HEALTH PLAN
FY2025 QUALITY WORK PLAN

ACTIVITY (* denotes monitoring of previously identified issue)	NCQA STANDARD	CATEGORY	OBJECTIVE	ACTIONS	PERFORMANCE TARGET/ GOAL	FREQUENCY	RESPONSIBLE POSITION	DUE DATE	DATE APPROVED	STATUS UPDATES/ RESULTS
QUALITY IMPROVEMENT AND EQUITY PROGRAM STRUCTURE/OPERATIONS										
QIHETP Program Description*	QI 1A	Quality of Care	Ensure compliance with accreditation, business and regulatory requirements.	1. Review and update QIPD annually	• Meets NCQA and applicable regulatory requirements • Reviewed and updated annually • Reviewed and approved by the QIC Ensure posting on the health plan webiste	Annually	Quality Manager, HEDIS/NCQA Director	09/30/24	QIHEC 9/2024, SJCHC 11/2024	Complete, presented and approved at QIHEC on 9/18/24
QIHETP Evaluation	QI 1B, Factor 5	Administrative	Evaluate the effectiveness of QI initiatives.		**QI Evaluation addresses the following related to the quality and safety of clinical care and quality of service:** • Completed and ongoing activities • Trending of QI measures/results • Evaluation of the overall effectiveness of the QI program and of its progress toward influencing networkwide safe clinical practices.	Annually	Quality Manager, HEDIS/NCQA Director	11/14/24	2/5/2025	Complete,
QIHETP Work Plan	QI 1A	Administrative	Ensure compliance with accreditation, business and regulatory requirements.	1. Collaborate with internal business owners to review and document ongoing QI activities and those identified in the QI evaluation for the annual work plan.	Meets NCQA and applicable regulatory requirements to include: • Yearly planned QI activities and objectives for improving: – Quality of clinical care. – Safety of clinical care. – Quality of service. – Members' experience. • Reviewed and updated annually • Reviewed and approved by the QIC	Quarterly	Quality Manager, HEDIS/NCQA Director	9/30/2024, 12/19/24, 3/1/24, 6/30/24	Sep-24	Work Plan format changed in Q1 FY2025.
				2. Facilitate periodic review and updates of the QI Work Plan activities throughout the year.		Ongoing	Quality Manager, HEDIS/NCQA Director	11/14/24	2/5/2025	Approval 2/5/25
QI, HE, PHM, Policies and Procedures	NA	Administrative	Ensure that QI policies and procedures are reviewed and updated annually as applicable	1. Review and update QI policies and procedures as needed to ensure compliance with accreditation, regulatory and health plan business needs	100% of QI policies and procedures reviewed and updated annually, as applicable	Annually and more frequently as needed	Policy business owners	06/30/25		Q2 Update: Multiple desk level procedures were transitioned to policies to adhere with Health Equity Accreditation. These include: 1. HEQ 02 Member Race/Ethnicity, Language, Gender Identity and Sexual Orientation Data 2. HEQ03 Practitioner Network Cultural and Linguistic Data Collection 3. HEQ04 Health Plan Diversity and Committee Membership Process
MEMBER EXPERIENCE										
Member Services Telephone Access	NA	Administrative	Assess and improve member experience with telephonic access to health plan member services. Improve and maintain customer service call quality metrics for accuracy of informaiton provided.	1. Collect and analyze internal health plan telephone access data for average speed of answer (ASA) and abandonment rate	**Telephone Access Goals:** • ASA: 30 seconds • Abandonment rate: ≤ 5%, call quality >90% accuracy	Quarterly	Customer Service Director	11/14/24, 2/13/24, 5/8/25, 8/14/25 (annual)		FY24 annual presented, QIFY25 presentedto QIHEOC
				2. Collect and analyze any delegate telephone access data for ASA and abandonment rate						On Track
				3. Develop and implement improvement plan internally for results that are below the performance goal						On Track

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Member Call Quality and Accuracy	ME6C	Mbr Experience	Information provided over the phone will maintain appropriate levels of quality and accuracy.	1. Collect data on quality and accuracy of the information provided to members over the phone. 2. Analyze data against goals. 3. Determine causes for deficincies, as applicable. 4. Act to improve identified decificiences, as applicable.	Quality and accuracy of information provided over the telephone will meet a goal of 90%.	Quarterly	Customer Service Director	11/14/24, 2/13/24, 5/8/25, 8/14/25 (annual)		On Track
Website Quality	ME6C	Mbr Experience	Information provided over the website will maintain appropriate levels of quality and accuracy.	1. Collect data on quality and accuracy of the information provided to members over the website. 2. Analyze data against goals. 3. Determine causes for deficincies, as applicable. 4. Act to improve identified decificiences, as applicable.	Quality and accuracy of information on the website will meet a goal of 90%.	Annually	CMME Director	05/01/25		On Track
Member Portal Response Evaluation	ME6D	Mbr Experience	Responses to member portal inquiries will be returned timely and will be of high quality.	1. Maintain process and oversight for responding to member portal inquiries within 1 business day. 2. Maintain process and oversight for responding with high quality to portal inquiries. 3. Annually analyze data on turnaround time and quality of responses. 4. Act to improve identified deficiencies, if applicable.	At least 90% of response to inquiries received electronically will be within 1 business day of receipt. Member portal responses will maintain an audit score of at least 95% of quality and accuracy components	Annually	Customer Service Director	02/28/25		On Track
Member Experience with health plan services (non-BH)	ME 7C,D	Mbr Experience	Assess and improve member experience with health plan services through analysis of complaint and appeal data	1. Collect health plan member complaint and appeal data related to non-BH services (noncoverage appeals addressed in Element A and Element B and UM coverage appeals from UM 8 and 9) from the following categories: • Quality of Care • Access • Attitude and Service • Billing and Financial Issues • Quality of Practitioner Office Site 2. Collaborate with relevant delegates and vendors to obtain member and complaint data related to non-BH services for all categories listed above. 3. Convene a team of PR, QI, CMME and MS leaders to conduct quantitative and qualitative analysis of complaint and appeal data 4. Correlate member CAHPS results into the overall analysis of complaint and appeal data 5. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement actions. 6. Develop and implement improvement plan as applicable that addresses causes/barriers to performance	Analysis of complaint, appeal and CAHPS data with development and implementation of improvement plans as applicable	Annually	Quality Manager, HEDIS/NCQA Director	11/14/24, 2/13/25, 5/8/25, 8/14/25 (annual)		On Track

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				7. Collaborate with PR, Network Ops, and QI to document all analysis and improvement plans on the AH Availability and Access Report, present to QIC						
				8. Monitor status/completion of improvement plans	100% of improvement actions are implemented as applicable	Quarterly		11/14/24, 2/13/25, 5/8/25, 8/14/25		
Assessment of Member Experience with Behavioral Health Care and Services	ME 7E, F	Mbr Experience	Assess and improve member experience with BH services through analysis of complaint and appeal data	1. Collect member complaint and appeal data **about BH services** from the following categories: • Quality of Care • Access • Attitude and Service • Billing and Financial Issues • Quality of Practitioner Office Site	Analysis of complaint, appeal and BH survey data with development and implementation of improvement plans as applicable	Annually	Quality Manager, HEDIS/NCQA Director	11/30/2024, 2/13/25, 5/30/25, 6/30/25		On Track
				2. Collaborate with applicable delegates to obtain member and complaint data related to BH services for all categories listed above.						
				3. Collect member CAHPS results for the supplemental BH questions (if applicable):						
				4. Convene a team of BH, PR, QI and MS leaders to conduct quantitative and qualitative analysis of member BH complaint, appeal data and results from CAHPS BH survey questions						
				5. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement, as well as the reasons for taking or not taking action.						
				6. Develop and implement improvement plans as applicable that address causes/barriers to performance						
				7. Collaborate with BH physician(s)/other practitioners, PR, Network Ops, and QI to document all analysis and improvement plans on the AH Availability and Access Report, present to QIC						
				8. Measure and document effectiveness of improvement actions to determine if interventions improved performance		Annually				On Track
				9. Monitor status/completion of improvement plans	100% of improvement actions are implemented as applicable	Quarterly				On Track

