Board of Directors'

Special Quality Assurance Committee Meeting

June 18, 2025

Quality Improvement Health Equity Committee (QIHEC) First Quarter 2025 Report

QIHEC Summary		
QIHEC Chair(s)	Quality Medical Director and Chief Health Equity Officer	
Reporting Period	Quarter 1, 2025	
QIHEC Meeting Dates	January 14, 2025, February 11, 2025, March 11, 2025	
Topics Presented and Discussed in QIHEC or subcommittees during the reporting period	• Access and Availability • Adolescent Care • Adverse Childhood Experiences (ACES) • Adult Wellness and Prevention • Appropriate Testing for Pharyngitis (CWP) and Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) • Behavioral Health Integration (BHI) • Case Management (CM) program • Comprehensive Community Cancer Screening Program • Consumer Assessment of Healthcare Providers and Systems (CAHPS) • Care Management and Care Coordination • Chronic Conditions Management • Continuity & Coordination of Care • Credentialing and Recredentialing • • Cultural and Linguistics Appropriate Services Program • Customer Service • Delegation Oversight • Demographic Data Collection • Department of Health Care Services (DHCS) Non-Clinical Performance Improvement Project (PIP) • Depression Screening • Diabetes Care	• Healthcare Effectiveness Data and Information Set (HEDIS) • Hospital Quality Program • Initial Health Appointment • Language Accessibility • Managed Care Accountability Set (MCAS) • Medicare Advantage Star Program Rating • Medication Adherence • Member and Provider Outreach and Education Plan • Member Experience (MemX) • National Committee for Quality Assurance (NCQA) Accreditation • OneCare Model of Care • Pay for Value (P4V) • Pediatric Wellness and Prevention • Performance Improvement Projects • Plan All Cause Readmission (PCR) • Policy • Population Health Management (PHM) • Potential Quality Issues (PQIs) • Prenatal and Postpartum Care • Preventive and Screening Services • Maternal Care • Quality Compliance Report • Quality Improvement Health Equity Transformation Program (QIHETP) and Work Plan (WP) • Quality Metrics

	• Diversity, Equity, and Inclusion (DEI) training • Diversity, Equity, and Inclusion (DEI) Committee Survey • Enhanced Care Management (ECM) • Facility Site Review (FSR)/Medical Record Review (MRR)/Physical Accessibility Review Survey (PARS) • Grievance & Appeals Resolution Services (GARS) • Health Education	• Student Behavioral Health Incentive Program • Utilization Management Committee • Utilization Management (UM) Program • Whole Child Model (WCM)

QIHEC Actions in Quarter 1, 2025

QIHEC Approved the Following Items:

- December 10, 2024, meeting minutes; January 14, 2025, meeting minutes; February 11, 2025, meeting minutes
- Three Quality Improvement policies:
  - Policy GG.1615: Corrective Action Plan for Practitioners and Organizational Provider
  - Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
  - Policy GG.1618: Member Request for Medical Records
- 2024 QIHETP Evaluation and Work Plan (Q1-Q4)
- 2024 Population Health Management Impact Report
- 2024 Cultural and Linguistically Appropriate Services (CLAS) Evaluation
- 2025 Quality Improvement Health Equity Transformation Program and Work Plan
- 2025 Quality Improvement Health Equity Transformation Program and Work Plan Revised
- 2025 UM/CM Integrated Program and 2024 UM/CM Integrated Program Evaluation

Accepted and filed the following items:

- 2024 Quality Improvement Work Plan Q4
- GARS Q3 2024 Committee Meeting Minutes
- MemX Committee October 15, 2024 Agenda and Meeting Minutes
- MemX Committee 2025 Charter
- UMC Meeting Minutes_11.21.24
- PHM Committee November 21, 2024 Meeting Minutes
- PHM Committee February 20, 2025 Consent Calendar
- UMC Meeting Minutes_01.23.25
- WCM CAC Mtg Minute_2024.11.12
- PowerPoint Appendix: 2025 UM Program and 2024 Evaluation
- PowerPoint Appendix: 2024 Population Health Management Impact Report (Evaluation)
- Appendix: Benefit Management Subcommittee Meetings
- Appendix: Member Experience (MEMX) Committee Oversight
- Appendix: PHM Committee Consent Calendar (Q1 2025)
- Appendix: Adverse Childhood Experiences (ACEs) Quarter 4, 2024 Update

QIHEC Actions in Quarter 1, 2025

Committee Updates:

- In Q1 2025, there were no changes made to committee membership.
- Annual Conflict of Interest and Confidentiality Forms were collected and reviewed.

QIHEC Quarter 1 2025 Highlights

- The Chief Medical Officer updated the committee on the following:
  - DHCS Medical Audit was scheduled for January 27, 2024. Optum Health Network was selected to be part of the audit.
  - The Provider Relations team will increase community visits to improve satisfaction. Focus areas include timely care, medication adherence, reducing hospital visits, and preventive screenings. A training session is scheduled for March.
  - CalOptima Health tracks Proportion of Days Covered for statins, blood pressure, and diabetes medications. The tool updates daily and shows when people have less than a 100-day supply, important for compliance.
  - Measles outbreak in Texas and providers are urged to inform parents about risks.
  - CalOptima Health found that 12 members are referred yearly for advanced care due to grinding stone countertops and encouraged the community to follow simple mitigation procedures, like mask use.
- QIHEC Chair promoted the two available programs:
  - The Outstanding Order Program allows CCN members to submit mammograms or lab tests through CalOptima Health, reducing provider workload.
  - A 30 to 90- or 100-day medication conversion is available for all CalOptima Health members, allowing pharmacists to convert 30-day prescriptions to 100-day ones to improve adherence.
- Quality Improvement Compliance Report –A compliance issue was presented to QIHEC regarding CalAIM Community Support program turnaround times. The 95% benchmark of determination completed within 5 business days was not met from November to December due to staff vacancies and increased referral volume. A Corrective Action Plan (CAP) was implemented that includes cross-training staff and adding temporary staff. Management improved oversight, resulting in a 98% compliance rate by the end of January. The CAP was reviewed, closed, and LTSS is currently meeting turnaround times with no open issues.
- The 2024 QIHETP Evaluation evaluated the Quality Improvement Work Plan for the year, including the Population Health Management Impact Report and Cultural and Linguistically Appropriate Services evaluations and below are highlights from the evaluation.
  - 2024 accomplishments include: CalOptima Health implemented grants, conducted community events, and expanded the Street Medicine Program in Orange County.
  - CalOptima Health met 4 of the 7 priority goals and will continue to focus on the following: closing racial/ethnic disparities in well-child visits and immunization, improving follow-up care for mental health and substance abuse, attaining a Four-Star rating for Medicare and meeting the minimum performance levels for all MCAS measures, focusing on follow up care for mental health and substance abuse after an emergency room visit.
  - In 2024, the Quality Improvement Health Equity Committee met monthly.
  - The 2024 Population Health Management Impact Report shows CalOptima Health effectively implements its strategy, with 7 of 8 programs on track.
  - Recommendations for 2025 include implementing diversity training and enhancing quality operations through technology.

QIHEC Quarter 1 2025 Highlights

  - The 2024 CLAS Evaluation showed success with positive outcomes. CalOptima Health's teams met five of the six goals, with one goal expected to finish by Q1 2025. Feedback was collected from advisory committees, and language services were accessible to members. In 2025, CalOptima Health will add Russian as a threshold language and provide DEI training for staff.
- 2025 Quality Improvement Health Equity Transformation Program (QIHETP) Description and Work Plan was presented and approved by QIHEC. The QIHETP includes the Population Health Management Strategy as well as the Cultural Linguistics Appropriate Services Program.
  - For 2025, priorities remain the same and have added attaining NCQA Health Equity Accreditation as a priority goal
  - The PHM Strategy was revised to align with the CalOptima Health Strategic plan and developed a specific workplan and goals to focus on keeping members healthy, managing members with emerging risk, increasing patient safety, managing multiple chronic illnesses (enhanced care management), and providing advance care support. QIHEC requested a report on depression screening for prenatal and postpartum members in the hospital setting.
  - Carlos Soto, Manager of Customer Service presented an update on 2025 Culturally and Linguistically Appropriate Services (CLAS) Program Description - Overall, the 2025 CLAS Program compared to 2024 program remains unchanged from 2024.
- The 2024 Utilization Management/Case Management Integrated Program Evaluation highlighted the year's achievements in workflow and process improvements and program enhancements. The management system changed to Jiva. Staff completed gender-affirming care training and improved the durable medical equipment (DME) workflow. Program enhancements included new clinical platforms and automation in provider portals. Utilization metrics showed fluctuating average lengths of stay (ALOS) for various patient categories, and Medi-Cal compliance maintained 95% turnaround times for prior authorizations.
- The 2025 Utilization Management (UM) and Case Management Program was presented to the QIHEC for approval. Work groups will evaluate UM programs bi-monthly and ensure compliance with regulations. Case Management (CM) program updates/changes include enhanced care management, clinical documentation improvements, staff training, and targeted outreach for members with specialized needs.
- NCQA Accreditation: The look back period for the NCQA Health Plan Accreditation survey starts on April 6, 2025, with a survey submission scheduled for April 6, 2027. An NCQA consultant provided training on report writing and standards. The Health Equity Accreditation look back period begins on April 7, 2025. Staff will continue preparing for NCQA submission on October 7, 2025.
- Diversity Equity and Inclusion (DEI): DEI training modules were developed and submitted to DHCS for approval. Upon approval, staff will pilot the program early in 2025. The goal is to achieve a 90% completion rate. The DEI surveys were sent to QIHEC and feedback will be used to improve DEI compliance and inclusivity within our quality committees.
- OneCare Star Measures Improvement: Staff compared MY2024 data up to November 2024 to the Star Ratings goals for 2026. 15 of the 29 measures performed at or above the 2026 Star Goal
  - Most administrative measures for Part C are performing better than the same time in 2023.
  - For Part D, improvements in complaints and price accuracy are noted, but adherence rates do not meet targets. However, there are ongoing efforts to improve adherence, including reminders to providers and members, which carried into 2025.
- Value Based Payment Program:

QIHEC Quarter 1 2025 Highlights

  - The Stars Ratings overall performance was 3.5 or above. Most Member Experience measures were also 3.5 or above, but Part D adherence measures were above 3 Stars. Health Network performance remained below the 3.0 or 2.5 range.
  - Payments for the OneCare Pay-for Value program had high performance with only one 3 Star rating. About 75% of the Pay-for-Value dollars were distributed.
  - Hospital Quality Incentive Program – Measurement Year 2023 Hospital Quality Program - CalOptima Health has calculated baseline hospital performance using measurement year 2023 and issued first-year incentives in December 2024. The Committee proposed improving follow-up care after ER visits.
- Behavioral Health Integration (BHI) Updates:
  - Student Behavioral Health Incentive Program (SBHIP): The SBHIP program is finalizing operations, with a project outcome report completed and awaiting DHCS approval. Notification on funding is expected by March 2025, and CalOptima Health has received the full funding amount, about $25 million.
  - BH Quality Measures: Staff reviewed the BH quality measures and identified that FUM and FUA were not meeting the goal, while (Follow-Up Care for Children Prescribed ADHD medication) ADD was on track. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) is used to monitor children and adolescents on antipsychotics and showed concerning rates as of September 2024. New activities include updating the provider portal with daily Emergency Department data, TeleMed2U's outreach to members after ED visits for follow-up care, and discussions with the Orange County Health Care Agency about data sharing.
- CalOptima Health Comprehensive Community Cancer Screening Program: A kickoff meeting took place in October 2024 to connect grantees, followed by a webinar in November for grant reporting instructions. Member text messages were sent for breast and cervical cancer screening.
- Customer Service: Metrics successfully met internal and regulatory goals in Q1. Customer service metrics improved in 2024 through staff recruitment and member engagement campaigns, including text messaging and callback capabilities.
- Cultural and Linguistic (C&L) and Language Accessibility: The goals to collect and manage members' Race, Ethnicity, Language, Sexual Orientation, and Gender (REL/SOGI) data were achieved with the development of surveys and mailing packets. A new survey for practitioner data was launched. For 2025, goals include adding Russian as a threshold language, increasing REL/SOGI data collection, and providing DEI training. Utilization of translation services grew significantly in 2024, demonstrating increased member awareness.
- Coordination of Care: Member movement across practitioners – Staff focused on VSP data distribution to HNs for the Eye Exam for Patients with Diabetes (EED) measure. Five of seven HNs are receiving VSP data, and two HN are in progress.
- Special Needs Plan (SNP) Model of Care (MOC) Health Risk Assessment (HRA): Minor edits for the MOC for 2025 were approved by CMS, and CalOptima Health is awaiting approval from DHCS. DHCS is also requiring changes to California specific requirements in the MOC, and staff will update the MOC for 2026.
- Medi-Cal Member Health Reward Program – For Medi-Cal, there were 11 different categories of Member Health Rewards in 2024. Most rewards were issued for Annual Wellness Visits, and the rewards had significantly increased from 2023 to 2024. The 2025 Member Health Rewards Program will continue the same criteria as the previous year for Medi-Cal. For OneCare, member rewards will

QIHEC Quarter 1 2025 Highlights

switch to digital self-submissions. The Committee requested a Health Network comparison and staff will monitor and analyze data for future reporting.

- Plan All Cause Readmission (PCR) – There was an upward trend in PCR readmissions seen in Q2 to Q3 of 2024. For OneCare, re-admit rates exceeded the 8% goal. Improvement efforts include contacting members in the hospital for post-discharge support and working with Quality teams on Medi-Cal readmission ratios and analyze data to improve rates.
- Maternal and Child Health:
    - Timeliness of Prenatal Care (PPC) is lower compared to last year. Postpartum Care has improved, but both metrics remain below the 50th percentile. Staff aims to improve performance with new data.
    - Maternal and Adolescent Depression Screening - In November 2024, CalOptima Health held maternal health events with UCI Family Health, serving 20 attendees. They completed seven postpartum screenings and other health evaluations. Four members showed elevated depression scores and received support. Staff also provided flu shots, safety education, and nutrition guidance.
- Maternity Care for Black and Native American Persons - Timely prenatal appointments for CalOptima Health's Black and Native American members are below the goal set for December 31, 2024. A partnership with OCHCA is promoting outreach to these members. The new Black Infant Health Program offers education and support. Staff reached 24 of 183 members by phone and mailed 169 members information on ECM, Black Infant Health, and doula services.
- Quality Improvement MCAS Minimum Performance Level: CalOptima Health is improving in Follow-Up After ER Visit for Mental Illness (FUM) and Follow-Up After ER Visit for Substance Use (FUA) but is still below target. Staff are working on text message campaigns, and Telemed2U is providing virtual care. Efforts are also underway to receive behavioral health data from county partners for better care coordination.
- Preventive and Screening Services – For Medi-Cal, cervical cancer screening have slightly decreased. This hybrid measure is expected to rise with medical record reviews. Breast and colorectal cancer screenings have increased, and additional data feeds will further boost these rates. Initiatives involve outreach and collaboration for colorectal cancer screening
- EPSDT/Children's Preventive Services: Preventative screenings for children have increased, except for immunization status combo 10. Three of the five measures have met the 50th percentile. Initiatives include calls, texts, and reminders.
- Chronic Care Improvement Projects (CCIPs) OneCare: Staff continue outreach to OneCare members with diabetes, providing telephonic health coaching. They targeted 184 members in Q1 2025, successfully contacting 17. Outreach will continue to reach more members at risk.
- Performance Improvement Projects (PIPs) Medi-Cal: CalOptima Health's PIP for Well-Child Visits in Black and African Americans achieved 40% success in member contact and will address barriers by offering scheduling assistance for visits.
- Appropriate Testing for Pharyngitis (CWP) and Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB): Staff are closely monitoring CWP and AAB. The CWP measure has improved by 9% compared to last year. The AAB measure decreased, and staff will focus on interventions to address these rates.
- Improve medication adherence for Cholesterol (Statins), Hypertension (RAS Antagonists) and Diabetes: The adherence star rating improved in 2024, and efforts will continue in 2025. Staff are making calls to remind members about medications, collaborating with doctors for 100-day supplies,

QIHEC Quarter 1 2025 Highlights

and tracking refills. They also send newsletters to providers and offer education through the Medication Therapy Management (MTM) program about the importance of medication refills and compliance.

- Demographic Data Collection: CalOptima Health: Staff fielded a provider satisfaction survey receiving 30 responses. -Next steps include following up with providers to complete the survey, adding REL questions to the annual data attestation, and requiring forms for credentialing. Information will be available in directories by April 1, 2025.
- Behavioral Health Outreach and Education Plan: Through Senate Bill 1019, the Department of Health Care Services reported low use of Non-Specialty Mental Health Services in California. CalOptima Health's Behavioral Health Integration department will implement an Outreach and Education Plan for members and providers. Staff sought feedback from the Member Advisory Committee and Provider Advisory Committee and shared their plan with the Orange County Mental Health Plan. After DHCS approval, the plan will be available online and reviewed annually for updates.
- Maternal and Adolescent Depression Screening: Prenatal and postpartum depression screenings for the perinatal population in December 2024 exceed the 50th percentile, with rates around 6% for postpartum and 8. 4% for prenatal. Maternal Mental Health Initiatives include a 16-week online training by Postpartum Support International, preparing individuals to support maternal mental health. In Fall 2024, 135 providers registered for this training. CalOptima Health is promoting routine depression screenings during well-child visits and is improving data exchange with community health networks.
- BH Quality Measures:
    - There is a new behavioral health Performance Improvement Project (PIP) that aims to increase the number Medi-Cal members with mental health and substance use disorders into care management programs by 2%. Baseline data for 2023 have been approved, and quality improvement activities have been validated. Data integrity issues were noted, which could affect baseline validity.
    - New measures for 2025 include adherence to antipsychotic medications for schizophrenia, psychosocial care for youths on antipsychotics, depression screening for those 12 and older, follow-up care for substance use disorders, and pharmacotherapy for opioid use disorder.
    - The committee requested CalOptima Health to educate providers on new BH measures and provide a pursuit list of members to follow up with.
- Adverse Childhood Experiences (ACEs): The ACES screenings occurred from 10/1/2024 to 12/31/2024, with the highest numbers in ages 6 to 12. The Hispanic population had the highest number of ACEs, reflecting city demographics.
- Delegation Oversight: In Q4 2024, CalOptima Health conducted three (3) delegates annual audits and CAPs were issued accordingly and addressed the following issues: Delegates not utilizing decision template(s) effective on date of decision(s) and not utilizing applicable attachment template(s) effective on date of decision(s).

QIHEC Subcommittee Report Summary in Quarter 1, 2025

Credentialing Peer Review Committee (CPRC)

CPRC met October 24, 2024, November 21, 2024 and December 19, 2024

- There were three Fair Hearings in process and a development of an expert panel, which consists of legal and medical experts, for Fair Hearing panels was approved.

