary care provider. Assess transportation needs and assist with connections to Modivcare, if necessary. These outreach efforts will continue into Q3 to further support member engagement and access to care.	Telephonic Outreach for Well-Care Visits. Through 1st Third Quarter of 2026, each month QI Engagement Coordination conducted two rounds of telephonic outreach to African American members who are missing a well-child visit. These calls aim to: Remind member to complete their well-care visits. Educate on the importance of well-care visits. Provide navigation support to connect with their primary care provider. Assess transportation needs and assist with connections to Modivcare, if necessary. These outreach efforts will continue into Q3 to further support member engagement and access to care.	Submitted intervention worksheet and submission form to DHCS on 8/7/2025. A member request to modify intervention was approved by DHCS and submitted to AIM by HEQIC on 9/30/2025. Current rate of improvement of relative to 10/30/2025. The PIP is continuing with outreach to members ages 0-15 months who have less than six visits completed in this measurement year. Additionally, we are continuing with our partnership with Children's Health Plan of California (CHPC) to provide outreach to members who are not in our network but are enrolled in the program. QI outreach start end 9/30/2026 and will continue through 2026 after TBD.	Member outreach continued after August 2026 remeasurement submission and concluded on December 31, 2025. The final PIP submission will occur in August 2026 (date to be determined) and will include final Remeasurement 2 data as well as the final intervention worksheets and corresponding data that potentially impacted Remeasurement 2 performance results.	Internal Quality Improvement Committee	12/31/26		This is a newly assigned PIP. PIP topic was assigned by the state based on low performance
Title: Senior Director, Quality Improvement Name: Michelle Stull	Title: Manager, Quality Improvement Name: Fawatha Zeinal	Title: QI Project Specialist II Name: Sungwoo Kwon	**Workgroup: Reproductive Health and Cancer Prevention**	Y	**Continued**	By December 31, 2026, the Alliance will improve on cancer prevention and reproductive health measures in the MCAS/PIP, by conducting improvement projects to increase the MY2026 rates by 2% over MY2024 rates. Increase breast and cervical cancer screening rates for Alliance direct providers to 3 percent over prior years rate by end of 2026 BCS: MY2024: 0.0% BCS-W: MY2024: 0.0% CCS: MY2024: 0.0% Increase Chlamydia screening rate for African American women: As of 1/1/2025: MY2024 rate is 42.87% Increase Chlamydia screening rate for African American women: As of 1/1/2025: MY2024 the rate is 32.38% below MPL at 42.98%. Aim to increase final rate by 3 percent. Continue to focus increasing CCS rates for age band 20-30 As of 1/1/2025: MY2024 rate is 37.83%. Aim to increase the final rate by 3 percent. Cancer Prevention and Reproductive Health Measures: CCS, BCS, CCS, PPC 1, PPC 2, and CHL	In Q1, the Cancer Prevention & Reproductive Health workgroup focused on targeted outreach. The following activities were completed: •CCS Incentive Birthday Card outreach for Alliance Direct Providers (10 providers) with follow up outreach calls from our internal engagement coordinators. •BCS Flyer + outreach call campaign for African American members under the Alliance Direct providers with follow-up outreach calls from our internal engagement coordinators. •BCS Incentive Outreach for Alliance Direct Providers (10 providers) •CCS Incentive Outreach for Alliance Direct Providers (10 providers) with follow up outreach calls from our internal engagement coordinators.	In Q2, the Cancer Prevention & Reproductive Health workgroup focused on the projects that launched in Q1, collecting data and analyzing data for. The CCS birthday card project contribute to send out reminder cards and outreach calls. The BCS flyer PDSA was completed and the results concluded that the flyer paired with an outreach call did not show improvement in BCS rates. The CCS incentive outreach was completed and we are developing targeted outreach focused on preventive care. These outreach calls specifically reach members who have no valid phone number on file or whose contact information is outdated. The workgroup also continued to monitor and support the CCS Incentive Outreach for Alliance Direct providers. We are also partnering with Alameda Health System to provide	In Q3, the Cancer Prevention & Reproductive Health Workgroup has successfully started the CCS cohort with 8 providers participating: TCHC, BACH, Lifelong, Roots, Baywell, AHS). Roots have successfully piloted their Lab Quest self-swab kits and shared results. Baywell piloted the at home testing kits with Lab Corp and shared results. Lifelong is piloting the at home testing kits with Lab Corp. Roots, Baywell, and Lifelong have shared results. Baywell piloted the at home testing kits with Lab Corp and shared results. Lifelong is piloting the at home testing kits with Lab Corp. Roots, Baywell, and Lifelong have shared results. PDSA started with a pilot with Dr. Ralph Reen. Dr. Ralph Reen partnered with AAH by placing mammogram orders for eligible moms and internal engagement coordination will conduct outreach calls to remind members of their mammogram appointment. Dr. Ralph Reen's office has 3,000 eligible members and is currently at a	CCS Cohort momentum: 3 of 8 cohort providers implemented HPV self swab workflows. Baywell launched at home HPV self swab kits pilot. Early results pending. BCS pilot (Direct Providers): PDSA on open mammogram orders with Dr. Ralph Reen. 38 mammogram orders were placed and outreach calls were completed. 3 members are scheduled for mammogram. CCS Dose work: Multiple CCS projects are wrapping, final outcomes are being assembled for sharing. Participation (PPC): network internal engagement coordinators have conducted outreach to members. Linkage to the participation PDSA, among 139 detentees (June-Oct 7, 2025): 20 members completed a	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/26		
Title: Senior Director, Quality Improvement Name: Michelle Stull	Title: Manager, Quality Improvement Name: Fawatha Zeinal	Title: QI Project Specialist I Name: Pattie Carrillo	**Workgroup: Well Child**	N	**Continued**	By December 31, 2026, the Alliance will improve performance on well-child measures within MCAS by conducting targeted improvement projects to raise rates currently below the Minimum Performance Level (MPL) and to further increase performance toward the 75th percentile for W15, W30, and W34. The goal is to achieve a 2% increase in the MY2026 measure rates compared to MY2024 rates, ensuring sustained improvement and the number of MPLs remaining below the minimum performance level is reduced. This approach aims to enhance overall quality, reduce disparities, and improve access to necessary resources and support. Progress will be reviewed quarterly to sustain momentum and adjust strategies as needed.	In Q1, the Well Child Workgroup contributed to the following initiatives: •Partnership with Alameda Health System to provide Well Child Visits Community Health Planning with Roots Community Health Center in Q1 and Q2 March. •Immunization Synergistics: in provider clinics. •Partnership with Alameda Health System and Alameda County promoting well-visits. •Text-to-Radio Stations to promote well-visits. •Video PSA in DMV to promote well-visits. •Planning for HEDIS Crunch begin in collaboration with CFMG.	Workgroup Activities and Member Engagement Initiatives: Q1 2025, the Workgroup has successfully implemented a series of initiatives aimed at improving performance across childhood measures. Key activities included outreach efforts, mailing, member incentives, supplemental remote data access, and the ongoing deployment of immunization pulses. Engagement Coordinators continued targeted outreach to members who were missing a well-child visit, and incorporating "sick visit" opportunities into the outreach process. Outreach efforts expanded with Pinch platforming W15, Q2 engagement	The Well Child workgroup contributed by advancing topical Youtube initiatives through provider education, school outreach, and community partnerships. Collaborations with Alameda Health System and Roots Community Health Center in Q2 and Q3 March, enhanced access to immunizations, and incorporating "sick visit" opportunities for families with immigration concerns. Outreach efforts expanded with Pinch platforming W15, Q2 engagement initiatives, and Q3 engagement initiatives. Additional efforts included Alameda Health System's Relaxed Parenting Program addressing African Americans. Additional efforts includes Alameda Health System's Relaxed Parenting Program addressing gift card incentives as the HEDIS spirit and strengthening data capture for newborn visits, vaccinations, and	During Q3, the Well Child workgroup supported multiple initiatives aimed at improving performance across childhood measures. Key activities included outreach efforts, mailing, member incentives, supplemental remote data access, and the ongoing deployment of immunization pulses. Engagement Coordinators continued targeted outreach to members who were missing a well-child visit, and incorporating "sick visit" opportunities into the outreach process. Outreach efforts expanded with Pinch platforming W15, Q2 engagement initiatives, and Q3 engagement initiatives. Additional efforts includes Alameda Health System's Relaxed Parenting Program addressing African Americans. Additional efforts includes Alameda Health System's Relaxed Parenting Program addressing gift card incentives as the HEDIS spirit and strengthening data capture for newborn visits, vaccinations, and	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/26		This workgroup is committed to fostering collaboration among QI departments to improve performance on Well Child measures.