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Assessment of Clinic and Group Member Experience Surveys. CG-CAHPS		Mbr Experience	Assess and improve member experience with health plan services through analysis of CG-CAHPS surveys	1. Collect provider specific member experience data **about services provided at outpatient provider offices** from the following categories: • Quality of Care • Access • Attitude and Service • TBD • TBD	Analysis of quarterly CG-CAHPS survey data with development and implementation of improvement plans as applicable	Quarterly	HEDIS & NCQA Director	12/19/24, 2/13/25, 5/8/25, (annual),		CG, FY Q1 complete, CG FYQ2 due 3/2024
				2. Collect member CAHPS results for the supplemental questions (if applicable):						CG, FY Q1 complete, CG FYQ2 due 3/2025
				3. Convene a team of PR, QI and MS leaders to conduct quantitative and qualitative analysis of results from CG-CAHPS survey questions						CG, FY Q1 complete, CG FYQ2 due 3/2026
				4. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement, as well as the reasons for taking or not taking action.						CG, FY Q1 complete, CG FYQ2 due 3/2027
				5. Develop and implement improvement plans as applicable that address causes/barriers to performance						CG, FY Q1 complete, CG FYQ2 due 3/2028
				6. Collaborate with BH physician(s)/other practitioners, PR, Network Ops, and QI to document all analysis and improvement plans on the AH Availability and Access Report, present to QIC						CG, FY Q1 complete, CG FYQ2 due 3/2029
				7. Measure and document effectiveness of improvement actions to determine if interventions improved performance		Annually				CG, FY Q1 complete, CG FYQ2 due 3/2030
				8. Monitor status/completion of improvement plans	100% of improvement actions are implemented as applicable	Quarterly				CG, FY Q1 complete, CG FYQ2 due 3/2031
Assessment of Consumer Assessment of Healthcare Providers and Systems Surveys (CAHPS).		Mbr Experience	Assess and improve member experience with health plan services through analysis of Adult and Child-CAHPS surveys	1. Collect provider specific member experience data **about services provided throughout the health plan ecosystem** from the following categories: • Getting Needed Care • Getting Care Quickly • Rating of Health Plan and Doctor • Customer Service • Getting Care Tests and Treatment	Analysis of quarterly CG-CAHPS survey data with development and implementation of improvement plans as applicable	Annually and more frequently as needed	HEDIS & NCQA Director	08/01/24		Complete, presented and approved at QIHEC on 2/2025
				2. Collect member CAHPS results for the supplemental questions (if applicable):				08/01/24		
				3. Convene a team of PR, QI and MS leaders to conduct quantitative and qualitative analysis of results from CG-CAHPS survey questions				08/01/24		

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				4. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement, as well as the reasons for taking or not taking action.				08/01/24		
				5. Develop and implement improvement plans as applicable that address causes/barriers to performance				08/01/24		
				6. Collaborate with BH physician(s)/other practitioners, PR, Network Ops, and QI to document all analysis and improvement plans on the AH Availability and Access Report, present to QIC				08/01/24		
				7. Measure and document effectiveness of improvement actions to determine if interventions improved performance		Annually	HEDIS/NCQA Coordinator	08/01/25		On Track
				8. Monitor status/completion of improvement plans	100% of improvement actions are implemented as applicable	Quarterly	HEDIS/NCQA Coordinator	08/01/25		On Track
Rights and Responsibilities Statement	RR 1A, B	Mbr Experience	Communicate HPSJ/MVHP's commitment to treating members in a manner that respects their rights, and health plan's expectations of members' responsibilities to new and existing members and practitioners annually	1. Review and update, as applicable, the member rights and responsibilities statement.	Member R&R statement is current and is provided to new members upon enrollment, new practitioners upon joining the network and existing members and practitioners annually.	Annually	Compliance Director, Accreditation Manager	02/13/25		Q3 Update: Annual review of R&R statement completed. Suggested edits were supplied to Compliance and will be shared with DHCS for integration ito the EOC.
				2. Once R&R statement is reviewed and updated, update the R&R statement located in the following areas/documents: • Health Plan website • Provider Reference Manual • Member EOC/COC • Member and Provider Newsletter template						Q3 Update: *Updated EOC was mailed to all members in annual mailings *Member and Provider Newsletter articles have been drafted with updated language.
Member Services Policies and Procedures		Administrative	Ensure that MS policies and procedures are reviewed and updated annually as applicable	1. Review and update MS policies and procedures as needed to ensure compliance with accreditation, regulatory and AH business needs	100% of MS policies and procedures reviewed and updated annually, as applicable	Annually	Customer Service Director	02/13/25		
CREDENTIALING										
Credentialing and Recredentialing Decision Notification Timeliness	CR 1A	Quality of Service	Ensure that credentialing and recredentialing decisions are communicated to practitioners within **30** calendar days of credentialing committee decision.	1. Collect data and report on notification timeliness for practitioner credentialing and recredentialing decisions	100% of practitioners are notified of Cred/Recred Committee decision within 30 days	Quarterly	Credentialing Supervisor	11/14/24, 2/13/25, 5/8/25, 8/14/25 (annual)		On Track

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	CR 4A	Administrative		2. Collect data and report on recredentialing cycle length	100% of practitioners are recredentialed ≤ 36 months	Quarterly	Credentialing Supervisor	11/14/24, 2/13/25, 5/8/25, 8/14/25 (annual)		On Track
	CR 5A	Member Safety		3. Collect and report Medicare and Medicaid sanction activity to PRC	All practitioners with Medicare and/or Medicaid sanctions are reported to the PRC monthly	Monthly	Credentialing Supervisor	7/1/2024 8/2024 9/2024 10/2024 11/2024 12/2024 1/2025 2/2025 3/2025 4/2025 5/2025 6/2025		On Track
	CR 5A	Quality of Service		4. Collect data and report on member complaints about individual practitioners for use in recredentialing process	The history of all complaints for all pracittioners are evaluated at least every 6 months	Quarterly	Credentialing Supervisor	11/14/24, 2/13/25, 5/8/25, 8/14/25		On Track
	CR 5A	Member Safety		5. Collect data and report on practitioner adverse occurrences/quality of care issues identified for use in recredentialing process	Adverse events are monitored at least monthly	Quarterly	Credentialing Supervisor	7/1/2024 8/2024 9/2024 10/2024 11/2024 12/2024 1/2025 2/2025 3/2025 4/2025 5/2025 6/2025		On Track
Credentialing and Recredentialing Policies and Procedures	NA	Administrative	Ensure that Cred and Recred policies and procedures are reviewed and updated annually as applicable	1. Review and update Cred and Recred policies and procedures as needed to ensure compliance with accreditation, regulatory and business needs	100% of Cred and Recred policies and procedures reviewed and updated annually, as applicable	Annually	Credentialing Supervisor	6/30/2025		Complete Credentailing policies have been updated to meet NCQA 2025 standards

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Credentialing Information Integrity	CR 8	Administrative	Ensure there are information integrity policies and procedures, conduct audits of credentialing information for inappropriate documentation and updates and implement corrective action that address identified information integrity issues.	1. Develop policy and procedure in line with 2025 NCQA Health Plan Accreditation Standards CR8 2. Develop information integrity training on inappropriate documentation and updates and organizational audits of staff, documenting and reporting information integrity issues. 3. Conduct staff training on information integrity 4. Audit credentialing information in line with CR8C 5. Conduct qualitative analysis of inappropriate documentation and updates, if applicable. 6. Implement corrective action to address all inappropriate documentation and updates found, if any. 7. Conduct an audit of the effectiveness of corrective actions on findings 3-6 months after completing annual audit	The goal is to have no inappropriate documentation or updates to credentialing information. If any inappropriate documentation or updates are found, immediate and effective action will be taken.	Annually	Credentialing Supervisor	1. 11/30/24 2. 12/31/24 3. 6/1/25 4. 6/30/25 5. 6/30/25 6. 9/30/25 7. 3/30/26		1. Complete 2. Complete 3. On Track 4. On Track 5. On Track 6. On Track 7. On Track
CLINICAL QUALITY										
Preventive (Practice) Guidelines		Quality of Care	Ensure that clinical practice guidelines reflect the most current evidence-based recommendations	1. Collaborate with health plan Medical Director to review evidence based sources for applicable updates to the following clinical practice guidelines: • Diabetes, Asthma, COPD, Heart Failure • AMA Adult and Pediatric Preventative Care	100% of clinical practice guidelines are reviewed and updated, as applicable, at least biennially	Biennially	Exec. Dir. Clinical Ops, Director of BH and SW, Health Education Manager	05/01/25		On track
				2. Collaborate with Behavioral Health phyisican to obtain applicable updates to the following BH clinical practice guidelines: • Depression • Substance use • Comorbid Medical/Behavioral Health						On track
				3. Provide current/updated clinical practice guidelines to members and practitioners via: • In writing, upon request • HPSJ/MVHP website • Provider reference manual • Provider Newsletter	Members and practitioners have access to clinical practice guidelines	Annually	Exec. Dir. Clinical Ops, Director of BH and SW, Health Education Manager	06/30/25		On track
Focus Studies										
Focus Studies- Blood Lead Screening	N/A	Quality of Care	Ensure that health plan meets DHCS required All Plan Letters.	1. Review and assess compliance with APL 20-026-Blood Lead Screening in Children	Health plan members recieve blood lead screening and members with identified risk and need receive appropriate follow up.	Annually	HEDIS Manager	11/14/24		Complete
				2. Review and update data collection template		Annually	HEDIS Manager/ HEDIS/NCQA Director	02/13/25		Complete
				3. Collect data and medical records for documentation of blood lead screening, anticipatory guidance and caregiver refusal.		Annually	HEDIS Manager	05/15/25		On Track