QIHEC Subcommittee Report Summary in Quarter 1, 2025

- There was one OB/GYN provider identified through On-going Monitoring which required no action.
- Proposal to set PCP minimum appointment hours which was recommended for additional policy refinement.
- Provider Action Workgroup to address quality-of-care provider issues organizationally which was recommended for additional policy refinement.
- Approved Credentialing/Recredentialing Clean Lists and Credentialing Closure Lists
- Six practitioners with issues identified during recredentialing and all were approved.
- A proposal to add Behavioral Health Quality physicians was approved with recommendation that a minimum number of CME in behavioral health be completed.
- Eight quality-of-care PQIs were presented and leveled.
    - Actions against the providers included:
        - Reporting to the Medical Board of California (non-805)
        - Referral to the LOA Resolution Workgroup for review of the process for oncology cases
        - Corrective Action Plan
        - Obtaining additional information and re-presenting to the Committee
- The following policies were approved:
    - GG.1604 - Confidentiality of Credentialing Files
    - GG.1607 - Monitoring Adverse Actions
    - GG.1633 - Board Certification Requirements for Physicians
    - GG.1643 – Minimum Provider Credentialing Standards
    - GG.1651 - Assessment and Reassessment of Organizational Providers
    - GG.1657 - State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting
    - GG.1659: System Controls and Confidentiality of Provider Credentialing Information
- The Diversity, Equity and Inclusion Survey was conducted, and Committee members were asked for their participation.

Grievance & Appeals Resolution Services Committee (GARS)

GARS met February 19, 2025

- The February 19, 2025 committee minutes were approved
- Grievance and appeals trends led to the following activities:
    - Health Network meetings to discuss GARS identified trends.
    - Transportation workgroup to address the following concerns with Modivcare: improve performance for dialysis trips and managing unassigned standing order weekly.

Member Experience Committee (MemX)

MemX met January 28, 2025

- Approved updates to 2025 charter
    - New committee members added: Director of Provider Relations, Director of Customer Service, and Executive Director Medicare Programs.
    - Title change from Director of Operations Management to Director of Provider Data Operations Management
    - Quorum changed from 7 to 9 voting members

QIHEC Subcommittee Report Summary in Quarter 1, 2025

- Strategic priorities and assignments were reviewed for monitoring improvement activities for access to care, customer service and provider office efficiencies. Continuing to monitor provider overcapacity. Issued CAPs to health networks with deficiencies based on Q4 network adequacy reporting.
- Prioritize Rheumatology, Neurology and Urology recruitment for specialties.

Population Health Management (PHM) Committee

PHMC met: February 20, 2025

- Approved updates to 2025 charter
  - Added Chief Medical Officer (or their designee) as a voting member of the committee through an amendment to the Charter.
- Health Equity & Community Engagement:
  - A new Diversity, Equity, and Inclusion (DEI) and Health Equity training was approved by the state and will be implemented in phases.
  - CalOptima Health's first annual Health Equity Report was published, highlighting collaborative efforts in health equity.
- Community Spotlight:
  - The Access California Services presentation highlighted the challenges and needs of the Middle Eastern, North African, and South Asian communities, emphasizing the lack of data representation, health disparities, and advocacy efforts for increased recognition and funding.
- Population Health Management (PHM) Strategy:
  - The PHM strategy focuses on five areas of care, covering preventive health, chronic disease management, complex care, and advanced care support.
  - Risk stratification data was presented, showing 1% of members classified as high-risk, with ongoing outreach efforts.
  - 62% of high-risk members received at least one intervention over the past year, and increased outreach efforts are being prioritized for those who have not yet been reached.
- Initial Health Appointment (IHA) Compliance:
  - The IHA completion benchmark is 50%, with significant variance across delegated health networks.
  - A chart review pilot identified documentation gaps, particularly in outreach attempts and lead level screenings for young children.
  - New strategies are being explored, including no-cost codes and improved documentation methods.
- PHMC recommended follow-up with Access California Services on CalOptima Health benefits education for SAMENA Collective.

Committee Approvals

- Approval of previous PHMC meeting minutes from November 21, 2024.
- Approval of amendment to the PHMC Charter to include the Chief Medical Officer (or designee) as a voting member.
- Approval of PHMC consent calendar items.

Utilization Management Committee (UMC)

- Benefits Management Subcommittee (BMSC)

QIHEC Subcommittee Report Summary in Quarter 1, 2025
• Pharmacy and Therapeutics Committee (P&T)

UMC met January 23, 2025

- Ad-hoc committee was held to perform an annual review of key documents
- Charter updates approved with addition of Chief Health Equity Officer and Sr. UM Manager
- The National Correct Coding Initiative (NCCI) criteria moved to a lower position in the hierarchy based on UM workgroup recommendation
- Approved 2025 Board-Certified Consultants
- 2024 UM Program Evaluation opportunities were discussed
- Approved 2025 UM/CM Integrated Program Description
- 2024 Behavioral Health Integration Inter-Reliability Assessment - IRR continued oversight & training
- Approved 7 UM policies

UMC Met February 20, 2025

- Approved 2024 UM Program Evaluation Revision:
    - Consolidated Temporary Assistance for Needy Families (TANF) 18+ goals: Aid categories identified with outlier trends addressed through workgroups.
    - Planned readmissions excluded from readmit rate: Increased readmit rate around oncology diagnosis to be explored.
- Membership volume for Over-Under Utilization Metrics Q3 2024 was reported stable with aa slight downward trend for OneCare (OC)
- Emergency Department (ED) Utilization
    - Utilization goal not met: Aid category- Seniors and Persons with Disabilities (SPD)
    - High Risk Workgroup reviews detailed data to identify opportunities for improvement
        - Implemented Point Click Care (PCC) surveillance
        - Embedded ED program at The University of California, Irvine Medical Center (UCI)
- High Risk Management Workgroup
    - Implemented post discharge Usher text messages
        - Transitional Care Services (TCS) call engagement improvements
    - Expand UCI embedded ED Program to OneCare
- Gender Affirming Care Workgroup
    - Review of APLs 24-003 & 24-018
    - Create roster for electrolysis
- Non-Emergency Medical Transportation (NEMT)/ Non-Medical Transportation (NMT) Utilization
    - Trip utilization & grievance data reviewed with no additional recommendations
    - Committee recommendation to compare utilization between WCM & non WCM
    - Recommendation for further analysis of and reporting of Health Networks
- Risk: Long Term Services & Supports (LTSS)
    - CalAIM Turn Around Time (TAT) compliance below goal due to increase in volume, staff vacancies, process changes. Remediation includes cross-training staff, hiring temp positions, daily meetings to review inventory, and daily leadership reports.
    - Develop Jiva report to present long-term care residents transitioning to the community
- 4 UM Policy and Procedures were approved

BMSC Met October 30, 2024 and December 18, 2024

QIHEC Subcommittee Report Summary in Quarter 1, 2025

- 19 codes identified for Prior Authorization (PA) required
- 24 codes removed from PA requirements
- 16 codes overseen by CalAIM deferred until 2025
- Transcranial magnetic stimulation (TMS), specialty mental health codes carved out

P&T met 11/21/2024

- Five monographs for new medications and seven protected drug class drugs were reviewed. Presented the quarterly drug recalls, OneCare Annual Formulary review, Medi-Cal quarterly Physician Administered Drug Prior Authorization (PAD PA) list review and retrospective Drug Authorization review (DUR) reports.
- They approved the drug monograph criteria and recommendations for formulary placement.

Whole-Child Model Clinical Advisory Committee (WCM CAC)

WCM met February 18, 2025

- Reviewed data and analysis of Quality Network Adequacy, Utilization (criteria for 30-day readmission data), Appeals and Grievances, Case Management, Behavioral Health, and Customer Service
- Discussion on Newborn Gateway: Starting in November, DHCS has a new registration process for newborn births aimed at timely obtaining immunization data for newborns. Staff meeting with health networks to explain the process
- Reviewed Access and Readmission Rates
    - Discussed timely access, ED readmission rates, and authorization turnover time
    - Focused on 30-day readmission rates but will also examine 7-day readmissions
    - Concerns raised about discharge planning and care coordination
- Future Presentations:
    - Address transportation issues in Whole Child and Non-Whole Child Models
    - Include CHOC Autism Comprehensive Care Program
- Next meeting is on May 20th, 2025

For more detailed information on the workplan activities, please refer to the First Quarter of the 2025 QIHETP Work Plan.

Attachment

Approved at QIHEC throughout Q1 2025: First Quarter 2025 QIHETP Work Plan 1Q

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
1	Program Oversight		2025 Quality Improvement Health Equity and Transformation Program (QIHETP) Description and Annual Work Plan	Obtain Board Approval of 2025 QIHETP Description and Workplan by April 30, 2025	QIHETP Description and Annual Work Plan will be adopted on an annual basis; QIHEC-QAC-BOD Development of the QIHETP Work Plan will include a review of the following: 1.Comprehensive Quality Strategy Report 2. Technical Report 3. Health Disparities Report 4. Preventive Services Report 5. Focus Studies 6. Encounter Data Validation Report	QIHEC: 01/14/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Quality Improvement	Program Specialist of Quality Improvement	Quality Improvement	The 2025 QIHETP Description and Annual Work Plan was presented and approved at QIHEC (2/11/2025) and QAC (3/12/2025) .	QI staff found that a QI staff position was missing in the Org Chart and updated the document to include Chief Administrative Officer.	Updated document was prepared and submitted to the Clerk of the Board for approval (4/3/2025)	N/A	The 2025 QIHETP Description and Annual Work Plan was submitted for approval by the BOD (04/3/2025).	
2	Program Oversight		2024 QIHETP Description and Work Plan Evaluation	Complete Evaluation of the 2024 QIHETP Description and Work Plan by April 30, 2025	2024 QIHETP Description and Work Plan will be evaluated for effectiveness on an annual basis; QIHEC-QAC-BOD. 2025 QIHETP Evaluation will be drafted in Q4 of 2025	QIHEC: 02/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Quality Improvement	Program Specialist of Quality Improvement	Quality Improvement	2024 QIHETP Description and Work Plan Evaluation was presented and approved at QIHEC (2/11/2025) and QAC	None noted.	None	N/A	2024 QIHETP Description and Work Plan Evaluation was presented for approved at the BOD	