Title: Senior Director, Quality Improvement Name: Michelle Stull	Title: Manager, Quality Improvement Name: Fawatha Zeinal	Title: QI Project Specialist II Name: Ginger Hirk	**Workgroup: Chronic Disease Management**	N	**Continued**	By December 31, 2025, Alameda Alliance for Health (AAH) will improve the administrative rates for chronic disease management hybrid measures as follows: CBP: 68% (MY2023) to 69% (MPL) GSD: 32% (MY2023 HBD) to 29% (MPL pull) By December 31, 2025, Alameda Alliance for Health (AAH) will improve the site for chronic disease management AMR as follows: AMR: 68% (MY2023) to 77% (MPL pull) By December 31, 2025, Alameda Alliance for Health (AAH) will improve data collection for CBP and GSD measures among direct providers from: CBP: 76% to 78% missing or incomplete GSD: 37% to 29% missing	QI Engagement team finished first round of outreach calls to members, pertaining to chronic care measures (HCC PCPs, with no PCP visit, in the last year), includes members who are missing A1c and/or BP, incomplete for either or both, or compliant for both. The second campaign is in partnership with Alameda Health System: call members with no record of receiving a BP monitor, ask if they want to have a monitor delivered. 100 members on outset list.	QI Engagement team finished first round of outreach calls to members, pertaining to chronic care measures (HCC PCPs, with no PCP visit, in the last year), includes members who are missing A1c and/or BP, incomplete for either or both, or compliant for both. The second campaign is in partnership with Alameda Health System: call members with no record of receiving a BP monitor, ask if they want to have a monitor delivered. 100 members on outset list.	Second round of Q3 Engagement calls for A1c and BP missing or noncompliant is underway. Exploring capacity of CHW partners to take on calls in support. Second round of BP monitor PDSA with AHS complete. Data is being analyzed. Results will be shared in Q4. Plan to start third round of BP monitor PDSA with AHS complete. Other projects in planning phase: educational sales to AMR and AAP. Pharmacy educational session planned for Oct 18 with NAHC. Diabetes management class: incentive explanation still in progress. Updates to measure highlights planned by the end of October.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/26		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 and the Health Equity team. Control of challenges collecting data for CBP and GSD measures, and improvement in achieving consistent administrative performance below hybrid rates, are steadily decreasing rates for AAH after several years of high performance.
Title: Senior Director, Quality Improvement Name: Michelle Stull	Title: Manager, Quality Improvement Name: Fawatha Zeinal	Title: QI Project Specialist II Name: Kalli Ikeuli	**Workgroup: Behavioral Health**	N	**Continued**	By December 31, 2025, Alameda Alliance for Health will watch FUA HBD06 rates and improve FUM HBD06 rate by 2% from MY2024 to MY2025 to meet/exceed MPL. MY 2024 rates as of 5/1: FUA: 61.44% FUM: 56.38 % Collaborate with BH Department in development of disease management for depression. Collaborate with ACBH to disseminate resources to providers and encourage data sharing.	QI collaborated with Behavioral Health and ACBH to plan a Behavioral Health Town Hall to disseminate information about the Alliance's Quality Improvement Initiatives. Planning for the Town Hall. QI Engagement coordinators called 100 members who were on the first FUA/FUM report. The coordinators were able to make 17 successful contact, i.e. 17 members picked up the phone and were either transitioned to a live person or provided information. Plan to make 100 more calls in the second round of calls. During the next PDSA in Q2, the QI engagement coordinators will warm transfer the member to the Behavioral Health team who will complete an assessment and connect the member to the appropriate level of care.	The 2nd round of PDSA was conducted, the QI engagement coordinators called members and warm transferred the member to the Behavioral Health team who completed an assessment and connected the member to the appropriate level of care.	Data was analyzed and presented for MY2025 follow ups for FUA and FUM. The dates showed that 13% of follow ups are conducted by PCPs and 13% of follow ups are conducted by Alameda Health Systems. The data also showed that around 80% of FUA and FUM members have not a PCP in the last 2 years. The group discussed how the Alliance can continue to support Alameda Health System in their work and also figured how to get members to connect with primary care. ACBH agreed to share data on their BD high utilizer follow up program and other outreach efforts in the future.	The workgroup continued to meet in Q4 to discuss rates and come up with new project ideas. In Q4, the workgroup completed a PDSA focused on FUA/FUM follow-up for Medi-Cal members, which resulted in similar or the first 2 testing periods. The QI engagement coordinators were able to successfully contact about 18-20% of members. Of those reached, 2-3% seemed to be connected to the behavioral health team for further support. Due to the small return based on the amount shifted to conduct these calls, the workgroup has decided to not continue the outreach PDSA. The workgroup has decided to continue the outreach PDSA for FUA/FUM in Q1 2026. In Q1 2026, the goal aim is to sustain or improve the FUA and FUM HBD06 rates a by 2% from MY2025 to MY2026. For MY 2026, the FUA rate was 61.44% and the FUM rate was 66.38%. The goal aim for the FUA and FUM HBD06 rates is to achieve the Minimum Performance Level (MPL) and performing above the 75th percentile. The MY2026 FUM rate is currently 63.86% which is below the targeted improvement; however, final performance cannot be determined until HEDIS rates are finalized in the coming months.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/26		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 and the Behavioral Health Departments. These goals were developed in the spirit of collaboration and sharing with Alameda County for the FUA and FUM measures.