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				4. Convene a team of leaders and SMEs to perform qualitative and quantiative analysis of data and determine if corrective action plans are warranted for evidence of APL non-compliance.		Annually	HEDIS Manager	07/14/25		On Track
				5. Identify whether improvement opportunities are warranted to improve systems of care and develop provider CAPs as needed		Annually		07/14/25		On Track
				6. Distribute provider education through the provider partnership and provider alerts and education CAPs		Annually	HEDIS Manager	02/13/25		On Track
				7. Distribute member education through member newsletters and gap in care calls.			HEDIS Manager	06/30/25		On Track
Lead Screening Follow Up	NA	Quality of care	Ensure provider follow-up of all elevanted blood lead screening levels	1. Collect and analyze data monthly on all members identified with elevated blood screening levels.	100% of all members with elevated blood lead levels receive follow-up monitoring and care	Annually	HEDIS Manager	02/13/25		On Track
				2. Monitor provider CAPs monthly to ensure that members are receiving follow-up care.		Annually	HEDIS Manager	02/13/25		On Track
				3. Conduct provider and member outreach as needed to reinforce need for follow-up and monitoring until member blood lead levels reach a normal level		Annually	HEDIS Manager	06/30/25		On Track
				4. Escalate any provider noncompliance issues to CMO and Provider Services		Annually	HEDIS Manager	06/30/25		On Track
Focus Studies- Initial Health Appointment	N/A	Quality of Care	Ensure that health plan meets DHCS required All Plan Letters.	1. Review and assess compliance with APL 22-020-Initial Health Appointment	Health plan members recieve initial health appointments and members with identified risk and needs receive appropriate follow up.	Annually	HEDIS Manager	11/14/24		Complete
				2. Collect data and medical records for documentation of initial health appointments and documentation of appropriate follow up.		Annually	HEDIS Manager	02/13/25		On Track
				3. Analyze data and determine if corrective action plans are warranted for evidence of APL non-compliance. Follow up on CAPs timely.		Annually	HEDIS Manager	07/30/25		On Track
				4. Convene a team to perform qualitative and quantiative analysis.		Annually		07/30/25		On Track
				5. Identify whether improvement opportunities are warranted to improve systems of care.		Annually		10/31/25		On Track
				6. Distribute provider education through the provider partnership and provider alerts.		Annually	HEDIS Manager	06/30/25		On Track
				7. Distribute member education through new member packets and outreach for preventative care.			HEDIS Manager	06/30/25		On Track

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Focus Studies - Diabetic Eye Exams	QI 3C	Quality of Care	Improve Diabetic Eye Exams	1. Conduct review of member and provider facing material related to diabetic eye exams in order to identify opportunities for improvement.	Increase the rate of diabetic eye exams from 38.93% to MY24 50th percentile by 12/31/2025	Once	HEDIS & NCQA Coordinators	12/31/24	12/4/2024	Q2 Update: Review completed of member and provider facing material. Opportunities exist in member education, website and customer service materials. There are opportunities to add provider materials regarding future grants for diabetic eye exam machines.
				2. Review at least 5 companies that offer diabetic eye exam machines that can be located in primary care offices for remote reading.		Once	HEDIS & NCQA Manager HEDIS & NCQA Coordinators	12/31/24	12/4/2024	Q2 Update: Meetings held with the following companies: 1. EyePacs 2. TopCon 3. Optos 4. Baxter 5. EyeCheq
				3. Review HEDIS data for DEE measure to determine need case and providers of focus.		Once	HEDIS & NCQA Coordinators	12/31/24	12/15/2024	Q2 Update: The HEDIS data for both MY23 and MY24 was analyzed to identify potential clinic partners and determine required impact by which to gague success of funding eye machines in PCP setting.
				4. Develop a proposal for diabetic eye exam machines within primary care settings.		Once	HEDIS & NCQA Manager HEDIS & NCQA Coordinators	02/28/25		On Track
				5. Update or create at least one provider-facing communication and one member facing communication to improve education around diabetic eye exams.		Once	HEDIS & NCQA Manager HEDIS & NCQA Coordinators	03/28/25		On Track
				6. Present proposal to Executive Leadership for purchase or support for diabetic eye exam machines in primary care setting.		Once	HEDIS & NCQA Manager HEDIS & NCQA Coordinators	04/30/25		On Track

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POPULATION HEALTH MANAGEMENT										
PHM Strategy and Program Description	PHM 1A	Administrative	Ensure PHM program strategy and related materials are reviewed and updated annually, as needed	1. Review and update PHM Strategy program description to include: target populations, goals, program and services, for each of the following focus areas: • Keeping members healthy • Managing members with emerging risk • Patient safety or outcomes across settings • Managing multiple chronic illnesses	Annual review and updates to the PHM program strategy description and applicable member materials	Annually	HEDIS/NCQA Director Accreditation Manager	11/29/2024, August 2025		Complete - Goals were updated to align across the organization and with HEDIS based on member need and identified opportunities for improvement.
	PHM 6A	Quality of Care		2. Based on PHM Assessment, determine if any changes are needed to the **4** measures that are used to evaluate the impact of the PHM program: • Clinical measure • Cost/utilization measure • Member expedience measures (at least one measure for two PHM programs)			HEDIS/NCQA Director Accreditation Manager	11/2024		Complete
	PHM 1B	Administrative		2. Review PHM Program Strategy description and applicable member materials; update descriptive information in the PHM Program Strategy as needed for: • Non-member interventions • How members are informed of all PHM programs • How members are provided the following information re: interactive PHM programs -- How members become eligible to participate. -- How to use program services. -- How to opt in or opt out of the program.			HEDIS/NCQA Director Accreditation Manager	11/2024		Complete - Opportunities were identified in member informing processes and updates are underway and expected to be finalized by 4/2025
	PHM 1A-B	Administrative		3. Present updated PHM Program Strategy Description and any applicable updated member materials to the QIHEC.			HEDIS/NCQA Director Accreditation Manager	2/2025		On Track
				4. Provide copies of updated PHM Program Strategy Description and all updated and approved materials to the Accreditation Manager.			HEDIS/NCQA Director Accreditation Manager	4/2025		On Track
Population Health Data Integration	PHM 2A	Administrative	Ensure data integration from all required sources to facilitate PHM program activities.	1. Review and update PHM program strategy description (or P&P), as needed, to reflect integration of data from the following: • Medical and behavioral claims or encounters. • Pharmacy claims. • Laboratory results. • Health appraisal results. • Electronic health records. • Health services programs within the organization. • Advanced data sources.	Annual review and updates to the PHM program strategy description or P&P to reflect integration of data for PHM activities	Annually	HEDIS/NCQA Director Accreditation Manager	11/2024		Complete
				2. Obtain copies of reports (PHI redacted) and/or screen shots showing integration of data for all sources listed in #1 (above) and provide to Accreditation Manager.			HEDIS/NCQA Director Accreditation Manager	6/30/2025		On Track