Domain abbreviations: PHM = Population Health Management Strategy; CoC = Continuity of Care; HE = Health Equity; CLAS = Cultural and Linguistically Appropriate Services

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
					and approved in Q1 2026.					(3/12/2025) .				(04/3/2025).	
3	Program Oversight		2025 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2025 Integrated UM and CM Program Description by April 30, 2025	Integrated UM and CM Program will be adopted on an annual basis; UMC-QIHEC-QAC-BOD	UMC: 01/23/2025 QIHEC: 2/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Executive Director of Clinical Operations	Director of Utilization Management	Utilization Management	The 2025 Integrated Utilization Management (UM) and Case Management (CM) Program Description was presented to the Committee's/BOD as indicated in Column H. Final approval by the BOD on 4/3/2025.	The 2025 Integrated Utilization Management (UM) and Case Management (CM) Program Description was approved by the BOD on 4/3/25.	None	None	Continue with plan as defined for 2025	

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
4	Program Oversight		2024 Integrated UM CM Program Evaluation	Complete Evaluation of 2024 Integrated UM CM Program Description by April 30, 2025	Integrated UM CM Program Description will be evaluated for effectiveness on an annual basis; UMC-QIHEC-QAC-BOD 2025 UM CM Program Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	UMC: 01/23/2025 QIHEC: 2/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Executive Director of Clinical Operations/Director Case Management	Director of Utilization Management	Utilization Management	The 2024 Integrated UM CM Program Evaluation was presented to the Committee's/BOD as indicated in Column H . Final approval by the BOD on 4/3/2025.	The 2024 Integrated UM CM Program Evaluation was approved by the BOD on 4/3/2025.	None	None	Continue with plan as defined for 2025	
5	Program Oversight	PHM	2025 Population Health Management (PHM) Strategy and PHM Work Plan	Obtain Board Approval of 2025 PHM Strategy and PHM Work Plan by April 30, 2025	PHM Strategy will be adopted on an annual basis; PHMC-QIHEC-QAC-BOD	QIHEC: 01/14/2025 PHMC: 02/20/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	2025 PHM Strategy and PHM Work Plan were presented at PHMC (2/20/2025) and approved by QIHEC (2/11/2025) and QAC (3/12/2025)	2025 PHM Strategy and PHM Work Plan was approved by BOD on 4/3/2025.	Implemented the progression of approvals	N/A	Seek BOD approval and adopt the 2025 PHM Strategy and PHM work Plan. Provide quarterly progress updates or as requested	

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
6	Program Oversight	PHM	2024 PHM Strategy Evaluation	Complete the Evaluation of the 2024 PHM Strategy by April 30, 2025	PHM Strategy will be evaluated for effectiveness on an annual basis (PHMC-QIHEC-QAC-BOD) and will include the following: 1. Develop collaborative evaluation process 2. Facilitate development of the evaluation process 3. Produce evaluation 4. Present evaluation to the appropriate governing committees 2025 PHM Strategy Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	QIHEC: 02/11/2025 PHMC: 02/20/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	2024 PHM Evaluation was presented at PHMC (2/20/2025) and approved by QIHEC (2/11/2025) and QAC (3/12/2025)	BOD approved at the 4/3/25 meeting.	Implemented the progression of approvals	N/A	Seek BOD approval and file the 2024 PHM Evaluation	
7	Program Oversight	CLAS	2025 Cultural and Linguistic Accessibility Services (CLAS) Program	Obtain Board Approval of 2025 CLAS Program by April 30, 2025	CLAS Program will be adopted on an annual basis; QIHEC-QAC-BOD	QIHEC: 01/14/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Customer Service	Manager of Cultural and Linguistics	Customer Service/Cultural and Linguistic Services	QIHETP Description and Annual Work Plan presented for BOD approval on 4/3/2025.	BOD approved at the 4/3/25 meeting.	None	N/A	Seek BOD approval	

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8	Program Oversight	CLAS	2024 CLAS Program Evaluation	Complete the Evaluation of the 2024 CLAS Program by April 30, 2025	The CLAS Program will be evaluated for effectiveness on an annual basis; QIHEC-QAC-BOD 2025 CLAS Program Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	QIHEC: 02/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Customer Service	Manager of Cultural and Linguistics	Customer Service/Cultural and Linguistic Services	QIHETP Description and Annual Work Plan presented for BOD approval on 4/3/2025.	BOD approved at the 4/3/25 meeting.	None	N/A	Seek BOD approval	
9	Program Oversight	PHM	**Population Health Management Committee (PHMC)** - Oversight of population health management activities to improve population health outcomes and advance health equity.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Workplan progress and outcomes. 2. Provide overall direction for the continuous improvement process and oversee that activities are consistent with CalOptima Health's PHM strategic goals and priorities. 3. Facilitate	PHMC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/9/2025 Q4 12/9/2025	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	The Q1 2025 PHM Committee Meeting was held on February 20, 2025 which included both internal CalOptima Health updates on the PHM Program and a community spotlight presentation from Access California Services. The Chief Health Medical Officer (or designee) was	N/A	Continue to assist the committee by reviewing relevant guidance, agenda setting, presentation development, and deliverables shared with QIHEC.	N/A	Next PHM Committee meeting is scheduled for May 2025. Report committee update to QIHEC in May 2025.	

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					quarterly meetings 4. Report PHMC activities to the QIHEC quarterly.					officially added as a voting member of the committee through PHMC Charter amendment. The Committee reviewed and approved Q4 2024 PHMC Meeting Minutes. Staff provided a PHM Committee update for QIHEC in March 2025.					

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10	Program Oversight		**Credentialing Peer Review Committee (CPRC) Oversight** - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review to ensure quality of care delivered to members	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Medical Record Review (MRR) and Physical Accessibility Reviews (PARS)); Quality of Care cases leveled by committee, critical incidence reports and provider preventable conditions. 2. Committee meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.	CPRC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Manager of Quality Improvement	Manager of Quality Improvement	Quality Improvement	The Committee met on 01/23/2025, 02/27/2025 and 03/27/2025. In addition, there were two ad hoc meetings on 03/06/2025 and 03/20/2025 for the development of questions to ask of two physicians undergoing Fair Hearing who will be attending CPRC in Q2.	Three physicians continue undergoing the Fair Hearing process. Twenty-one PQIs leveled as 1 or 2 were presented to CPRC for leveling and actions; there were no level 3 cases in Q1. There were 3 quality-of-service cases presented and 2 level-2 PQIs re-presented. One Ob/Gyn was presented for on-going monitoring. The PQI trends (6-month) and statistics for Q4 were presented. There were two hospitals, one transportati	Three providers with issues were presented and approved for recredentialing; there were no providers with issues presented for credentialing. Approved the Credentialing Clean Lists for the following dates: 12/12/2024, 12/31/2024, 01/17/2025, 01/31/2025, 02/07/25, 02/14/2025, 02/19/2025, 02/21/2025, 02/25/2025 and 02/28/2025. Approved the Practitioner Closure Lists for the following dates: 12/31/2024, 01/31/2025 and 02/28/2025. Credentialing, FSR, MRR, and Incident Reporting was presented for Q4.	N/A	It was suggested that the ABA groups receive additional training by the BH Department. It was recommended that a policy be developed to address egregious incidents immediately.	

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											on vendor, one orthopaedic surgeon, and six ABA groups that trended from 07/01/2024 - 12/31/2024 . Most of the ABA groups received PQIs related to documentation.				
11	Program Oversight		**Grievance and Appeals Resolution Services (GARS) Committee** - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. The GARS Committee reviews the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima Health's network and the delegated health networks. 2. Trends and results are presented by product time to the committee quarterly. 3. Committee	GARS Committee Report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Associate Director of Grievance and Appeals	Manager of Grievance and Appeals	GARS	1) MC and OC grievances resolved timely 2) MC and OC appeals resolved timely	1) Grievance trends: Provider/Staff Attitude, Timely Access, Treatment Concerns 2) Appeal Trends- Modifications to In-Network who cannot treat, Integrated Medicare and Medi-Cal criteria not utilized during initial UM decision.	1) Tracking and trending of specific providers quarter over quarter	1) Tracking and trending of specific providers quarter over quarter	1) Tracking and trending of specific providers quarter over quarter	

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					meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.										
12	Program Oversight		**Member Experience (MEMX) Committee Oversight** - Oversight of Member Experience activities to improve quality of service, member experience and access to care.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. The MEMX Committee reviews the annual results of CalOptima Health's CAHPS surveys, monitors the provider network including access and availability (CCN and the HNs), reviews customer service metrics and evaluates complaints, grievances, appeals, authorizations and referrals for the "pain	MemX Committee report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Project Manager Quality Analytics / Manage of Quality Analytics	Quality Analytics	Committee met on 1/28/25 and accepted minutes from the10/15/24 meeting. The 2025 charter was updated and adopted with the addition of 3 new voting members. Follow up item was presented about CalOptima members access to home blood pressure	QIHEC accepted the MemX update and did not have additional questions, comments or feedback.	Strategic priorities will include expansion of drill down to issue.	None noted.	Next meeting 4/15/2025	

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					points" in health care that impact our members. 2. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.					monitors. The meeting focus was on strategic priorities for 2025. Timely access, network adequacy, customer service, behavioral health survey results , complex case managmen t survey results and GARS data were moved to consent items. A MemX update was provided to QIHEC on 3/11/25 with submission of 2025 Charter, approved minutes and consent calender.					