Title: Senior Director, Quality Improvement Name: Michelle Stull	Title: Manager, Quality Improvement Name: Fawatha Zeinal	Title: Supervisor, Quality Improvement Name: James Burke	**Member Engagement Program**	N	**Continued**	By 12/31/2025, the Member Engagement Program will close care gaps in the DHCS MCAS measures by reaching or exceeding the MPLs. This will be achieved through the following actions: Conducting at least 3,000 outcalls quarterly to engage with members and identify care gaps. Collaborate with at least one provider, quarterly, to implement member-focused campaign. Conduct outreach to at least four quality improvement projects, to the year, related to member engagement, contributing to measurable improvements.	Continued and started campaigns on BCS, CBP, CCS, FUA, FUM, GSD, W15 and WCV.	Continued and started campaigns on BCS, CBP, CCS, FUA, FUM, GSD, W15 and WCV.	Outcalls have continued. Additional measure focused campaigns have been added: TFL-CH and PPC-Pos.	Outcalls have continued. Over 8,000 unique members have been outreached to with a success rate of 24% for the year.	Internal Quality Improvement Committee	12/31/26		
Title: Senior Director, Quality Improvement Name: Michelle Stull	Title: Manager, Quality Improvement Name: Fawatha Zeinal	Title: Supervisor, Quality Improvement Name: James Burke	**IHCIHCS Equity Learning Collaborative - Children's Health**	Y	**Continued**	The focus of the Child Health Equity Collaborative is to improve the completion of well-child visits, ages 0-21. The Alliance will conduct Evidence-Based Interventions: Equity & Transparent, Stratified, and Actionable Data (April-May 2024) Understand Provider and Patient/Caregiver Experiences (June-July 2024) Plan and Implement PDSAs with Provider Partners (August-October 2024) Analyze Results and Share Learnings (November-December 2024) Partnership for Effective Education & Communication (January-March 2025)	Project concluded with IHCIHCS. Roots abandoned their PDSA and is starting a new one on Birthday Cards. Lefler stopped their participation. IH announced another learning collaborative will be announced in Summer 2025.	Pre IH, phase 5 delayed to September 2025.	**Phase 5a** Bid meeting was conducted on 8/26/25 **Strategic Scan**: 9/15/2025, open 10 years old: W15 and W30 **Provider Recruitment**: September 2025 - December 2025 **Focus initiatives**: (1) Enhance Appointment Access and Scheduling, (2) Connect Members to Available Resources to Report Completion of Well-Child Visits, and (3) Connect Families to Patient Navigation **Provider partner**: TBD. IH has requested we partner with at least three clinics over the course of this project. **Estimated start date**: By September 2026. MCPs will increase W30 (6+ and W30 (3+ rates by at least 5 percentage points for children 0-2, focusing on counties with racial/ethnic disparities.	Partnered with Centro Valley Pediatrics has changed over to UCSF Health Medical Foundation (UHMF) Centro Valley Pediatrics for this collaboration.	N/A		**Provider Partners**: Previous partners selected did not have the capacity to lift the requirements of this project.
Title: Sr. QI Director Name: Michelle Stull	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**	Provide meaningful contributions to LHJ CHA/CHIPs (including resources, in-kind staffing, and data sharing) by Q4 of 2025.	Received and processing resource contribution and in-kind staffing requests from Alameda County and other LHJs. Attended CHA/CHIP collaborative and monthly meetings with both LHJs and Kaiser Permanente for collaboration updates and discussion.	Received and processing resource contribution and in-kind staffing requests from Alameda County and other LHJs. Attended CHA/CHIP collaborative and monthly meetings with both LHJs and Kaiser Permanente for collaboration updates and discussion.	Held various data sharing discussions with ACPHD and the City of Berkeley. Submitted Analytics request to share HEDIS data with the City of Berkeley. Developing additional data sharing requests regarding immunizations and opioid use with ACPHD. Received updates from LHJs describing how financial contributions were used for CHA/CHIP.	Participated in City of Berkeley World Café CHIP implementation meeting in December. ACPHD presented CMAA findings to Alliance CAC in December. Discussed statewide behavioral health goals and ACBH/DD integrated plan development. Data sharing requests with ACPHD still in progress. Plan to contribute the same dollar amount to LHJs in FY2026.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025		
Title: Sr. QI Director Name: Michelle Stull	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Population Health Management - PHM Workflows**	Y	**Continued**	Implement population-based PHM framework to inform monitoring processes and RISS guidance by the end of 2025.	PHM consultant ideas32 shifted a measurement framework with input from other departments involved in population health. Proposed dashboard design and functions under review by Analytics.	PHM consultant ideas32 submitted four deliverables for measurement framework, dashboard prototype, and analysis of use of RISS and member connections to disease management.	Held leadership meetings to prepare for Medi-Cal Connect RIDER implementation.	Requested data on Alliance vs. DHCS RIDER members to review with RIDER implementation leads. PHM dashboard mockup to be submitted to Analytics in Q1 2026.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025		
Title: Sr. QI Director Name: Michelle Stull	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 2025- PHM Strategy to address priority gaps in care and disparities in compliance with DHCS and NCQA requirements.	Completed 2024 PHM Evaluation, 2025 PHM Assessment, and activities and resources update for 2025 PHM Strategy development.	2025 PHM Strategy updated and presented to QIHEC in May for approval. Strategy was also presented to CAC for input in June.	N/A - Completed.	N/A - Completed.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025		
Title: Senior Director, Pharmacy Services Name:	Title: Clinical Pharmacist Name: Ramon Tran Tang	N/A	**QIP #5: Opioid / SUD - Continuation**	N	**Continued**	Goal 1: By 12/31/25, educate chronic opioid users on health habits, management of chronic pain, and alternative therapy and care (<120 MME/day). Goal 2: By 12/31/25, educate opioid users at risk of becoming chronic users (i.e., 60 to 119 MME/day).	Next automated mailing on 6/12th. All educational handouts are updated. CBO request will be sent in May.	CBO request was sent out in June. Mailings were sent out in mid to end of June.	Next mailing is on track to be sent out around 12/12th	Mailing sent out near the end of December	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025		Staff bandwidth and staffing transition
Title: Senior Director, Pharmacy Services Name:	Title: Clinical Pharmacist Name: Ramon Tran Tang	N/A	**QIP #5: Opioid / SUD - Continuation**	N	**Continued**	Goal 3: By 12/31/25, 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.	Next automated mailing on 6/12th. All educational handouts are updated. CBO request will be sent in May.	CBO request was sent out in June. Mailings were sent out in mid to end of June.	Next mailing is on track to be sent out around 12/12th	Mailing sent out near the end of December	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025		Staff bandwidth and staffing transition