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Population Health Assessment	PHM 2B-C	Administrative	Review and update the PHM strategy, including programs, services, activities and resources to meet member needs.	1. Collect population health data, assess the characteristics and needs for the following categories of members, and document findings in the Population Health Assessment Report: • Social determinants of health • Children and adolescents age 2-19 • Members with disabilities • Members with serious mental illness or serious emotional disturbance • Members of racial or ethnic groups • Members with limited English proficiency • Relevant member subpopulations (as defined by HPSJ)	Annual assessment of population characteristics and needs to ensure PHM program services, activities, and resources meet member needs	Annually	HEDIS/NCQA Director Accreditation Manager	11/2024		Complete
				2. Based on member needs identified (from #1 above), conduct and document the following in the Population Health Assessment Report: • Review and update of PHM activities • Review and update of PHM resources • Review and update of a PHM program, service, activity, or resource to address health care disparities for at least one identified population • Review community resources for integration into program offerings			HEDIS/NCQA Director Accreditation Manager	11/2024		Complete
				3. Update PHM program strategy to reflect updates to programs, activities, services or resources.			HEDIS/NCQA Director Accreditation	12/5/24		Complete
Population Health Stratification	PHM 2D	Administrative	Segment or stratify the entire population into subsets for targeted intervention.	1. Segment the entire population into appropriate population health management programing based on need and risk. 2. Assess segmentation methodology for racial bias	All Health Plan members will have population health management interventions appropriate for their level of risk and specific medical needs.	Annually	HEDIS/NCQA Director Clinical Analytics Director	11/2024		Complete
Population Health Management		Quality of Care	Assess and improve member status by implementing population health management programs with provider and members. Implement programs in alignment with NCQA Standards and DHCS requirements.	1. Collect health plan member risk stratification data to evaluate performance and update current PHM program and identifying health disparities for focus areas: Analyze stratification data with development and implementation of population health management programs that address focus areas: • Disengaged • Keeping members healthy, • High Risk Obstetric Care, • Managing emerging risk, • Mitigating rising risk, • Safety Across Settings, • Complex Case Management, • Enhanced Case Management	Disengaged Members: Decrease the number of members with no ambulatory or preventive visit within a 12-month period by 5% by 12/31/2025. Keeping members healthy: Well child visits meet 50th percentile. High Risk Obsetric Care: Improving the rate of prenatal and postpartum care for Black and African American birthing Emerging Risk: An additional 5% of eligible prediabetic members will enroll and complete the Diabetes Prevention Program by 12/31/25. Mitigating Rising Risk: Decrease the rate of diabetic members whose A1c is poorly controlled as measured by an A1c greater than 9% from the 50th percentile to the 66th percentile based on the MY24 Medicaid Managed Care benchmark by 12/31/2025 Safety Across Settings: Increase rate at which pregnant people receive prenatal care within the first trimester or 42 days of enrollment from above the 50th to above the 75th percentile based on the National Medicaid Managed Care	Quarterly	Accreditation Manager	3/30/25 6/31/25 9/30/25 12/31/25		In progress: PHM Project taskforce has reviewed goals and is developing a dashboard and project plan to track progress. Interventions are being reviewed for potential expansion. Baseline data is being gathered.
				2. Collaborate with internal stakeholders to determine proper alignment of programs to member needs.						
				3. Ensure program materials are shared with network providers and members.						

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				4. Integrate data for population health. Obtain screen shots and reports for PHM data integration.	percentile based on the National Medicaid Managed Care Benchmark by 12/31/2025. Complex Case Management: An additional 10% of members meeting eligibility criteria for complex case management will enroll in program services by 12/31/2025.					
				7. Reevaluate programs and processes to ensure focus area programs are updated if needed.						
				8. Communicate programs to members and providers and make available on the web.	Ensure 100% of PHM programs are communicated to members and providers.	Annually				
Provider Delivery System Supports	PHM 3A	Administrative	Promote collaborative to practitioners or providers to achieve HPSJ population health management goals.	1. Evaluate existing provider delivery system supports and determine if any changes are needed: • Sharing data • Offering evidence-based or certified decision-making aids • Providing practice transformation support to primary care practitioners • Providing comparative quality information on selected specialties • Providing comparative pricing information on selected services • Providing training on equity, cultural competency, bias, diversity or inclusion	Minimum of 3 provider delivery system supports in place	Annually	HEDIS/NCQA Director Accreditation Manager	4/2025		Complete: Improvements were identified in additional documented process for sharing data with providers. Accreditation and Quality team collaborated to draft updated process document.
				2. Update PHM Strategy description or P&P to reflect current delivery system supports.			HEDIS/NCQA Director Accreditation	4/2025		Complete - No updates needed
				3. Obtain screen shots or copies of materials evidencing how delivery system support is provided for at least 3 of the 6 NCQA categories (outlined in #2), and provide to Accreditation Manager.			Accreditation Manager	6/2025		On Track
Provider Value Based Payment (VBP) Arrangements	PHM 3B	Administrative	Ensure that HPSJ has practitioner agreements that promote quality, value, and improved health outcomes	1. Collaborate with Contracting and Finance department to obtain information on value based payouts to practitioners and providers and complete the VBP worksheet.	At least 1-2 VBP contracts in place	Annually	Sr. Financial Analyst Accreditation Manager	4/2026		On Track
Self-Management Tools	PHM 4B	Administrative	Ensure that self-management tools are derived from evidence-based sources and are avaiable to members	1. Review and update P&P or program description (as needed) to reflect PHM self-management tools and their evidence based sources that are available to members: • Healthy weight (BMI) maintenance • Smoking and tobacco use cessation • Encouraging physical activity • Healthy eating • Managing stress • Avoiding at-risk drinking • Identifying depressive symptoms	Self-management tools and evidence based sources reviewed and updated annually	Annually	Health Education Manager	4/2025		Complete - Health Plan continues to delegate this responsibility to NCQA certified vendor.

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				2. Provide screen shots and a description of each self-management tool available to members (as outlined in #1 above) to the Accreditation Manager.			Accreditation Manager	4/2025		Complete - Health Plan continues to delegate this responsibility to NCQA certified vendor.
Complex Case Management	PHM 5A-C	Quality of Care	Assist members with multiple or complex conditions to obtain access to care and services, and coordinate their care.	1. Review and update CCM program description or P&P re: referrals to CCM and provide to Accreditation Manager: • Medical management program referral • Discharge planner referral • Member or caregiver referral • Practitioner referral	CCM program description or P&Ps updated annually to refect cuurent CCM processes and that complies with DHCS and NCQA requirements	Annually	Case Management Director	9/2024		Complete - The Program Description has been udpated with appropriate and accurate description of referral pathways
				2. Provide screen shots, reports, or member/provider materials evidencing how members can access CCM services for each of the 4 referral methods (outlined in #1) to the Accreditation Manager		Annually	Case Management Director	6/30/25		In progress: CM team has confirmed transition to new Case Management system will maintain required functions and will provide screenshots by end of fiscal year.
				3. Review and update CCM program description or P&P to reflect CCM system capabilities re: • Evidence-based clinical guidelines or algorithms to conduct assessment and management. • Automatic documentation of staff ID, and the date and time of action on the case or when interaction with the member occurred. • Automated prompts for follow-up, as required by the case management plan.		Annually	Case Management Director	9/2024		Complete - The Program Description has been updated iwth appropriate and accurate description of CCM system capabilities.
				4. Prepare screen shots evidencing CCM system capabilities (as outlined in #3) to the Accreditation Manager.		Annually (or every 2 years)	Case Management Director	6/30/25		On Track
				5. Review and update CCM Assessment and Care Plan P&Ps to ensure compliance with all NCQA factors/requirements for CCM 5C (see NCQA standard for full details of requirements of factors 1-17).		Annually	Case Management Director	1/2025		Complete - Policies have been reviewed and are compliant for meeting NCQA standards
				6. Conduct quarterly audits of a random sample of CCM files to assess compliance with DHCS and NCQA requirements.		Quarterly	Case Management Director	9/2024 12/2024 3/2025 6/2025		On Track
				7. Present updated CCM P&Ps, Program Descriptions, and audit results to QIHEC at least annually.		Annually	Case Management Director	6/30/25		On Track