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13	Program Oversight		**Utilization Management Committee (UMC) Oversight** - Conduct internal and external oversight of UM activities to ensure over and under utilization patterns do not adversely impact member's care.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. UMC reviews medical necessity, cost-effectiveness of care and services, reviews utilization patterns, monitors over/under-utilization, and reviews inter-rater reliability results. 2. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	UMC Committee report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Executive Director of Clinical Operations/Director Case Management	Director of Utilization Management	Utilization Management	Internal and external oversight of UM activities to ensure over and under utilization patterns do not adversely impact member's care was presented to the CalOptima Health UMC on Jan. 23, 20205 and Feb. 22, 2025. Next meeting is scheduled for May 22, 2025.	Continue with planned activities. UM presented UMC actions & recommendations from the Feb. 20, 2025 UMC meeting. *UMC minutes for Jan. 23, 2025 *Increase in oncology readmissions *Final Rule Health Equity Analysis of the Use of Prior Authorization data. GARS to review the root cause for overturns *Russian treshold language to be added July 2025 *4 revised policies presented & approved *Expansion, TANF18+	Continue track/trend data.	None	Continue with plan as defined for 2025	

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											& OC ALOS & readmission above goal. TANF under 18 admits above goal *IP TAT Q4 2024 above goal of 95% *PA TAT Q4 2024 above goal of 95%				

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14	Program Oversight		**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for eligible children with California Children Services (CCS) are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee key findings/updates, activities, and recommendations to QIHEC.3	Conduct and report on the following activities: 1. WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. 2. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. 3. Annual Pediatric Risk Stratification Process (PRSP) monitoring (Q3)	WCM CAC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Medical Director of Whole Child Model / Director of Case Management	Program Specialist of Quality Improvement	Medical Management	WCM met 2/18/25.	Quarter 1, met all goals	Collected annual Conflict of Interest and Confidentiality Forms. Discussed Newborn Gateway, Timely Access, 7-day vs 30 day Readmission, ED Re-admit, TAT for all HN's, data for Telemed2U Mental health non ABA WCM vs non-WCM	Meaning ful data for 7 day vs 30 days.	Action items is timely Access Data, 7day Readmiss ion rate, ED Readmiss ion rate, TAT for all HN's, future report of Autism Compreh ensive Care Program.	
15	Program Oversight	PHM	Care Management (CM) Program	Report on key activities of CM program, analyze CM data compared to goal, and improvement efforts.	Report on the following activities: 1. Basic PHM/CM 2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Medical Management (Case Management)	Quality Improvement Nurse	Medical Management	Report on the following activities: 1. Basic PHM/CM: Ongoing HRA assesment s which are being shared with PCP.	Quarter 1, met all goals	Report on the following activities: 1. Basic PHM/CM: Ongoing HRA assesments which are being shared with PCP. 2. Early and Periodic Screening,	None	Report on the following activities: 1. Basic PHM/CM: Continue to share assessme nts collected with the PCP.	

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										2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM: Continued meeting in workgroup and review collected data to address potential gaps in delivery of EPSDT services, including vision, dental, and BH screenings. 3. Medical Directors re-reviewed EPSDT requirements in Caloptima Clinical Ops meeting with delegated HNs on 3/6/2025 4. Medical Director met with CHOC on 3/31 and		Diagnostic and Treatment (EPSDT) CM: Continued meeting in workgroup and review collected data to address potential gaps in delivery of EPSDT services, including vision, dental, and BH screenings. 3. Medical Directors re-reviewed EPSDT requirements in Caloptima Clinical Ops meeting with delegated HNs on 3/6/2025 4. Medical Director met with CHOC on 3/31 and Optum on 3/17 to discuss EPSDT reviews.		2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) 3. CM: Future meeting with HN to review EPSDT. 4. Continued meeting in workgroup and review collected data to address potential gaps in delivery of EPSDT services, including vision, dental, and BH screenings.	

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										Optum on 3/17 to discuss EPSDT reviews.					
16	Program Oversight	PHM	Complex Case Management Program	Implement Complex Case Management Program and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: (1) Ensure provision of CCM services resulting in optimal care coordination as evidenced through monthly auditing of 5 files or 5% of files for each health network resulting in a minimum score of 90% through December 31, 2025. (2) Obtain 85% member satisfaction in CCM program by December 31st, 2025. (3) 85% of members surveyed who participated in CCM between January 1, 2024-December 31, 2025, will report that the case management process helped them meet their care plan goals.	Conduct and report on the following activities: 1. Continue training and educational opportunities to staff on the 2025 PHM5 Element D and E and complex conditions/situations (Goal 1) 2. Member Satisfaction scores will be shared with the CCN and the delegates to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care, member outcomes, and improve the member experience of	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Medical Management (Case Management)	Nurse Specialist of Utilization Management	Case Management	Conduct and report on the following activities: 1. Continue training and educational opportunities to staff on the 2025 PHM5 Element D and E and complex conditions/ situations (Goal 1): Trainings provide for both CCN and Health Networks on 2/27/2025 and 3/4/2025. 2. Member Satisfaction scores will be shared with the	Quarter 1, met all goals	Conduct and report on the following activities: 1. Continue training and educational opportunities to staff on the 2025 PHM5 Element D and E and complex conditions/situations (Goal 1): Trainings provide for both CCN and Health Networks on 2/27/2025 and 3/4/2025. 2. Member Satisfaction scores will be shared with the CCN and the delegates to provide valuable insight to help identify strengths and areas for improvement	None	Conduct and report on the following activities: 1. Continue training and educational opportunities to staff on the 2025 PHM5 Element D and E and complex conditions /situations (Goal 1): Ongoing. 2. Member Satisfaction scores will be shared with the CCN and the delegates	

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					CM programs (Goal 2) 3. Ongoing training and support for new and existing staff. (Goal 2) 4. Continue to gather member feedback to improve outcomes. (Goal 3) 5. Training and Education on member centric care plans. (Goal 3)					CCN and the delegates to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care, member outcomes, and improve the member experience of CM programs (Goal 2) Quarter 1 results pending and being finalized. 3. Ongoing training and support for new and existing staff. (Goal 2) 4. Continue to gather member feedback to improve outcomes. (Goal 3) Conduct and report on the following activities: Quarter 1 results pending and being finalized. 5. Training and Education on member centric care plans. (Goal 3): Develop training for CCN team to be provided in Quarter 2.		to enhance the quality of care, member outcomes, and improve the member experience of CM programs (Goal 2) Quarter 1 results pending and being finalized. 3. Ongoing training and support for new and existing staff. (Goal 2) 4. Continue to gather member feedback to improve outcomes. (Goal 3) Conduct and report on the following activities: Quarter 1 results pending and being finalized. 5. Training and Education on member centric care plans. (Goal 3): Develop training for CCN team to be provided in Quarter 2.		to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care, member outcomes, and improve the member experience of CM programs (Goal 2) Q1 results to be shared. 3. Ongoing training and support for new and existing staff. (Goal 2) Ongoing. 4. Continue to gather member feedback to improve outcomes. (Goal 3)	

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										Quarter 1 results pending and being finalized. 5. Training and Education on member centric care plans. (Goal 3) Develop training for CCN team to be provided in Quarter 2.				Ongoing. 5. Training and Education on member centric care plans. (Goal 3) Future training planned for Q2 on ICP: Report on date of training.	
17	Program Oversight	PHM	Population Health Management (PHM) Strategy and Program	Implement initiatives for the 2025 PHM program starting January 1, 2025.	Conduct and report the following activities: 1. Population Needs Assessment (PNA) 2. Develop and implement a PHM Work Plan and includes the following: a. Risk stratification b. Screening and Assessment c. Wellness and prevention	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Equity and Community Health	Manager of Population Health Management/ Sr. Director Medical Management	Equity and Community Health	1. Drafted the 2025 PNA 2. Implementation of 2025 PHM work plan is in progress 3. Quarterly 2025 PHM work plan monitoring is in progress	N/A- work in progress	1. Internal review and approval of 2025 PNA 2. Obtained approval of the 2025 PHM work plan 3. Developed quarterly reporting process to avoid duplication	N/A	1. Finalize and seek approval of 2025 PNA from PHMC; NCQA submission 2. Continue implementing the 2025 PHM work plan 3. Continue monitoring progress	

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					3. Collect quarterly progress reports from PHM Work Plan implementation owners										
18	Program Oversight	PHM	Disease Management Program	Implement 2025 Disease Management Program and report key findings and/or activities, analyze barriers, and improvement efforts and meet the following goal: 1. By December 31, 2025, 85% of members who participate in Disease Management program from January 1 – December 31, 2025 will report satisfaction	Conduct and report on the following activities: 1. Evaluation of current utilization of disease management services 2. Enhance identification of gaps in care to better promote quality care across all Disease Management interventions. 3. Use multimodal methods of outreach to identify members in need of Disease Management services and	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	1.Two-Way Text Campaign Launched: 5,200 diabetes members and 5,900 asthma members were contacted through two-way text messages, demonstrating scaled outreach efforts 2.Initiated Stratification Criteria Revision: Stratification and risk-level criteria to better	1.Increased Reach Through Text Campaigns: •For members with diabetes and asthma to opt in to health coaching services 2.Real-Time Feedback Improves Response Rate: •The Disease Management Satisfaction survey received in just 2	1.Continue two-way text message campaigns: For member with diabetes and asthma 2.Monthly Stratification Criteria Logic Updates: Revisions include removing members already engaged with other departments and improving visibility of care gaps across Disease Management interventions. 3.Expansion of Disease Management Satisfaction	There have been ongoing issues with staff not being able to launch the text message satisfaction survey. Issue is being addressed by vendor.	Continue to implement activities.	

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					reduce cold calls. 4. Integrate new methods to measure and improve member satisfaction.					target low to moderate-risk members and avoid duplicative outreach. 3.Launch of Disease Management Satisfaction Survey: Survey is a text-based survey delivered to members after a via text after follow-up session. The Disease Management Satisfaction survey received 57 responses out of 131 texts sent.	months — over half of the previous annual total (100), indicating a likely improvement in response rates using this new survey method.	Survey: Planning to supplement with a paper survey included in the education packet sent by health coaches following telephonic outreach.			