Title: Sr. QI Director Name: Michelle Stull Title: Sr. Medical Director Name: Dr. Stephanie Brown	Title: Sr. QI Director Name: Michelle Stull Title: Sr. Medical Director Name: Dr. Stephanie Brown	Title: Sr. QI Director Name: Michelle Stull	**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.	Q1 results for PQI QDC case closure met the threshold at 97.62%	Q2 is the first quarter in many years where PQI TATs fell below the 95% threshold. This is primarily a result of the absence of the Medical Director in Q2 2025 which resulted in a shortage of time available from alternate Medical Directors to meet and review PQI cases. Approximately 20% of cases were not closed within the 120 days. A new queue has been developed in Quality Suite for MD remarks to access QDC PQIs that are ready for MD review.	Q3 continued to have PQI TATs that have fallen below the 95% threshold. Now that a Q2 Medical Director has been hired, this trend should begin to reverse in Q4. Per DHCI, the PQI TAT was changed to 180 days. As of 9/30/25, there were 80 QDC cases still open after 180 days, which is equivalent to 16.67%.	Q4 continued to have PQI TATs that have fallen below the 95% threshold. Now that a Q2 Medical Director has been hired, this trend should begin to reverse in Q4. Per DHCI, the PQI TAT was changed to 180 days. As of 9/30/25, there were 80 QDC cases still open after 180 days, which is equivalent to 16.67%. Process improvements have been underway since September 2025 to minimize duplication of PQIs from team members as most of these cases were resulted upstream by the SMA team. The QI team is monitoring SMA tools and trend reports and addressing system issues and fixes/some such members as associate	Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025		
Title: Sr. QI Director Name: Michelle Stull Title: Sr. Medical Director Name: Dr. Stephanie Brown	Title: Sr. Medical Director Name: Dr. Stephanie Brown	Title: Sr. QI Director Name: Michelle Stull	**PQI Corrective Action Plan Tracking & Trending**	N	**New**	Monitor, evaluate and take effective action where appropriate on all Corrective Action Plans (CAPs) issued. Assess effectiveness of track and trend reports and refine if needed.	In Q1 2025 there were a total of 5 CAPs issued with no trends identified. These included 3 LTC providers and 2 Medicaid QDC issues.	There were 12 CAPs issued from QDC cases received in Q3. 9 of the CAPs issued are still pending provider response. Of the 12 CAPs, 3 were PPCs and 2 were LTC. Trends were identified.	As of 10/9/2025, there are 11 CAP responses pending. 3 of these involve Butler facilities who have a history of not responding to CAPs based on information being confidential and privileged. Standard processes are followed in order to obtain a response but, ultimately, these cases are treated and closed by the Medical Director based on validated clinical rationale. Trends are being monitored. Compliance to resolved this week. No trends identified for other providers.	As of 11/9/2025, there are 11 CAP responses pending. 2 of which are Butler cases with a history of not responding to CAPs. For the remaining cases, the team is treated and closed by the Medical Director based on validated clinical rationale. Trends are being monitored. Compliance to resolved this week. No trends identified for other providers.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025		2024 CAP report presented at BCC and IQEC in March 2025
Title: Sr. QI Director Name: Michelle Stull Title: Sr. Medical Director Name: Dr. Stephanie Brown	Title: Sr. Medical Director Name: Dr. Stephanie Brown	Title: Sr. QI Director Name: Michelle Stull	**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.	An Exempt Grievance audit was performed in January which returned a compliant score of 100%. Next audit will be performed in June 2025.	Exempt Grievance Audit is due in Q2	EG audit was performed in January 2025 with results presented at July IQEC. The goal of 80% was met consistently at a rate of 100%. Next audit is in January 2026.	Next audit will be done in January/February 2026.	Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025		
Title: Sr. QI Director Name: Michelle Stull Title: Sr. Medical Director Name: Dr. Stephanie Brown	Title: Sr. Medical Director Name: Dr. Stephanie Brown	Title: Sr. QI Director Name: Michelle Stull	**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 frontline entity for the intake of all potential quality of care grievances.	PQI annual training was done in February at HCS All Staff meeting and with CHCN in March. MSD provides training to their staff.	Next training will be done in January/February 2026.	Next training will be done in January/February 2026.	Next training will be done in January/February 2026.	Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025		
Title: Sr. QI Director Name: Michelle Stull Title: Sr. Medical Director Name: Dr. Stephanie Brown	Title: Sr. Medical Director Name: Dr. Stephanie Brown	Title: Sr. QI Director Name: Michelle Stull	**Provider Preventable Conditions (PPCs) workflow**	N	**New**	Refine Provider Preventable Conditions (PPCs) workflow in collaboration with other departments.	The PPC workflow was reviewed and updated with appropriate State portal access for reporting purposes. Collaboration between Claims and QI occurred in Q1 and led by QI Director.	The PPC workflow has been fully implemented per changes made in Q1 2025.	No changes have been made in the PPC workflow	No changes have been made in the PPC workflow	Internal Quality Improvement Committee	12/31/2025		
Title: Sr. QI Director Name: Michelle Stull Title: Sr. Medical Director Name: Dr. Stephanie Brown	Title: Sr. Medical Director Name: Dr. Stephanie Brown	Title: Sr. QI Director Name: Michelle Stull	**PQI Multi-Care Focus**	N	**New**	On tracking and trending of PQI cases as well as a review of grievances, we note a substantial number of CT / CI cases and member complaints related to missed care. Collaborate with Medicare and Vendor Management to address any preventable system issues.	Ongoing collaboration between Medicaid and AAH Vendor Mgt. CMDM, QI&A and QI continues to be an effective process. Since the PQI workflow was implemented, the team has been able to review and resolve PQI cases to address trends, system issues and improve Medicaid and attain CAP closure.	PQI Medicaid process continues per the usual process including collaboration with AAH Vendor Management, CMDM and QI&A. Tracking and trending is done with routine reporting of the Medicaid JCSM.	No changes have been made in the Medicaid focus	No changes have been made in the Medicaid focus.	Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025		
Title:

2025 Quality Improvement & Health Equity (QIHE) Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Health Equity Focus (Y/N) *Include Revisions Both	Continued or New?	Goal/Justification *(Update this column)	Q1, 2025	Q2, 2025	Q3, 2025	Q4, 2025	Subcommittee	Project Due Date	Met (Y/N)?	Monitoring of Previously Identified Issues (if applicable)
Title: Sr. QI Director Name: Michelle N. Stull	Title: Sr. QI Director Name: Michelle N. Stull	N/A	**Annual QIHB Program Evaluation**	Y	**Continued**	Conduct an annual written evaluation of the QIHB program that includes: 1. A description of completed and ongoing QIHB activities that address quality and safety of clinical care and quality of service 2. Assessment of progress towards achieving the goals of the QIHB program and its impact on health care quality 3. Analysis and evaluation of the overall effectiveness of the QIHB 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	The QIHB Program Evaluation was updated and approved in IQIC, with final approval by QIHBC on May 9, 2025.	The QIHB Trilogy document was approved at the July 11, 2025 Board meeting.	The 2025 QIHB Program Description was updated to reflect DSRIP requirements.	The 2026 QIHB Program Description was approved in QIHBC on 11	All Sub-Committees and QIHBC	12/31/25		Incorporated BH and SNF/LTC Quality Monitoring
Title: Sr. QI Director Name: Michelle Stull	Title: Access to Care Manager Name: Lue 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 2026. Started Q2 2024, CG-CAHPS will includes BH providers. Specialist providers will be added to CG-CAHPS survey starting Q1 2026.	**~~Q4, October-Dec 2024~~** **Call Return Time (PCP)** Numerator: 1,512 Denominator: 2,110 Compliance Rate: 70.0% Goal Met: Y **In-Office Wait Time (PCP)** Numerator: 2,609 Denominator: 2,866 Compliance Rate: 90.9% Goal Met: Y **Time to Answer Call (PCP)** Numerator: 1,756 Denominator: 2,270 Compliance Rate: 77.0% Goal Met: Y **Call Return Time (BH)** Numerator: 208 Denominator: 282 Compliance Rate: 73.7% Goal Met: Y **In-Office Wait Time (BH)** Numerator: 409 Denominator: 426 Compliance Rate: 89.7% Goal Met: Y **Time to Answer Call (BH)** Numerator: 233 Denominator: 281 Compliance Rate: 81.9% Goal Met: Y	**~~Q1, January-March 2025~~** **Call Return Time (PCP)** Numerator: 1,512 Denominator: 2,110 Compliance Rate: 70.0% Goal Met: Y **In-Office Wait Time (PCP)** Numerator: 2,609 Denominator: 2,866 Compliance Rate: 90.9% Goal Met: Y **Time to Answer Call (PCP)** Numerator: 1,756 Denominator: 2,270 Compliance Rate: 77.0% Goal Met: Y **Call Return Time (BH)** Numerator: 208 Denominator: 282 Compliance Rate: 73.7% Goal Met: Y **In-Office Wait Time (BH)** Numerator: 409 Denominator: 426 Compliance Rate: 89.7% Goal Met: Y **Time to Answer Call (BH)** Numerator: 233 Denominator: 281 Compliance Rate: 81.9% Goal Met: Y	**~~Q2, April-June 2025~~** **Call Return Time (PCP)** Numerator: 1,512 Denominator: 2,110 Compliance Rate: 70.0% Goal Met: Y **In-Office Wait Time (PCP)** Numerator: 2,609 Denominator: 2,866 Compliance Rate: 90.9% Goal Met: Y **Time to Answer Call (PCP)** Numerator: 1,756 Denominator: 2,270 Compliance Rate: 77.0% Goal Met: Y **Call Return Time (BH)** Numerator: 208 Denominator: 282 Compliance Rate: 73.7% Goal Met: Y **In-Office Wait Time (BH)** Numerator: 409 Denominator: 426 Compliance Rate: 89.7% Goal Met: Y **Time to Answer Call (BH)** Numerator: 233 Denominator: 281 Compliance Rate: 81.9% Goal Met: Y **Emergency Non-Life Threatening (BH)** Numerator: 75 Denominator: 78 Compliance Rate: 96.1%	**~~Q3, July-Sept 2025~~** **Call Return Time (PCP)** Numerator: 1,512 Denominator: 2,110 Compliance Rate: 70.0% Goal Met: Y **In-Office Wait Time (PCP)** Numerator: 2,609 Denominator: 2,866 Compliance Rate: 90.9% Goal Met: Y **Time to Answer Call (PCP)** Numerator: 1,756 Denominator: 2,270 Compliance Rate: 77.0% Goal Met: Y **Call Return Time (BH)** Numerator: 208 Denominator: 282 Compliance Rate: 73.7% Goal Met: Y **In-Office Wait Time (BH)** Numerator: 409 Denominator: 426 Compliance Rate: 89.7% Goal Met: Y **Time to Answer Call (BH)** Numerator: 233 Denominator: 281 Compliance Rate: 81.9% Goal Met: Y **Emergency Non-Life Threatening (BH)** Numerator: 75 Denominator: 78 Compliance Rate: 96.1%	**~~Q4, October-Dec 2025~~** **Call Return Time (PCP)** Numerator: 1,512 Denominator: 2,110 Compliance Rate: 70.2% Goal Met: Y **In-Office Wait Time (PCP)** Numerator: 1,371 Denominator: 1,476 Compliance Rate: 92.9% Goal Met: Y **Time to Answer Call (PCP)** Numerator: 1,756 Denominator: 2,270 Compliance Rate: 76.9% Goal Met: Y **Call Return Time (BH)** Numerator: 139 Denominator: 282 Compliance Rate: 47.7% Goal Met: N Gap to Goal: 2.3% **In-Office Wait Time (BH)** Numerator: 209 Denominator: 330 Compliance Rate: 91.8% Goal Met: Y **Time to Answer Call (BH)** Numerator: 139 Denominator: 281 Compliance Rate: 82.0%	Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025		
Title: Sr. QI Director Name: Michelle Stull	Title: Access to Care Manager Name: Lue 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 2025.** Goal: 2% increase from previous year overall satisfaction rate.	Results received Dec. 2024. Overall Satisfaction Plan Rating for MY2024 is 90.7% up by 2.3% points from MY2023 - 78.4%. Met or significantly higher scores compared to PG Commercial and Aggregated Bulk. Results shared with CGC/IQCC for review and evaluation of next steps. Next meeting with PG on Feb 18, 2025.	Last SPH JOM was on 05.28.25. SOW in process. On Track.	Per JOM on 08.21.25. Provider Satisfaction to begin fielding on 09/02/2025	On Track. 2025 Provider Satisfaction results revoted in December.	Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025		
Title: Sr. QI Director Name: Michelle Stull	Title: Access to Care Manager Name: Lue Tran	Title: QI Specialist Name: Fiona Guan	**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 2025**. Goal: 2% increase from previous year overall satisfaction rate.	MY2024 Survey Results still in pending from PG	Last SPH JOM was on 05.28.25. Fielding timeline to be posted shortly. On Track.	Survey results presented at Q2 2025 A&A Sub-Committee on 08/12/2025. Top Rx: Flu Shot Urgent Appointment: 52.7%+ Non-Urgent Appointment: 68.8% Getting Care, Test, Or Treatment: 78.8%+	On Track. MY2026 CAHPS Survey Sample Frame will be submitted next quarter	Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025		
Title: Sr. QI Director Name: Michelle Stull	Title: Access to Care Manager Name: Lue 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 2025.**	**Primary Care Providers** Numerator: 37 Denominator: 40 Compliance Rate: 92.5% Goal Met: Y Goal: 80% **Specialists** Numerator: 161 Denominator: 170 Compliance Rate: 98.6% Goal Met: Y Goal: 80% **Behavioral Health** Numerator: 93 Denominator: 97 Compliance Rate: 77.8% Goal Met: N Gap to Goal: 2.2% Goal: 80%	Last SPH JOM was on 05.28.25. SOW in process. On Track.	Per JOM on 08.21.25. After Hours Care to begin fielding on 09/02/2025	Results received from SPH in November. A&A to conduct reassessment of failed providers then analysis.	Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025		