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PHM Program Impact Assessment	PHM 6A-B	Quality of Care	Assess the impact and effectiveness of the PHM program strategy	1. Collect data on each of the following clinical, cost/utilization, and member experience measures used to monitor and evaluate the effectiveness of the PHM program strategy: **DM Program** • ED visit rates • Inpatient admission rates • Member experience survey **Me and My Baby Program** • Prenatal care • Postpartum care • Member experience survey **Keeping Members Healthy** • Well child visit rates (0-15 months, 15-30 months, and children and adolescents from 3-21 years)	**Keeping Members Healthy** • **Well child visit rates: 50th %tile** -- 0-15 mos: 58.38% -- 15-30 mos: 66.76% -- 3-21 years: 48.07% **DM Program** • ED visit rates: <602.025/1000 mbr years • AMR: 65.61% (50th %ile) • DM Member experience survey: 80% • Hypertension Member experience survey: 80% **Me and My Baby Program** • Prenatal care: 88.33% (75th %tile) • Postpartum care: 82.00% (75th %tile)	Annually	HEDIS/NCQA Director Accreditation Manager	11/2024		Complete: Results **Keeping Members Healthy** SJ 0-15 Mo: 51.67% ST 0-15 Mo: 46.21% SJ15-30 Mo: 62.46% ST 15-30 Mo: 62.67% SJ 3-21years: 49.44% ST 3021 years: 46.04% **Disease Management** ED visit rates: 561.02 AMR: 64.48% Member Experience: DM Program: 87.5% Hypertension Class: 100% **Me and My Baby**: Prenatal Care: 83.94% Postpartum Care: 83.21%
				2. Convene a team of PHM, QI and other leaders and SMEs to conduct quantitative and qualitative analysis of results, and a comprehensive assessment of the impact of the PHM program.			HEDIS/NCQA Director Accreditation Manager	11/2024		**Keeping Members Healthy** None of the well visit measures met the 50th percentile goal for the year. There were large increases in rates from MY22, particularaly in Stanislaus which has historically underperformed San Joaquin. Barriers identified include transportation, time constraints and social stressors. **Disease Management Program** Measures for ED utilization and member experience all exceeded goals. AMR rate was below the goal of the 50th percentile but did increase an impressive 5.1 percentage points and was only below the goal 1.13 percentage points.While there remains improvement, case managers work with patients and PCPs appears to be effectively improving care and members have overwhelmingly positive experiences. **Me and My Baby** The goal was met for postpartum care but prenatal care fell below the 75th percentile. Barriers to meeting the goal for prenatal care are attributed to the growth of few members joining hte plan already pregnant, which makes timely

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				3. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement, as well as the reasons for taking or not taking action.			HEDIS/NCQA Director Accreditation Manager	11/2024		Prioritized opportunities for improvement based on analysis are as follows: 1) Health Plan has partnered with Golden Valley Health Centers, the largest provider of pediatric care in Stanislaus County, in order to improve well visit completion for 15-18 year-olds. As the area with lower rates, this County was selected to pilot interventions for change in order to develop promising practices throughout the Health Plan service area. 2) Efforts are underway to improve data collection through the CAIR registry, which will lead to a more accurate representation of immunization completion and improve identification of those who truly need outreach and services. 3) A vendor has been engaged to pull gaps in care and conduct outreach to members. As member outreach calls can be a time intensive use of staff resources,
				4. Develop and implement improvement plans as applicable that address causes/barriers to performance.			HEDIS/NCQA Director Accreditation Manager	6/30/25		In Progress: HP has parntered with GVHC and engaged in PDSA cycles to test Saturday clinics leveraging Locum providers. This has been successful in increasing the number of 15-18-year-old members served. HP will trend data to determine if this effectively increased the rate of visits for this population.
				5. Measure and document effectiveness of improvement actions to determine if interventions improved performance			HEDIS/NCQA Director Accreditation Manager	11/2025		On Track
				6. PHM lead person documents all analysis and improvement plans, to include the comprehensive assessment/conclusion of the impact of the PHM program, on the PHM 6A-B Population Health Impact report and presents to QIC.			HEDIS/NCQA Director Accreditation Manager	11/2025		On Track
				7. Monitor status/completion of improvement plans			HEDIS/NCQA Director Accreditation Manager	11/2025		On Track
CULTURAL AND LINGUISTICS PROGRAM										

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Cultural and Linguistics Program		Mbr Experience	1. Increase Interpreter Services Utilization*	1/2.1 Roll out at least one new onsite, phone, or video remote interpreting service to at least one provider entity. 1/2.2 Update provider-based and internal training/informational material on interpreter services and disseminate through multiple channels, such as email, provider alerts, Provider Relations, and PlanScan. 1/2.3 Conduct Formal Request for Quotation (RFQ) from service area onsite interpreter services vendors and establish or reconfirm contracts to ensure the availability of onsite interpreters. 1/2.4 Complete HHS's Implementation Checklist for the National CLAS Standards, selecting at least 1 item to implement that could increase interpreter services utilization. 1/2.5 Implement the 1 item prior to calendar 2024 end 1/2.6 Coordinate with CBO that is focused on serving a language group with low interpreter service utilization to complete at least one activity to increase engagement with the Health Plan, Providers, or Langage Access Services	1.1 Increase Interpreting Encounters vs Membership Ratio by 3% for Khmer 1.2 Increase overall interpreter services utilization by 10% 1.3 Increase ratio of total fiscal year interpreted encounters vs average fiscal year LEP member count by 5%	Annually	C&L Manager; C&L Speacialists	1.1 6/30/25 1.2 6/30/25 1.3 6/30/25		1.1 In Progress 1.2 In Progress 1.3 In Progress
			2. Meet C&L FY25 Quality Benchmarks	1/2.1 Roll out at least one new onsite, phone, or video remote interpreting service to at least one provider entity. 1/2.2 Update provider-based and internal training/informational material on interpreter services and disseminate through multiple channels, such as email, provider alerts, Provider Relations, and PlanScan. 1/2.3 Conduct Formal Request for Quotation (RFQ) from service area onsite interpreter services vendors and establish or reconfirm contracts to ensure the availability of onsite interpreters. 1/2.4 Complete HHS's Implementation Checklist for the National CLAS Standards, selecting at least 1 item to implement that could increase interpreter services utilization. 1/2.5 Implement the 1 item prior to calendar 2024 end	2.1 Grievances related to language access vendors: <2/mo ave 2.2 Potential Quality Issues (PQIs) related to language access vendors: <3/mo ave 2.3 Video Remote Interpreting Star Rating by provider entity for interpreter quality: >/= 4.8/5.0 monthly average 2.4 Video Remote Interpreting Star Rating by provider entity for video quality: >/= 4.8/5.0 monthly average 2.5 Vendor Written translation timeliness: >/= 99% 2.6 Internal staff qualified bilingual contingent (% of member-facing staff): >/= 35% 2.7 Onsite Interpreting Request vs Fulfillment rate: >/= 90% per mo monthly average	Annually	C&L Manager; C&L Speacialists	2.1 6/30/25 2.2 6/30/25 2.3 6/30/25 2.4 6/30/25 2.5 6/30/25 2.6 6/30/25 2.7 6/30/25		2.1 In Progress 2.2 In Progress 2.3 In Progress 2.4 In Progress 2.5 In Progress 2.6 In Progress 2.7 In Progress