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19	Program Oversight	PHM	Health Education	Implement interventions for the 2025 Health Education program and report key findings and/or activities, analyze barriers, and improvement efforts. 2025 Health Education program focuses on promoting early detection, fostering healthy habits, and empowering members to be proactive with preventive care.	Conduct and report on the following activities: 1. Evaluation of current utilization of health education services 2. Enhance methods for outreaching, promoting, and enrolling members in Health Education services and classes (e.g. text message outreach, member self-referral, etc.) 3. Expand health education offerings in various community classes and events (e.g. clinic days, virtual and in-person classes, etc.) and tech-based modalities (app/web-based services).	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	Total referrals in Q1 2025 to ECH for health education was 1580. Shape Your Life held 26 classes with 96 total attendees, with 6 in person and 20 virtual classes.	Referrals increased in Q1 2025 by 25% compared to Q1 2024 and were 29% higher than Q4 2024.	None this quarter. Please see barriers.	In Q1 2025, there was an issue with the text messaging vendor which caused 11,900+ members to receive duplicate text messages. The outcome was 2,700+ opted out of text messages. Changes implemented to prevent this from happening again include no text messages to be sent on the weekends or overnight.	1. Decide when DHCS approved text messages regarding classes and ECH services can send and to what population. 2. Determine the day and time for monthly hypertension classes offered virtually in English, Spanish and Vietnamese going forward.	

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20	Program Oversight	PHM	CalAIM Community Supports and Enhance Care Management (ECM)	Implement CalAIM and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: 1. By December 31, 2025, enhance community support services (e.g., housing transition navigation services, housing deposits, and housing tenancy and sustaining services) to achieve optimal care coordination, as demonstrated by auditing the performance of 10 providers. 2. Increase number of members authorized for ECM services by 10%, from 2,500 to 2,842 by December 31, 2025.	Community Supports Activities: 1. Conduct housing transition navigation services audits. 2. Conduct housing deposits audits. 3. Conduct housing tenancy and sustaining services audits. ECM Activity: Track ECM outreach, authorizations and services.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Medi-Cal and CalAIM	Director of Medi-Cal and CalAIM	Medi-Cal and CalAIM	1. As of February 20, 2025, Community Supports audit oversight process, templates, and report for Housing are in development and will be implemented by July 2025 (Q4). 2. Goal has been met for 2025.	1. There are a total of 47 Housing Providers that will be audited on services rendered from 01/01/24 - 06/30/25. 2. High demand for ECM Services.	1. Community Supports: • Developed required Housing Assessment Tools and Plan that will be standardized • Scheduled Office Hours for Community Support Providers by Community Support Services 2. ECM: • Increased the ECM Network.	1. No barriers at this time. 2. No barriers.	1. Finalize Housing Assessment Tools and Plan and Housing Audit Monitoring Template 2. None as goals have been met.	

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21	Program Oversight	PHM	Street Medicine Program	Implement Street Medicine Program and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: (1) By December 31, 2025, connect 80% of unhoused participating members to an active Primary Care Physician (PCP). (2) By December 31, 2025, connect 90% of unhoused participating members with CalAIM ECM and Housing Navigation. (3) By December 31, 2025, connect 20% of unhoused participating members to a shelter or other housing option.	Conduct and report on the following activities: Goal 1: ▪ Offer all members the opportunity to utilize the Street Medicine Provider as their PCP. ▪ Utilize Releases of Information when member has active PCP to increase collaboration and communication. ▪ Support member with PCP change, as needed. ▪ Care scheduling and delivery. Goal 2: ▪ Make attempts to engage with members weekly. ▪ Provide ECM and/or Housing Navigation appointments face to face at least every other week. ▪ Care scheduling and	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director, CalAIM Outreach Operations	McKenzie Rodriguez	Medi-Cal and CalAIM	By February 20, 2025, 84% of unhoused participating members were connected to an active Primary Care Physician (PCP). By February 20, 2025, 98% of unhoused participating members were connectced to CalAIM ECM and Housing Navigation. By February 20, 2025, 16% of unhoused participating members were connected to a shelter or another housing option.	The outcome for connecting unhoused participating members was 4% higher than the goal of 80%. The outcome of unhoused participating members connected to CalAIM ECM and Housing Navigation was 8% higher than the goal of 90%. The outcome of unhoused participating memebers connected to shelter or other housing option was 4% less than the goal of 20%.	Goal 1: ▪ Offered all members the opportunity to utilize the Street Medicine Provider as their PCP. ▪ Utilized Releases of Information when member has active PCP to increase collaboration and communication. ▪ Supported member with PCP change, as needed. Goal 2: ▪ Made attempts to engage with members weekly. ▪ Provided ECM and/or Housing Navigation appointments face to face at least every other week. ▪ Documented all encounters. Goal 3: ▪ Outreached and engaged unsheltered individuals ▪ Provided	Affordable and availabl e perman ent housing coninue to be a barrier for all unshelte red individu als.	Continue to deliver compassionate and whole person care services to unsheltered members within the cities our Street Medicine Program operates. Continue to carry out the goals and objectives of the program.	

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					delivery. ▪ Document all encounters. Goal 3: ▪ Outreach to and engage unsheltered individuals ▪ Provide ECM and/or Housing Navigation ▪ Enter members in to the Coordinated Entry System ▪ Connect individuals to local shelters ▪ Work with members on completing housing documentation							ECM and/or Housing Navigation ▪ Entered members in to the Coordinated Entry System ▪ Connected individuals to local shelters ▪ Worked with members on completing housing documentation			

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22	Program Oversight		Long-Term Support Services (LTSS)	Implement LTSS Program and meet the 95% compliance with the following TATs: (1) CalAIM Turnaround Time (TAT): Determination completed within 5 business days (2) CBAS Inquiry to Determination (TAT): Determination completed within 30 calendar days (3) CBAS Turnaround Time (TAT): Determination completed within 5 business days (4) LTC Turnaround Time (TAT): Determination completed within 5 business days	Assess and report the following activities: 1. Evaluation of current utilization of LTSS 2. Maintain business for current programs and support for community 3. Improve process of handling member and provider requests 4. Meet goal/TATs	Report to UMC Q1: 02/20/2025 Q2: 05/22/2025 Q3: 08/22/2025 Q4:11/20/2025	Director of Long Term Support Services	Manager of Long Term Support Services	Long Term Support Services	Jan-25 Feb-25 Mar-25 CBAS Inquiry to Determination: 99.04%; 100.00%; 99.03% CBAS TAT: 99.88%; 99.82%; 100.00% LTC TAT: 98.72%; 98.57%; 98.59% CalAIM TAT: 79.17%: 99.36%: 99.85%	LTSS utilization remains stable/unchanged. CalAim volume of referrals continues to grow primarily in housing navigation and personal care services. January the TAT in CalAim fell below the compliance threshold.	CalAim: Implemented staffing (OT, Temps, recruitment)and process changes to improve and stablize compliance with TAT which resulted in complaint TAT in February and March.	Unfilled staff positions. Process efficiencies	Fill open positions. Update all 14 community support workflows.	
23	Program Oversight		Delegation Oversight	Implement annual oversight and performance monitoring for delegated activities and report key findings and/or activities, analyze barriers, and improvement efforts.	Report on the following activities: Implementation of annual delegation oversight activities; monitoring of delegates for regulatory and accreditation standard compliance that, at minimum, include comprehensive annual audits and corrective actions.	Report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/9/2025 Q4 12/9/2025	Director of Delegation Oversight	Manager of Delegation Oversight	Delegation Oversight	Delegate: • Family Choice Medical Group (83)/Family Choice Health Services (21)/Conifer Health Solutions • Family Choice Medical Group (83)/Family Choice Health Services (21)/Family Choice Manageme	Family Choice Medical Group (83)/Family Choice Health Services (21)/Conifer Health Solutions: • Claims (Medi-Cal) – Not accepted • Claims, Provider Dispute Resolutions (Medi-Cal) – Not accepted • Utilization	Continue to remediate Corrective Action(s) as applicable.	None noted.	As per Corrective Action Plan agreed upon monitoring date(s).	