Title: Sr. QI Director Name: Michelle Stull	Title: Access to Care Manager Name: Lue Tran	Title:QI Specialist Name: Fiona Guan	**Initial Pre-Natal Visits Continuation (Annual)**	N	**Continued**	To ensure that the survey aligns with DMHC requirements and is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities related to CHBOTN audits offered according to Timely Access Standards. Reach or exceed 75% compliance rate for First Prenatal appointment. **Fielding Sep - Oct. 2025** **HEDIS Prenatal visits: 85.30 baseline to 85.60 admin (MPL) - increase by 3%**	MY2024 Survey Results were presented at the March 20, 2025 A&A Sub Committee Numerator: 31 Denominator: 46 Compliance Rate: 69.2% Goal: 75% Goal Met: No Gap to Goal: 2% 1 Non-Response, 14 Non-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 Non-Delegates. 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. 1 Non-Delegate. Provider education regarding the First Pre-Natal Visit survey and regulatory requirements. A&A have issued corrective action plans (CAPs) to non-compliant providers. 4 Track and trend CHBOTN QOA PCP reports to identify non-compliant providers for education and ongoing compliance.	On Track	On Track. Analytics Prepping Survey Tool.	Non-PAAS 2025 is currently in fielding process	Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025		
Title: Sr. QI Director Name: Michelle Stull	Title: Sr. QI Director Name: Michelle Stull Title: Sr. Medical Director Name:	Title: QI Specialist Name: Fiona Guan	**PAAS (Provider/Appt Availability Survey) Continuation (Annual)**	N	**Continued**	To ensure that the annual survey aligns with DMHC requirements to assess appointment availability in 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 Sep - Dec. 2025**	MY2024 Survey Results pending from QMetric	MY 2026 results were presentated at the A&A Sub-Committee meeting on May 21, 2025	Fielding Started August 18, 2025	PAAS 2025 is currently in fielding process	Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025		
Title: Sr. QI Director Name: Michelle Stull	Title: Sr. QI Director Name: Michelle Stull Title: Sr. Medical Director Name:	Title: QI Specialist Name: Fiona Guan	**Provider Visits and Training**	N	**Continued**	Conduct at least 4 site visits per quarter to provider offices/clinics and provide training on timely access standards through the end of 2026.	03/13/2025 TVHC 03/26/2025 AIBS Community Health	05/01/2025 Alta Bates Permanente 05/07/2025 Kaiser Permanente Oakland Medical Group 05/08/2025 TVHC 05/14/2025 Lifelong Medical Care 05/20/2025 CARE Health 05/22/2025 Alameda Community Health 05/30/2025 Alameda Medical Group 06/04/2025 Kaiser Permanente 06/04/2025 Sand Bay Orthopaedic & Medical Specialist (SL) 06/13/2025 UCSF 06/24/2025 CPMG	07/03/2025 Asian Health Services 07/10/2025 Dave Street Primary Care 08/12/2025 CPMG 08/19/2025 Alameda Community Health 09/26/2025 John Muir Physician Network	10/2/25 - Brighter Beginnings - 2744 E 11th Street, Oakland, CA 94601 10/23/25 - Native American Health - 2980 International Blvd, Oakland, CA 94601 10/27/25 - Lifelong Berkeley Total - 800 University Ave, Berkeley, CA 94710 11/6/25 - Kaiser - 3333 Mt. Diablo Blvd, Lafayette, CA 94549 11/12/25 - LIFER Pediatrics - 1103 E Stanley Blvd, Livermore, CA 11/18/25 - Allina Medical Corporation - 3755 Bacon Ave, Fremont, CA 94538 11/20/25 - Joe Health - 5799 Market Street, Oakland, CA 94608 12/1/25 - East Bay Advanced Care - 3100 Summit St, Oakland, CA 94609 12/1/25 - Lifelong Medical Care - 1950 Sacramento St, Berkeley, CA 94709 12/2/25 - Joe Health - 1960 Maxey Ave, Fremont, CA 94538 12/3/25 - Joe Health - 5833 Stoneridge Dr, Pleasanton, CA 94588 12/10/25 - Kaiser - 2000 Peralta St, Oakland, CA 94612 12/11/25 - East Bay Cardiovascular - 27206 Calaroga Ave, Hayward, CA 94545 12/12/25 - La Clinica Tierrasol Village - 3487 E 12th St, Oakland, CA 94601 12/29/25 - Reach Been, MD - 1960 Maxey Ave, Fremont, CA 94538	Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025		
Title: Sr. QI Director Name: Michelle Stull	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**	1.0 - Maintain a 95% fulfillment rate for health education material requests and referrals within 10 business days for threshold languages and within 30 business days for translation materials through the end of 2025. 1.1 - Support coordination and logistics of Community Advisory Committee meetings, monthly and quarterly team meetings through the end of 2025.	1.0 - Maintained a 98.9% fulfillment rate for health education material requests in Q1 2025. 1.1 - Successfully supported coordination of March CAC meeting and monthly PHE team meetings.	1.0 - Maintained a 97% fulfillment rate within 10 business days for health education requests in Q2 2025. 1.1 - Successfully coordinated the Q2 CAC and PHE monthly team meetings.	1.0 - 99.6% fulfillment rate within 10 business days (Metric Met for Q3) 1.1 - Successfully coordinated the Q3 CAC meeting.	1.0 - 99.6% fulfillment rate with 10 business days (metric met for Q4). 1.1 - Successfully coordinated the Q4 CAC meeting.	Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	12/31/2025		
Title: Sr. QI Director Name: Michelle Stull	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**	2.0 - Develop at least one strategy to support senior (DSRIP) populations with health education or wellness and prevention services by the end of 2026. 2.1 - Conduct annual health education program evaluations to drive process and program improvements by Q3 2026. 2.2 - Address low Well Child Visit rates in Farsi, Tagalog and Arabic speaking communities, by ensuring prevention services health education materials are culturally aligned for Farsi, Tagalog and Arabic speaking members (added 9/2025, NCQA HBM).	2.0 - Reviewed DSRIP Model of Care and DSRIP Assessment questions to identify opportunities for health education resource development. Attended Senior Injury Prevention Partnership conference to identify population needs. 2.1 - Completed evaluation summary tables for the Diabetes Prevention Program and Continent Card Exercise Surveys.	2.0 - Developed three health education material packages focused on needs identified for the DSRIP population. 2.1 - Completed annual health education program evaluations for Family Paths, BEAD, Stoller, and DPP Healthy.	2.0 - As DSRIP HED materials were finalized and submitted to C&O for review/design. Completed 3 RAAS and HED material crosswalk. 2.1 - N/A - completed. 2.2 - Reviewed Well-Child Visit HED material and language availability.	2.0 - 3x DSRIP materials were field tested with Community Advisory Committee (CAC) members to gather feedback on clarity and cultural relevance. Feedback was compiled and shared with C&O to inform the next round of design revisions. 2.1 - N/A - activity completed. 2.2 - The Well-Child Visit handout was submitted to C&O for Arabic translation, expanding on existing Farsi and Tagalog versions. HED is preparing a targeted mailing that will include the handout and a cover letter, which is currently being drafted by a HED Specialist.	Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	12/31/2025		