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			3. Meet C&L FY25 Timely Access for LEP Survey Benchmarks*	3.1 Confirm the instructions members are given by the health plan to acquire appointments with primary care providers, as well as urgent care appointments. 3.2 Evaluate the appointment request process for PCPs and urgent care providers to identify gaps. 3.3 Evaluate process for instructions given to PCPs, urgent care providers, and member-facing health plan staff on how to engage language access services. Identify gaps. 3.4 Analyze identified gaps to confirm at least one PCP or urgent care provider, and at least one health plan team for which to provide focused support in the provision of meaningful, timely access to members with limited English Proficiency. 3.5 Begin implementing improvement strategies no later than December 30th, 2024. Use the 2025 timely access survey to measure any immediate progress. 3.6 Continue efforts through 2026 timely access survey, and measure against those results. (Carry over to FY26 project tracker)	3.1 Regarding written information from doctors, increase % of respondents who felt that doctors gave them written information they needed in their language quickly: 89% 3.2 Regarding verbal interpreting from doctors, increase % of respondents who believed they got the same information as an English speaker would: 92% 3.3 Regarding written information from the Health Plan, increase % of respondents who felt that if information was not available in their language, the Health Plan was able to translate it for them: 90% 3.4 Regarding verbal interpreting from the health plan, increase % of respondents who believed the health plan told them the same information they would have given to an English speaker: 89% 3.5 Create report on overall network provider and staff language capabilities (qualified interpreter services, qualified bilingual/multilingual staff) compared against member language reports to evaluate adequacy of network language and cultural responsiveness at a high level. Report will include perceived gaps.	Annually	C&L Manager; C&L Speacialists	3.1 6/30/25 3.2 6/30/25 3.3 6/30/25 3.4 6/30/25 3.5 6/30/25		3.1 In Progress 3.2 In Progress 3.3 In Progress 3.4 In Progress 3.5 In Progress
			4. Provide C&L Support to Improve Clinical Outcome	4.1 Connect with Quality Improvement team to identify HEDIS or MCAS measure to focus on for improved clinical Outcomes. 4.2 C&L to provide interpreting or translation support to reach relevant limited English proficient population to improve the given outcome. 4.3 Measure the impact of the C&L intervention in the	4.1 Increase HEDIS performance of Controlling Blood Pressure (CBP) measure for Punjabi speakers from 45.29% to 59.73% (12/31/2025). Continue focus until reaching ultimate goal of 64.48% (12/31/2026)	Annually	C&L Manager; C&L Speacialists	4.1 12/31/25		4.1 In Progress
			5. FY25 Evaluation of CLAS Program and FY26 Workplan Formation	5.1 Perform end of fiscal year review of C&L/CLAS program workplan, identify goals and metrics that are met, as well as needs for following fiscal year projects,	5.1 Complete C&L and CLAS evaluation, with deliverables being an annual evaluation report and preparation of the FY26 C&L/CLAS workplan	Annually	C&L Manager; C&L Speacialists	5.1 12/31/25		5.1 Not Started
			6. DEI Training Dev Phases 2-3 + TGI	6.1 Coordinate with Project Manager to meet milestones. 6.2 Work proactively with internal and external stakeholders to gather required training feedback. 6.3 Work with instructional designer to apply feedback to training program. 6.4 Work with web team to upload training to appropriate external website location, or for TGI, work with HR to add training to HealthStream 6.6 Work with configuration team and HR to track appropriate training completion.	6.1 Begin development of DEI Program 6.2 Cross colaborate with other area MCPs in DEI Creation 6.3 Submit DEI Training Program to DHCS for review 6.4 Launch Pilot of DEI Training Program 6.5 Assess the training programs and address issues/concerns learned from pilot 6.6 Acquire vendor for Transgender, Gender Diverse, and Intersex Training 6.7 Train all internal, member-facing staff on Transgender, Gender Diverse, and Intersex Themes 6.8 Implement reporting and monitoring structure per DEI and TGI regulations.	Annually	C&L Manager; C&L Speacialists	6.1 9/30/24 6.2 10/30/24 6.3 12/31/24 6.4 4/30/25 6.5 5/30/25 6.6 11/30/24 6.7 2/14/25 6.8 4/30/25		6.1 Complete 6.2 Complete 6.3 Complete 6.4 Not Started 6.5 Not Started 6.6 Not Started 6.7 Not Started 6.8 Not Started

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QUALITY AND EQUITY PROJECTS										
Improving MCAS performance with Controlling Blood Pressure (CBP)		Quality of Care	Assess and improve member blood pressure control by implementing improvement initatives with provider and members and improved data capture.	1. Collect health plan member blood pressure data to evaluate current performance and health disparities.	Analysis of barriers and rate stratification data with development and implementation of improvement plans as applicable. Improve MCAS CBP measure	Quarterly	Quality Manager, HEDIS/NCQA Director	11/14/24, 2/13/25, 5/8/25, 8/14/25 (annual)		1. Complete 2. Complete 3. Complete 4. Complete 5. Complete - Prioritized opportunities include targeting Punjabi speaking members for CBP health information 6. Health Equity/Quality Punjabi Speaking members recieving intervention. 7. On Track 8. On Track
				2. Collaborate with providers to obtain provider, member and data barrier analysis .						
				3. Convene a team of PR, QI and MD leaders to conduct quantitative and qualitative analysis of blood pressure data						
				4. Correlate blood pressure rate results into the overall analysis of health plan performance						
				5. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement actions.						
				6. Develop and implement improvement plan as applicable that addresses causes/barriers to performance						
				7. Collaborate with PR, Network Ops, and QI to document all analysis and improvement plans on the DHCS template documents and present to QIHEOC.						
				8. Monitor status/completion of improvement plans	100% of improvement actions are implemented as applicable	Annually		08/14/25		
CHILD HEALTH EQUITY PROJECTS										
Improving MCAS performance with Childhood Vaccination Status, Combo 10, for two year olds.		Quality of Care	Assess and improve child member vaccination status through analysis of HEDIS rate performance and member characteristic data	1. Collect and analyze member, provider and data current performance and perform a barrier analysis of childhood vaccination processes. Analyze data by antigen to identify patterns of non-compliance. Analyze data by subpopulation to identify health disparities.	Analysis of provider, member and process data with development and implementation of improvement plans as applicable.	Quarterly	Quality Manager, HEDIS/NCQA Director	11/14/24, 2/13/25, 5/8/25, 8/14/25 (annual)		1. Complete 2. Complete 3. Complete 4. Complete 5. Complete - Prioritized opportunities include targeting white and black members 6. Health Equity/Quality White and Black Children members recieving intervention. 7. On Track 8. On Track
				2. Collaborate with applicable stakeholders to obtain member and provider performance data related to vaccination services.						
				3. Collect member CIS-10 results by antigen and member characteristics:						
				4. Convene a team of QI, HE, PHM and MD leaders to conduct quantitative and qualitative analysis of vaccination rate performance and subpopulation stratifications.						

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				5. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement, as well as the reasons for taking or not taking action.						
				6. Develop and implement improvement plans as applicable that address causes/barriers to performance						
				7. Collaborate with physician(s)/other practitioners, QI, Network Ops, and BI to document all analysis and improvement plans on the DHCS QI/HE Report Template present to QIHEOC.						
				8. Measure and document effectiveness of improvement actions to determine if interventions improved performance		Quarterly	Quality Manager, HEDIS/NCQA Director			
				9. Monitor status/completion of improvement plans	100% of improvement actions are implemented as applicable	Quarterly	Quality Manager, HEDIS/NCQA Director			On Track
CONTINUITY AND COORDINATION OF CARE PROJECTS										
Continuity and Coordination of Care	QI3	Quality of Care	Assess and improve member continuity and coordination of care between practitioners and across care settings by evaluating health plan services using HEDIS metrics.	1. Collect specific continuity and coordination of care data **about services between practitions and across provider settings** from the following categories: • Diabetic Eye Exams • Prenatal and Pospartum Care	Analysis of continuity and coordination of care data with development and implementation of improvement plans as applicable. Behavioral Health measures will be presented and monitored through Clinical Operations Committee.	Annual	Accreditation Manager, Director of HEDIS, NCQA	9/1/2024		Complete
				2. Collect member HEDIS results for the applicable measures. Provide Qualitative and Quantiative analysis on measures with stakeholders.				10/1/2024		Complete
				3. Convene a team of PR, QI and MS leaders to evaluate opportunities for improvement.				10/1/2024		Complete
				4. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement, as well as the reasons for taking or not taking action.				10/01/24		Complete 1) Develop grant programming to allow providers to purchase point of care eye exam machines 2) Hold baby showers in collaboration with community organizations that serve the Black community.