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										nt Services/Altura MSO Area(s) Assessed: • Case Management • Claims • Compliance • Credentialing • Customer Service • Provider Network Contracting • Provider Relations • Sub-Contractual • Utilization Management	Management (Medi-Cal) – Not accepted • Claims (OneCare) – Not accepted • Utilization Management (OneCare) – Not accepted Family Choice Medical Group (83)/Family Choice Health Services (21)/Altura MSO: • Compliance (All Lines of Business) – Accepted • Provider Relations (All Lines of Business) – Accepted • Customer Service – Accepted				

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24	Program Oversight		National Committee for Quality Assurance (NCQA) Accreditation	CalOptima Health must have full NCQA Health Plan (HP) Accreditation and NCQA Health Equity (HE) Accreditation by January 1, 2026	1. Implement activities for NCQA Standards compliance for HP and HP Renewal Submission by April 6, 2027. 2. Implement activities for NCQA Standards compliance for Initial HE Accreditation Survey and submit requirement documents to NCQA by October 7, 2025.	1) By December 31, 2025 2) By October 7, 2025 Report program update to QIHEC Q1:01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director Quality Improvement	Program Manager of Quality Improvement (NCQA)	Quality Improvement	The Quality Improvement (QI) Department has a National Committee for Quality Assurance (NCQA) team consisting of three Program Managers who oversee both Health Plan Accreditation and Health Equity Accreditation. The Health Equity accreditation focuses on five key workstreams, which involve the review and collection of documents necessary for the upcoming accreditation. Here is the current status update for	Health equity and health plan accreditations are on schedule, with preparations underway for the start of the look-back periods on April 6, 2025 (HPA) and April 7, 2025 (HEA). 1) Several annual reports have been reassigned to new owners. 2) A few health plan policies required clarification.	1) Complete the required website screenshots for both Health Equity and Health Plan accreditation by April 15. 2) NCQA Program Managers will set up meetings with each stakeholder to review the work plan, the documents due, and the deadlines for each deliverable. 3) Finalize all documents for the upcoming Health Equity Accreditation submission by October 7, 2025. 4) Collaborate with stakeholders to review and collect the Year one documents for Health Plan Accreditation to meet the lookback period from April 6, 2025, to April 6, 2026.	No barriers have been identified for both Health Equity and Health Plan accreditation.	**Health Plan Accreditation (HPA)**: Continue submitting year one documents for consultant review. NCQA has released a list of proposed standards for 2026. The final 2026 NCQA standards will be released after July 2025, with an effective date of July 1, 2026. Please note that for the HPA 2027 submission, we will be assessed based on the 2026 HPA standards. **Health**	

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										each accreditation: 1. **Health Plan Accreditation:** All policies, annual programs, evaluations, and work plans have been reviewed and approved by NCQA consultants. Some documents from 2024 and the present have been evaluated against the latest standards. The NCQA consultants have trained stakeholders on the 2025 Health Plan Standards. Additionally, the NCQA team met with stakeholders responsible for writing		5) Purchase the 2026 Health Plan Standards and provide training to stakeholders on these standards, as there are several changes in the upcoming version, standards will be available for purchase July/Aug.		**Equity Accreditation (HEA)**: Consultants will continue to review documents as they become available or finalized, guiding the team until identified gaps are addressed. CalOptima will revise and finalize all documents and share them with consultants until submission.	

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										analytical reports to establish due dates. A comprehensive work plan is currently being developed. 2. **Health Equity Accreditation**:The consultants have conducted reviews that include policies and procedures, desktop-level procedures, training materials, survey materials, language services contracts, reports, program descriptions, and program evaluations. The current assessment score is 66.67% out of a					

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										possible 100 points					

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25	Program Oversight		Quality Performance Improvement: Managed Care Accountability Set (MCAS) OneCare STAR measures DHCS Quality Withhold Health Plan Accreditation (QI3) Health Plan Rating	Track and report quality performance measures required by regulators against the following goals: (1) Achieve 50th percentile MPL or above (2) Achieve 4 Stars or above (3) Achieve 100% of withhold (4) Achieve 3 or higher (5) Achieve 5.0	1. Track rates monthly 2. Share final results with QIHEC annually 3. Review and identify measures for focused improvement efforts after each monthly refresh 4. Streamline data validations of monthly refresh data. HEDIS software vendor is currently solving medical record review tool issues and cannot work on concurrent data processing which delays processing of monthly data. Anticipating improvement once issues are resolved.	By December 2025 Report program update to QIHEC Q1: 01/14/2025 Q2: 05/13/2025 Q3: ~~07/08/2025~~ 08/12/25 Q4: 11/04/2025 Q1: 02/10/2026	Director of Quality Analytics/Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	As of 4/14/2025, the most recent data set available is January 2025. Member-measure level detail for data through January 2025 was provided in Q1 to Health Network and CHCN providers for both lines of business.	As of 4/14/2025, summary level data has not yet been provided to CHCN providers for both lines of business.	As of 4/14/2025, OneCare summary level data has been provided to Health Networks but not MediCal.	Challenges running reports with the new system.	Working with EDI and Financial Analysis to automate the new prospective rate report format (member-measure level and summary reports) in Q2.	

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26	Program Oversight		Value Based Payment Program	Implement a value-based payment program and report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants - HN P4V - Hospital Quality	Assess and report the following activities: 1. Share HN performance on all P4V HEDIS measures via prospective rates report each month. 2. Share hospital quality program performance 3. Develop monthly P4V report to show HNs the estimated amount of P4V dollars based on current performance	Report program update to QIHEC Q1: 01/14/2025 Q2: 05/13/2025 Q3: 07/08/2025 Q4: 11/04/2025	Executive Director of Quality Improvement	Director of Quality Analytics	Quality Analytics	HN performance of P4V measures are shared with HN. Estimated P4V dollar amount will be developed in Q3 because of the calculation fomular changed.	None	Data is available.	New HEDIS software and new P4V score calculation method.	Data is available and waiting for generating reports.	
27	Quality of Clinical Care		Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance	Monitor PCP, High Volume Specialist and ancillary sites utilizing the DHCS audit tool and methodology and report any findings, barriers and improvement efforts.	Review and report initial and periodic reviews conducted for PCP, high volume specialists and ancillary sites and ensure periodic reviews are conducted every three years. Tracking and trending of reports are reported quarterly.	Report to CPRC Q1:02/27/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	Site Review, PARS, Community-based Adult Services (CBAS), and Nursing Facilities (NF) Oversight: A. FSR: Initials FSRs=7; Periodic FSRs=42; On-site Interims=17; Failed	**FSR/MRR:** The number of Periodic and Initial FSRs and MRRs completed decreased slightly from Q4 2024 to Q1 2025. The number of Periodic FSRs completed timely increased slightly from 92%	Please refer to results for site reviews conducted in the quarter.	N/A	Continue implementing work plan	

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										FSRs=0; 93% of Periodic FSRs were completed timely. B. MRR: Initial MRRs=11; Periodic MRRs=54; Failed MRRs=6 C. CAPs: Critical Element (CE)=33; FSR=43; MRR=61 D. PARS: Completed PARS=74; Basic Access=38 ; Limited Access=36 E. CBAS Oversight: Critical Incidents=1 ; Non-Critical Incidents=4 2; Falls=15; Audits Completed =8; CAPs Issued=6; Unannounc ed Visits=1 F. NF Oversight: Critical Incidents=1 ; On-site	in Q4 2024 to 93% in Q1 2025. The number of failed FSRs decreased from 3 in Q4 2024 to 0 in Q1 2025. The number of failed MRRs decreased significantly from 19 in Q4 2024 to 6 in Q1 2025. **CAPs**: The number of CE CAPs issued decreased from 44 in Q4 2024 to 33 in Q1 2025. The number of FSR CAPs issued decreased from 60 in Q4 2024 to 43 in Q1 2025. The number of MRR CAPs remained stable from Q4 2024 and Q1 2025. **PARS:** The number of				

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										Visits=16; Unannounced Visits=0	PARS completed decreased slightly from 82 in Q4 2024 to 74 in Q1 2025. The number of PARS with BASIC access increased from 32% in Q4 2024 to 51% Q1 2025. **CBAS Oversight:** The number of Critical Incidents reported decreased from 2 in Q4 2024 to 1 in Q1 2025. The number of Non-Critical Incidents reported increased from 31 in Q4 2024 to 42 in Q1 2025. The number of Falls reported remained stable from Q4 2024 to Q1 2025. The				

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											number of audits completed decreased from 12 in Q4 2024 to 8 in Q1 2025. The number CAPs issued decreased from 9 in Q4 2025 to 6 in Q1 2025. **NF Oversight:** The number of Critical Incidents reports received increased from 4 in Q4 2014 to 13 in Q1 2025. The number on on-site visits completed increased from 14 in Q4 2024 to 16 in Q1 2025.				

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28	Quality of Clinical Care		Potential Quality Issues Review	PQIs are reviewed timely to ensure care and services provided fall within the range of professionally recognized standards of health care.	Review and report quality-of-care cases for peer review (CPRC), determine appropriate severity level and make recommendations for actions based on findings.	Report to CPRC Q1:02/27/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director Quality Improvement	Manager of Quality Improvement	Quality Improvement	Twenty-one PQIs leveled as 1 or 2 were presented to CPRC for leveling and actions; there were no level 3 cases in Q1. There were 3 quality-of-service cases presented and 2 level-2 PQIs re-presented. The PQI trends (6-month) and statistics for Q4 were presented. There were two hospitals, one transportation vendor, one orthopaedic surgeon, and six ABA groups that trended from 07/01/2024 - 12/31/2024.	The number of PQIs closed in Q4 increased over all of 2023 and 2024, though the number of cases presented to CPRC remained steady. Quality of Care grievances declined but declined grievances increased. Medical Care remained the greatest category of PQIs. Most of the ABA groups received PQIs related to documentation.	We are working on developing a plan address the PQI backlog.	The number of open PQIs was 710 at the end of Q4.	It was suggested that the groups receive additional training by the BH Department. Continue to reduce the overall number of open PQIs. Further develop the Provider Action Workgroup.	