Title: Sr. QI Director Name: Michelle Stull	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**	3.0 - Measure the impact of doula utilization on maternal and child health outcomes by the end of 2025.	Developed key questions for member story spotlight in member newsletter and to share at a doula event for members. Identified metrics to review with Diversity Uplifts to measure maternal health outcomes. Attended Sutter health Perinatal collaboration.	Continued development of doula utilization report. Developed draft maternal mental health program description.	Finalized the Maternal Mental Health Program Description. Launched the Doula Member Experience Survey campaign.	Maternal Mental Health Program measures reviewed and discussed in Behavioral Health QI workgroup in October.	Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	12/31/2025		
Title: Sr. QI Director Name: Michelle Stull	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Disease Management**	Y	**New**	6.0 - Implement at least one new strategy to engage members in a Disease Management program by the end of 2025. 6.1 - NCQA HBS Address hypertension in Black members through culturally targeted hypertension education and coaching using culturally relevant messaging to promote engagement and address unique concerns, such as SDOH (added 9/2025).	6.0 - Launched member program for participation in health coaching. Journey Health CHWs will conduct outreach to Anthem and AB members with uncontrolled hypertension and diabetes. Targeted health coaching outreach to Group Care members.	6.0 - Combined targeted outreach to DC members. Journey Health completed phase 1 outreach to Anthem and AB members with uncontrolled hypertension and diabetes.	6.0 - Launched Journey Health Disease Management Phase 2 referrals. Goal completed. 6.1 - Prioritized Black members in multiple chronic condition subpopulation with care gaps for referral and engagement the Good Life Path.	6.0 N/A - Goal met in Q3. 6.1 - In 2025, the Alliance implemented a culturally targeted hypertension engagement strategy by prioritizing Black/African American members for CHW-led education, coaching, and nutrition programming through the Good Life Path, integrating culturally relevant messaging and social determinants of health barriers such as technology access, transportation, and health literacy concerns.	Utilization Management/Quality Improvement and Health Equity Committee	12/31/2025		
Title: Sr. QI Director Name: Michelle Stull	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Disease Management**	N	**New**	5.0 - Develop tailored disease management outcomes measures for subpopulations by the end of 2025.	Identified DM subpopulations for referral to the Good Life health education program via the development of tailored multiple chronic condition care gap and diabetes and hypertension risk lives report.	Developed Journey Health and the Good Life outcome metrics for subpopulations.	Finalized measures, referral report, and reporting schedule with Journey Health.	5.0 - Finalized measures, referral report, and reporting schedule with Journey Health.	Utilization Management/Quality Improvement and Health Equity Committee	12/31/2025		
Title: QI Senior Director Name: Michelle Stull	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Max Moua	**Member Cultural and Linguistic Assessment**	Y	**Continued**	1.0-Advance the cultural and linguistic needs of plan enrollees and identify action items that may need addressed to ensure the cultural and linguistic needs of member are met. 1.1- Use interpreter services provision data to identify language needs for the "Other Chinese and Unknown groups." Share with key leaders at internal and external committees (NCQA HEI). 1.3- CLS Subcommittee quarterly review of member demographics trends (NCQA HBM).	1. CLS needs assessed at 01/22/2025 CLSS Meeting	1. CLS needs assessed at 04/22/2025 CLSS Meeting.	1.0- CLS needs assessed at 07/22/2025 CLSS Meeting. 1.1-Collaborated with the Analytics team to investigate the increase in members with ethnicity listed as "Unknown." Findings confirmed that the increase was caused by a cached data mapping issue in the reporting system. The team is addressing the mapping error to ensure accurate capture and reporting of member demographic data. 1.2-Planned implementation Q4.	1.0- CLS needs assessed at 10/22/2025 CLSS Meeting 1.1-Implemented Q3 2025 - Completed 1.2-Member demographic trends reviewed at 10/22/2025 CLSS Meeting.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	Partially met due to planned implementation in Q1 2026	
Title: QI Senior Director Name: Michelle Stull Title: QI Medical Director Name:	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Max Moua	**Language Assistance Services/Fulfillment**	Y	**Continued**	2.0-Reach or exceed an average fulfillment rate of ninety-five percent (95%) or more for in-person, video, and telephonic interpreter services.	1. Q1: 99% fulfillment rate for all modalities (Metric Met for Q1).	1. Q2: 99% fulfillment rate for all modalities (Metric Met for Q2).	2.0- Q3-99% fulfillment rate for all modalities (Metric met for Q3).	2.0-Q4-99% fulfillment rate for all modalities (Metric met for Q4).	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	Y	
Title: QI Senior Director Name: Michelle Stull Title: QI Medical Director Name:	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Max Moua	**Language Assistance Services/Fulfillment**	Y	**Continued**	3.0-Increase monthly use of on-demand vs. in-person services by 2 percentage through improvements to on-demand access.	1. Planned implementation in Q2.	1. Met with Provider Relations team to prevent situation and plan to address high-utilizing prescheduled interpreter services provider sites. 2. Presented and reviewed situation and plan with QI Senior Leadership for review and approval. 3. Provided utilization data for top 5 high-utilizing prescheduled interpreter service provider sites.	3.0- Met with Tri-City (09/30/2025) and East Bay (10/29/2025/30) to discuss transitions to on-demand interpreter services calls. 3.1- Discussed interpreter services calls information and deployment plan with the interpreter services vendor, Propio.	3.0- Met with Tri-City (11/12/2025) to discuss on-demand interpreter services calls transition plan. 3.1- Provided updates regarding interpreter services calls deployment plan with the interpreter services vendor, Propio.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	Continued planned implementation in Q1 2026	