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				5. Develop and implement improvement plans as applicable that address causes/barriers to performance				03/01/25		In progress
				6. Collaborate with BH physician(s)/other practitioners, PR, Network Ops, and QI to document all analysis and improvement plans and present to QIHEOC				6/30/2025		On Track
				7. Measure and document effectiveness of improvement actions to determine if interventions improved performance		Annually	Accreditation Manager, Director of HEDIS, NCQA	08/01/25		On Track
				8. Monitor status/completion of improvement plans	100% of improvement actions are implemented as applicable	Quarterly	HEDIS/NCQA Coordinator	08/01/25		On Track
CHILDHOOD WELL VISITS- DHCS/IHI Collaborative										
Equity Collaborative- Childhood Well Visits - Facilitated by the Institute for Health Improvement	NA	Quality of Care	To improve the rate of well visits at Golden Valley Health Centers	1. Collect data and stratify data for childhood well visits.	Meet with clinic to unconver inequities and determin population of focus	One time	Accreditation Manager	06/27/24	N/A	Complete
				2. Collect data and report on barriers to care. Understand member experience.	Combine quantiative and qualitative data with insights gathered. Summarize findings.	One time	Accreditation Manager	08/22/24	N/A	Complete
				3. Collect and report barriers and outline opportunites for improvement. Evaluate reliable and equitable processes.	Gather results and review with clinic partners. Initiate tests of change.	One time	Accreditation Manager	10/31/2024	N/A	Complete
				4. Asset mapping and community partnerships to improve childhood well visits	Choose community parther that operates independently. Provide resources.	One time	Accreditation Manager	12/12/24	N/A	Complete
				5. Partner for effective education and communication.	Develop connections with priority populations to create resources, processes and activities aht can address WCV gaps.	One time	Accreditation Manager	03/20/25	N/A	On Track
				6. Monitor and report status of improvement plan.	100% of improvement plans are implemented as applicable.	Annually	Accreditation Manager	06/30/25		On Track
HEALTH EQUITY ACCREDITATION										
Health Equity Accreditation		Administrative	Achieve Health Equity Accreditation	HE 01- Organizational Readiness	Update Policies to align with HEA standards	Ongoing	Accreditation Manager	05/05/25	N/A	On Track
				HE-02 Race, Ethnicity and Language, Gender Identiity and Sexual Orientation Data Capture, storage and Retrieval.		Ongoing	Accreditation Manager	05/06/25	N/A	On Track

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				HE-03 Access and Availability of Language Services. Interpretation, translation, provider education and taglines		Ongoing	Accreditation Manager	05/07/25	N/A	On Track
				HE 04- Practitioner and Network Responsiveness. Collect and publish provider REaL data.		Ongoing		05/08/25	N/A	On Track
				HE 05 Cultural and Linguistic appropriate programs including C&L Program, Work Plan and Evaluation.		Quarterly		05/09/25	N/A	On Track
				HE 06 Reducing Health Disparities. Startify CAHPS by language or REaL.		Ongoing	Accreditation Manager	05/10/25	N/A	On Track
				Identify, Implement and Evaluate interventions to improve health care outcomes and language services.		Annually	Accreditation Manager	06/30/25	N/A	On Track
REPRODUCTIVE CARE										
Improving MCAS performance with reproductive health measures		Quality of Care	Assess and improve rproductive health measures through analysis of HEDIS rate performance and member characteristic data	1. Collect and analyze member, provider and data current performance and perform a barrier analysis of reproductive health processes. Analyze data to identify patterns of non-compliance. Analyze data by subpopulation to identify health disparities.	Analysis of provider, member and process data with development and implementation of improvement plans as applicable.	Quarterly	Quality Manager, HEDIS/NCQA Director	11/14/24, 2/13/25, 5/8/25, 8/14/25 (annual)		Completed data disparity analysis
				2. Collaborate with applicable stakeholders to obtain member and provider performance data related to reproductive health services.						Complete
				3. Collect rate reports and member characteristics:						Complete
				4. Convene a team of QI, HE, PHM and MD leaders to conduct quantitative and qualitative analysis of vaccination rate performance and subpopulation stratifications.						Complete
				5. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement, as well as the reasons for taking or not taking action.						In progress
				6. Develop and implement improvement plans as applicable that address causes/barriers to performance						In progress
				7. Collaborate with physician(s)/other practitioners, QI, Network Ops, and BI to document all analysis and improvement plans on the DHCS QI/HE Report Template present to QIHEOC.						On Track

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				8. Measure and document effectiveness of improvement actions to determine if interventions improved performance		Annual	Quality Manager, HEDIS/NCQA Director	08/14/25		On Track
				9. Monitor status/completion of improvement plans	100% of improvement actions are implemented as applicable	Annual	Quality Manager, HEDIS/NCQA Director	08/14/25		On Track
EQUITY AND PRACTICE TRANSFORMATION										
Actively engaging selected provider practices to improve quality of care and reduce health disparities.		Quality of Care	IMp	1. Collect and analyze member, provider and data current performance and perform a barrier analysis of follow up processes. Analyze data by subpopulation to identify health disparities.	Analysis of provider, member and process data with development and implementation of improvement plans as applicable.	Quarterly	Director of Special Projects, Quality, Quality Manager	11/14/24, 2/13/25, 5/8/25, 8/14/25 (annual)		EPT Provider baseline data shared with the Populaiton Health Learning Collaborative 12/2024
				2. Collaborate with applicable stakeholders to obtain member and provider performance data related to follow-up processes.						
				3. Collect FUA/FUM rates and member characteristics:						
				4. Convene a team of QI, HE, PHM and MD leaders to conduct quantitative and qualitative analysis of vaccination rate performance and subpopulation stratifications.						
				5. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement, as well as the reasons for taking or not taking action.						
				6. Develop and implement improvement plans as applicable that address causes/barriers to performance						
				7. Collaborate with physician(s)/other practitioners, QI, Network Ops, and BI to document all analysis and improvement plans on the DHCS QI/HE Report Template present to QIHEOC.						
				8. Measure and document effectiveness of improvement actions to determine if interventions improved performance		Quarterly	Director of Special Projects, Quality, Quality Manager			
				9. Monitor status/completion of improvement plans	100% of improvement actions are implemented as applicable	Quarterly	Director of Special Projects, Quality, Quality Manager			

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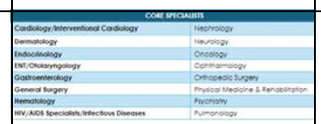
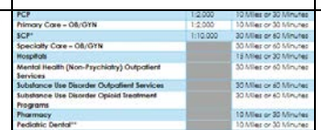
NETWORK MANAGEMENT										
Member to Provider Ratio		Administrative	Ensure member:provider ratios are in compliance with regulatory standards	Evaluate member:provider ratios	• Primary Care Practitioners 1:2,000 • Specialty Provider 1:10,000	Quarterly	Director, Provider Services	10/2024, 4/30/2025		Complete - Annual evaluation of member to provider ratios completed and presented in Quality Program Evaluation 12/24. All performance goals were met.
High Volume and High Impact Specialties		Administrative	Identify high volume and high impact practitioners	Identify Idenfity high volume specialty practitioner types based on claims volumes. Identify high impact providers by evaluating practitioners that have high probability of high morbiditiy and mortality. At a minimum oncology, neurology and HIV-AIDS, orthopedic surgery.		Annually	Director, Provider Services	04/30/25		On Track
Geographic access		Administrative	Ensure provider access requirements are met for the entire membership	Identify the time and distance members must travel to access practitioners and providers using time and distance standards.		Annually	Director, Provider Services	04/30/25		On Track
Provider Appointment Availability		Administrative	Ensure appointment availability for routine, urgent and follow up appointments throughout the network.	Ensure Appointment Availability for Medical Care.	**Primary Care: Urgent Care**: 96 Hours, **Routine Care:** 10 business days, **Specialty Care**: **Urgent**: 96 hours, **Routine Care**: 15 business Days, **Non-Physician BH: Urgent Care:** 96 Hours**, Routine:** 10 business days.	Annually, quarterly if non-compliant	Director, Provider Services	05/01/25		On Track
				Ensure Appointment Availability for Behavoral Health Care.		Annually, quarterly if non-compliant	Director, Provider Services	05/01/25		On Track
				Ensure After Hours Access to all practitioner types. Ensure access to Emergency Services.		Annually, quarterly if non-compliant	Director, Provider Services	05/01/25		On Track
				Ensure Appointment Availability for First Prenatal Appointments		Annually, quarterly if non-compliant	Director, Provider Services	05/01/25		On Track
Physician Directory Accuracy	NET 5CD	Quality of Service	Ensure a rate of 85% or greater for accuracy in provider address/phone number, hospital affiliations and whether providers are accepting new patients by June 30, 2025.	1. Conduct provider data validation study.	Accuracy of 85% or greater in each of the following areas: 1. Provider address/phone number 2. Hospital Affiliations 3. Accepting New Patients	Annually	Director, Provider Services	05/30/25		On Track

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				2. Develop report summarzing accuracy of provider directory data	4. Awareness of physician office staff of physician's participation in the organization's networks.	Annually	Director, Provider Services	05/30/25		On Track
				3. Identify opporutnities for improvement and, if any, take actions on those opportunities.		Annually and more frequently as needed	Director, Provider Services	06/30/25		On Track
PS Policies and Procedures	NA	Quality of Service	Ensure that provider services and network policies and procedures are reviewed and updated annually as applicable	1. Review and update PS/NET policies and procedures as needed to ensure compliance with accreditation, regulatory and business needs	100% of QI policies and procedures reviewed and updated annually, as applicable	Annually and more frequently as needed	Policy business owners	06/30/25		On Track
PROVIDER SATISFACTION										
Provider Satisfaction	NA	Administrative	Assess and improve provider experience with health plan provider services. Improve and maintain providerexperience with health plan systems and processes.	1. Collect and analyze provider satisfaction data to identify provider satisfaction opportunities.	**Achieve top 25% provider satisfaction acheivement and Improve Provider Satisfaction Composites until achievement is maintained in the top 25% for all composites:** • Overall Satisfaction • Other Plan Compare • Finance Issues •UM and Quality • Customer Service Staff • Provider Relations	Annually	Director, Provider Services	3/2025		On Track
				2. Collect and analyze survey results agains book of business and trending over time. Identify key drivers of satisfaction.						On Track
				3. Develop and implement improvement plan internally for results that are below the performance goal. Report to QIHEOC						On Track
Provider and Practitioner Supports	PHM 3A	Administrative	Provide supports to providers and/or practitioners to include at minimum three of the following: -Sharing data -Offering evidence-based or certified decision-making aids -Providing practice transformation support to primary care practitioners -Providing comparative quality information on selected specialties -Providing comparative pricing information on selected services -Providing training on equity, cultural competency, bias, diversity, or inclusion.	1. Hold Provider Partnership meetings to share provider HEDIS data		Ongoing	Manager, Quality Improvement	03/31/25		In progress - PPP meetings happening monthly with data sharing for MCAS measure rates, trends and claims volume to quickly identify progress and potential areas for concern.
				2. Provider financial and consultant support to providers to adopt practice transformations through the Equity Practice Transformation program		Ongoing	Director, Special Projects	03/31/27		In progress - EPT support is being provided to selected provider groups
				3. Provide training to practitioners and providers on cultural competency upon joining the network, annually, and upon demand through the Health Plan website		Ongoing	Director, Provider Services	03/31/27		In progress - New provider onboarding includes cultural competency training and annual mandatory training continues to be held and tracked

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PROVIDER PARTNERSHIP/Clinical Quality MCAS										
MCAS/HEQMS Rate Improvement with Provider Partners		Quality of Care	Assess and improve HEDIS/MCAS/HEQMS measures through analysis of Quality Metric Reporting	1. Collect health plan MCAS data by provider for the following metric domains; • Children's Health • Cancer Prevention • Reproductive Health • Behavioral Health • Chronic Conditions • Long Term Care	Analysis HEDIS/MCAS/HEQMS data with development and implementation of improvement plans as applicable to achieve NCQA Quality Compass Medicaid Managed Care 50th percentile.	Quarterly	Quality Manager, HEDIS Manager	11/14/24, 2/13/25, 5/8/25, 8/14/25 (annual)	9/18/2024	Complete
				2. Collaborate with providers to share and compare quality metric rate data for all categories listed above.						
				3. Convene a team of PR, QI, NCQA leaders to conduct quantitative and qualitative analysis of HEDIS data						
				4. Correlate barriers to rate data						
				5. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement actions.						
				6. Develop and implement improvement plan as applicable that addresses causes/barriers to performance						
				7. Collaborate with PR, Network Ops, and QI to document all analysis and improvement plans in partnership meetings, present to QIHEOC.						
				8. Monitor status/completion of improvement plans	100% of improvement actions are implemented as applicable.	Quarterly		11/14/24, 2/13/25, 5/8/25, 8/14/25 (annual)		
Provider Resources		Quality of Service	Provide resources to provider partners that assist with care and service to members and facilitate more accurate MCAS reporting.	Facilitate access to provider enablement software. Offer best practice supports from high performing providers.	Implement data sharing with at least 10 provider partners.	Quarterly, Annually	HEDIS Manager	09/18/24	N/A	Complete
Funding opportunities		Quality of Service	Facilitate provider partner collaboration with incentive and promotional activities designed to improve MCAS rates.	Inform provider partners about grant projects, data exchange opportunities and screening tools and and referral resources.	Offer provider partners all eligible funding opportunities.	Quarterly	Director of Special Projects, Quality	11/14/24, 2/13/25, 5/8/25, 8/14/25		On Track
Provider Education		Quality of Service	Ensure that regulatory and accreditation, and equity and health education resources are communicated to practitioners within 60 days of publication.	1. Create provider friendly educational materials related to regulatory and accreditation resources.	100% of provider partnership providers receive information.	Annually	Health Education Manager, HEDIS Manager	06/30/25	N/A	On Track
PROVIDER ALERTS										

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Provider Alerts for high priority MCAS metrics		Administrative	Ensure updates to MCAS measures are shared through provider alerts	1. Review HEDIS Specification changes	Distribute provider alerts annually. Initial Health Assessment Controlling High Blood Pressure Follow-Up after ED Visit for Mental Illness Follow-Up after ED Visit for Substance Use Follow-Up After High-Intensity Care for Substance Use Disorder Follow-Up After Hospitalization for Mental Illness Diabetes Screening for People w/ Schizophrenia Bipolar Disorder Using Antipsychotic Medications Adherence to Antipsychotic Medications for Individuals With Schizophrenia Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics Initiation and Engagement of Substance Use Disorder Treatment - Engagement of SUD Treatment Colorectal Cancer Screening Breast Cancer Screening Cervical Cancer Screening Childhood Immunizations Status - combonation 10 Immunizations in Adolescents Combonation 2 Well Child exams for babies 0-30 months of age (0-15 6+ visits & 15-30 2+ visits) Child and Adolescent Well-Care Visits Well Child Exams - BMI Percentile (article merged with WCV) Developmental Screening in the first three years of life Lead Screening in Children Topical Fluoride for Children HbA1c Control and Poor Control for people with Diabetes Eye Exams for people with Diabetes Kidney Health Evaluation for Patients with diabetes Controlling Blood pressure for people with diabetes Statin Therapy for Patients with Diabetes Metabolic Monitoring for Children and Adolescents on Antipsychotics	Annually	HEDIS Manager	12/31/24		Complete
				2. Validate provider contact information.		Annually	HEDIS Manager	12/31/24		Complete
				3. Create alert schedule		Annually	HEDIS Manager	12/31/24		Complete
				4. Distribute alerts on schedule.		Annually	Provider Services Director	06/30/25		On Track
ENHANCING NETWORK RESPONSIVENESS										
Ensure the practitioner network is able to meet the cultural and lingistic needs of the membership.	HE 4B	Administrative	Assess practitioner network's ability to meet language and cultural needs of the membership and take actions to address	1. Develop practitioner-focused survey questions to assess practitioner network cultural responsiveness baseline	At least one action will be taken to address identified gaps in network responsiveness by 6/30/2024.	Annually	Accreditation Manager C&L Manager	12/01/24		Complete

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			any identified gaps.	2. Gather network language capacity data, including languages spoken by practitioners, presence of bilingual staff in practitioners' offices, and whether practitioners have worked with an interpreter		Annually	Accreditation Manager Provider Network Program Manager C&L Manager	02/15/25		In progress - Provider Services team collaborating with Corporate Analytics to gather data
				3. Field surveys to network practitioners and gather responses.		Annually	Accreditation Manager Provider Network Program Manager	02/28/25		In progress - Surveys began fielding 1/29/25
				4. Consolidate practitioner demographics, findings from network language capacity data and practitioner network cultural responsiveness survey results into quantitative analysis.		Annually	Accreditation Manager	03/31/25		On Track
				5. Conduct qualitative analysis to understand causal factors for results and assessment of identified needs.		Annually	Accreditation Manager Provider Network Program Manager C&L Manager	03/31/25		On Track
				6. Develop plan to address gaps.		Annually	Accreditation Manager C&L Manager	03/31/25		On Track
				7. Take action to address gaps.		Annually	Accreditation Manager Provider Network Program Manager C&L Manager	04/30/25		On Track