Title: QI Senior Director Name: Michelle Stull	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Max Moua	**Language Assistance Services (Member Health)**	Y	**Continued**	4.0-Ensure tracking, analysis and reporting of interpreter services utilization for behavioral health services.	1. The Alliance met with the vendor to re-evaluate the call prompt categories. The vendor confirmed they would review the data collection points within the call flow to explore alternative methods for inputting data into the platform, specifically to accurately indicate whether it was a BH call.	1. The vendor reviewed call flow data and reported that utilization tracking is only feasible if the initial call prompt identifies the call as involving a behavioral encounter. 2. The Member Services Quality Assurance and Regulatory Reporting Manager to explore existing member call tracking and determine whether behavioral encounter calls are currently being identified.	4.0-The CLS team will track utilization of interpreter services for behavioral health through our internal (MAI Behavioral Health Department) and external (MAI Behavioral Health Providers) PHLAs along with prescheduled interpreter service requests.	4.0-Met CLS team with Behavioral Health Department to review CAC interests for better youth who have AAI/Ice Breaker activities and Alliance Services Coalition of Alameda County (10/08/2025) and received one (1) application. 5.1-Best CAC information, including application materials to five (5) CAC interests. 5.2-Received three (3) applications.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	Y	
Title: QI Senior Director Name: Michelle Stull	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Max Moua	**Provider Language Capacity Continuation (Monitoring)**	Y	**Continued**	4.0-Attested at the Member CG-CAHPS Survey 87% of adult members and 90% of child members who need interpreter services will report receiving a non-family qualified interpreter through their doctor's office or health plan.	1. Q1 2025-Adult: 87.2%, Child: 92.1% (Metric Met for adult and child in Q1) 2. Q1 2026-Planned implementation Q3.	1. Q2 2025-Adult: 89.7%, Child: 91.9% (Metric Met for adult and child in Q2) 2. Q2 2026-Planned implementation Q3.	4.0-Q3 2025-Adult: 86.6%, Child: 92.3% (Metric met for Adult and Child in Q3). 5.1- Q3 2026-Planned implementation Q4.	4.0-Q4 2025-Adult: 86.6%, Child: 92.3% (Metric met for Adult and Child in Q4). 5.1- Q4 2026-Planned implementation Q1 2026.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	Goal met for Q1-Q3; planned implementation Q4 2025 and Q1 2026	
Title: QI Senior Director Name: Michelle Stull	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Max Moua	**Language Assistance Services (Member Satisfaction)**	Y	**New**	5.0-Increase the Timely Access Requirement (TAR) Survey response rate by 2% for combined adult and child. 2025 Adult Baseline: 3.8% 2025 Child Baseline: 5% 5.1-NCQA HBS Create member facing outreach and education on access to interpreter services in additional languages and distribute through channels. 5.2-NCQA HBS Launch multilingual education campaign reinforcing interpreter service rights.	1. Walk Dropped. 09/11/2025	1. Data Collection ended on 04/16/2025. 2. Received raw data files on 06/27/2025. 3. Scrubbed raw data files and developed final report. 4. Submitted the TAR Survey Report to DHCS, Regulatory Affairs on 08/30/2025. 5. Overall, 3% increase in responses from MY 2023.	5.0-Goal completed in Q2 2025. 5.1-Planned implementation for Q1 2026. 5.2-Planned implementation for Q1 2026.	5.0-Goal completed in Q3 2025. 5.1-Planned implementation for Q1 2026. 5.2-Planned implementation for Q1 2026.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	Partially met due to planned implementation in Q1 2026	Monitoring plan for 2025 Update: Met goal from the last year for both adult and child responses.
Title: QI Senior Director Name: Michelle Stull	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Max Moua	**Provider Language Capacity and Race and/or Ethnicity (Provider Network)**	Y	**New**	7.0-Conduct NCQA NET 1 "A Report: Analysis of Capacity of Alliance Provider Network to meet Cultural and Linguistic and share findings with internal and external stakeholders by May 31, 2026.	1. Completed gathering of data and reports. 2. Started on draft Net 1 A Report.	1. Finalized draft Net 1A Report. 2. Submitted to NCQA consultants and received feedback. 3. Updated draft Net 1A per feedback. 4. Presented Net 1A Report at QI Committee. 5. Presented Net 1 A Report at CLSS (09/22/2025) and QIHBC (09/09/2025) and received approval.	7.0-Goal completed in Q2 2025.	7.0-Goal completed in Q3 2025.	7.0-Goal completed in Q4 2025.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	Y	
Title: QI Senior Director Name: Michelle Stull	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Max Moua	**Community Engagement Community Advisory Committee (CAC)**	Y	**New**	8.0-Recruit at least one (1) committee member in each of the three (3) identified areas of representation gaps: Men, individuals aged 19-64 and those who are Limited English Proficient (LEP).	1. Connected and presented information about the CAC as part of membership recruitment efforts to the following organizations: • Greater New Beginnings on 07/17/2025 and received two (2) CAC candidate applications. • Anthem Blue Program, AOPHC, 12/9/2025 • Presented at Anthem Blue on 9/10/2025 2. Conducted initial outreach and provided information to Native American Health Center and Asian Health Services as email.	1. Connected and presented information about the CAC as part of membership recruitment efforts to the following organizations: • Greater New Beginnings on 07/17/2025 and received two (2) CAC candidate applications. • Anthem Blue Program, AOPHC, 12/9/2025 • Presented at Anthem Blue on 9/10/2025 2. Conducted initial outreach and provided information to Native American Health Center and Asian Health Services as email.	8.0-Connected with Alameda County Social Services to recruit CAC interests for foster youth who have AAI/Ice Breaker activities and Alliance Services Coalition of Alameda County (10/08/2025) and received one (1) application. 5.1-Best CAC information, including application materials to five (5) CAC interests. 5.2-Received three (3) applications.	8.0-Connected and presented information about the CAC as part of membership recruitment efforts to the following organizations: • Alliance Services Coalition of Alameda County (10/08/2025) and received one (1) application. 8.1-Held a CAC Selection Committee Meeting to present CAC interests (11/10/2025). 8.2-Conducted recruitment strategies with the DSRIP team for DSRIP members or caregivers to recruit new CAC members from the following representation areas: Parents/ guardians of Alliance members, advocates, and/or youth and LTSS advocates, or Alliance members participating in LTSS. 8.3-Discussed recruitment strategies with the DSRIP team for DSRIP members or caregivers.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	Y	
Title: QI Senior Director Name: Michelle Stull	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Max Moua	**Potential Quality Issue: Quality of Language (PQI: QOL)**	Y	**Continued**	9.0-Monitor, evaluate, and conduct appropriate interventions for PQI-QOLs with a closure rate of 85% or more within 60 business days.	1. Q1-90% closure rate.	1. Q2-92% closure rate (Goal Met MM). 2. QL2: team experienced staffing challenges and increased volumes in coordinating/scheduling interpreter services.	9.0- Q3-92% closure rate (Goal Met MM). 9.1-QL3 team experienced staffing challenges and increased volumes in coordinating/scheduling interpreter services.	9.0- Q4-92% closure rate (Goal Met MM). 9.1-QL3 team experienced delays in getting a timely response from an interpreter services vendor regarding one case.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	N	