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29	Quality of Clinical Care		Provider Credentialing and Recredentialing	All providers are credentialed and recredentialed according to regulatory requirements	Review and report providers are credentialed according to regulatory requirements: • No more than 180 days between verification and approval • Providers are recredentialed within 36 months	Report to CPRC Q1:02/27/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director Quality Improvement	Manager of Quality Improvement	Quality Improvement	Initial BH Credentialing Q1 = 643 Initial CCN Credentialing Q1 = 56 BH Recredentialing - Q1 = 48 CCN Recredentialing Q4 = 122 For Q1 we did not have any recredentialing files out of compliance	Initial credentialing/Recredentialing: We have contracted with a Credentialing Verification Organization (CVO) to assist with the credentialing of providers. This will ensure compliance and timeliness of the initial and recredentialing files.	We are working on developing a plan address the credentialing backlog.	Need resources	2 FTEs hiring in process. Aquiring help from other Depts per leadership request.	
30	Quality of Clinical Care		Special Needs Plan (SNP) Model of Care (MOC)	Increase the number of members completing an HRA, and ICP and ICT to meet the following goal: Percent of Members with Completed HRA: Goal 100% Percent of Members with ICP: Goal 100% Percent of Members with ICT: Goal 100%	Assess and report the following activities: 1. Monthly communication process with Networks on ICP development 2. DHCS HRA1 and ICP1 Quarterly reporting 3. HRA Star status 4. MOC Updates 5. Face to	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director Medical Management	QI Nurse Specialist	Medical Management	Assess and report the following activities: 1. Monthly communication process with Networks on ICP development: ICP dashboard being updated with MOC updates and MOC	Quarter 4 2025 and 2024 annual DHCS reports submitted to DHCS 2025 MDVA for CY 2024 data file submitted to CMS	Assess and report the following activities: 1. Monthly communication process with Networks on ICP development: ICP dashboard being updated with MOC updates and MOC tracking file additions. MOC tracking file implemented two additional	Members who are UTC or decline to participate in the HRA or the ICP.	Assess and report the following activities: 1. Resume monthly communication process with Networks on ICP development: -add ICT status 2. Submit DHCS	

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					Face interactions					tracking file additions. 2. DHCS HRA1 and ICP1 Quarterly/Annual Reporting 2024: Q4 2024 HRA1 Completed 84% Non-adjusted Q4 2024 ICP1 Complete 82% Non-adjusted 2024 ICP2 Element D: 82% Total number of members with a ICP completed within 365 days of the most recent ICP completed (Subset of C) 2024 HRA2 Element D: 93% Total number of members with a reassessment completed within 365 days of the most recent		columns to track sharing of ICP with Member and PCP. 2. DHCS HRA1 and ICP1 Quarterly reporting and annual reporting 2024: Q4 2024 HRA1 Completed 84% Q4 2024 ICP1 Complete 82% 2024 ICP2 Element D: 82% Total number of members with a ICP completed within 365 days of the most recent ICPcompleted (Subset of C) 2024 HRA2 Element D: 93% Total number of members with a reassessment completed within 365 days of the most recent assessment completed (Subset of C) 3. HRA Star status: as of 3/31/2025 Completed		HRA1 and ICP1 Q1 2025 Quarterly reporting. 3. Assesses HRA Star status for Q2. 4. MOC Updates: Report on changes or trainings; continue quarterly audits. 5. Face to Face interactions: Reports status for Q2 2025 to date. 6. ICP dashboard as of 4/14/2025 : 97% initial Care Plan; 95.4% annual care plan 7. Finalize SNPE universe testing and begin reporting Q2	

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										assessment completed (Subset of C) 3. HRA Star status: as of 3/31/2025 Completed 28.83% had qualifying HRA in 2025 4. MOC Updates: MOC 2025 updated and approved Palliative Care Contract for OC/CCN LOB. 5. Face to Face interactions: as of 3/31/2024 40% of OC members had an interaction in 2025. 6. ICP dashboard as of 4/14/2025: Members with 97% initial Care Plan; Members with 95.4%		28.83% had qualifying HRA in 2025 4. MOC Updates: MOC 2025 updated and approved Palliative Care Contract for OC/CCN LOB. 5. Face to Face interactions: as of 3/31/2024 40% of OC members had an interaction in 2025. 6. ICP dashboard as of 4/14/2025: 97% initial Care Plan; 95.4% annual care plan		members with ICT.	

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										annual care plan					

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31	Quality of Clinical Care	PHM - LSC	Pediatric and Adolescent Wellness: EPSDT/Children's Preventive and Screening Services	Childhood Immunization Status (CIS) MC Combo 10: 42.34% Increase from 36.50% to 42.34% by 12/31/2025. Immunizations for Adolescents (IMA) MC Combo 2: Increase from 47.45% to 48.66% by 12/31/2025. Well-Child Visits in the First 30 Months of Life (W30) MC First 15 Months: Increase from 58.92% to 63.38% by 12/31/2025. MC 15 to 30 Months: Increase from 72.44% to 73.09% by 12/31/2025. Child and Adolescent Well-Care Visits (WCV) MC Total: Increase from 53.03% to 55.29% by 12/31/2025. Lead Screening in Children (LSC) MC LSC: Increase from 63.75% to 63.84% by 12/31/2025.	Goal not met - W30. Continue to assess and report the following activities: 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored and age-appropriate messaging to improve engagement 3. Update outreach materials to include personalized content based on individual health needs (e.g. provide insight into CIS Combo 10 status for each vaccine) 4. Implement a comprehensive outreach strategy utilizing multiple modalities (e.g. mail, SMS, IVR, email, telephone) 5. For CIS Combo 10, identify members missing only the first Hep B vaccine and	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/14/2025 Q3: 08/12/2025 Q3: 11/04/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Manager of Quality Analytics	Quality Analytics	Childhood Immunization Status (CIS) MC Combo 10: 21.50% Immunizations for Adolescents (IMA) MC Combo 2: 38.25% Well-Child Visits in the First 30 Months of Life (W30) MC First 15 Months: 15.54% MC 15 to 30 Months: 62.45% Child and Adolescent Well-Care Visits (WCV) MC Total: 6.38% Lead Screening in Children (LSC) MC Total: 65.77% Rates are as of 2/28/25. We currently do not have rates for the first quarter (data through	Year over year comparison between 2024 and 2025 to be reported as part of quarter 2 updates. Vaccine hesitancy post COVID continues to be a common barrier reported by health networks. Quality Analytics team will explore best practices to share with providers in support of vaccine hesitancy.	1. Vendor supported member outreach to provide education and care coordination with PCP. 2. Vendor supported SMS messaging to provide education and reminders about the importance of care (well-child/well-care visits, lead testing, vaccination) 3. Standing Orders Program participation: 14 CHCN providers have opted into the program.	1. Standing Orders Program is currently being operationalized. Agreement for one major lab is projected to be received in Q2 2025 for Contracting department review. Step is needed prior to operationalizing data exchange between lab and CalOptima Health. 2. Year round chart chase efforts for 1st Hep B vaccine pending.	1. Q2 - finalize the mailing materials to be personalized with each vaccine status. 2. Create provider and member materials to address vaccine hesitancy. 2a. A Communication Strategies for Promoting Adolescent Vaccinations article is scheduled for the April 2025 provider monthly update.	

					complete chart chase efforts year-round 6. Begin prospective outreach to members that will age into the measure for the following year (i.e. message 1 year old members to ensure compliance with recommended vaccine schedule thus far) 7. Create educational materials for addressing vaccine hesitancy and distribute to providers and members 8. Drive provider participation in the Standing Orders Program to place lab orders for blood lead testing 9. Provide point-of-care lead testing equipment and supplies to providers via the Quality Improvement Grant Program 10. Early Identification and Data Gap					March) due to a system upgrade. The most recent data available is reflective of claims/encounters processed through January 2025.					

					Bridging Remediation for early intervention										

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32	Quality of Clinical Care		Adult Wellness: Preventive and Screening Services	Cervical Cancer Screening (CCS) MC: Increase from 58.31% to 60.10% by 12/31/2025. Colorectal Cancer Screening (COL) OC: Increase from 66.84% to 70.33% by 12/31/2025. Breast Cancer Screening (BCS-E) MC: Increase from 58.39% to 59.51 % by 12/31/2025. OC: Increase from 66.88% to 75.00 % by 12/31/2025. Immunization Status - Flu, Pneu, Tdap, Zoster MC Flu Total: Increase from 22.19% to 26.40% by 12/31/2025. OC Flu Total: Increase from 47.17% to 49.12% by 12/31/2025. MC Pneumococcal 66+: Increase from 38.18% to 38.73% by 12/31/2025. OC Pneumococcal 66+: Increase from 44.96% to 56.76% by 12/31/2025. MC Tdap Total: Increase from 25.43% to 33.40% by 12/31/2025. OC Tdap Total: Increase from 24.57% to 31.56% by 12/31/2025. MC Zoster Total: Increase from 17.52% to 20.56% by 12/31/2025. OC Zoster Total: Increase from 23.62% to 40.94% by 12/31/2025.	Assess and report the following activities: 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored messaging to improve engagement 3. Update outreach materials to include personalized content based on individual health needs 4. Provide facility listings for services completed outside the PCP office setting, such as diagnostic sites for mammography 5.Provide mobile mammography services in collaboration with other departments, Health Network partners, and CHCN providers 6. Provide at-home Cologuard testing for	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Quality Analyst of Quality Analytics / Manager of Quality Analytics	Quality Analytics	Cervical Cancer Screening (CCS) MC: 42.21% Colorectal Cancer Screening (COL) OC: 52.55% Breast Cancer Screening (BCS-E) MC: 46.75% OC: 53.49% Immunization Status - Flu, Pneu, Tdap, Zoster (AIS-E) MC Flu Total: 16.64% OC Flu Total: 41.62% MC Pneumococcal 66+: 36.89% OC Pneumococcal 66+: 45.31% MC Tdap Total: 35.98% OC Tdap Total: 39.54% MC Zoster Total: 17.19%	CCS MC: A 5.37 percent point increase compared to March 2024. COL OC: A 2.55 percent point increase compared to March 2024. BCS MC: A 6.14 percent point increase compared to March 2024. BCS OC: A 0.49 percent point increase compared to March 2024. MC Flu Total: A 1.33 percent point decrease compared to March 2024 OC Flu Total: A 2.48 percent point decrease compared to March	General Cancer Screening Texting Campaign (approx 290K MC Members) Updated CCS, BCS, COL cover letter for member screening reminder mailing Completed facility listing for CHCN MC and OC members for mobile mammography location Flu Thank You Postcard Care gap member outreach to commence Q3 and Q4	None identified.	Continue Outreach modalities for CCS, BCS and COL (text, IVR, mailing, telephone) Standing Order telephonic and mailing member outreach for BCS Initiate 2025 Cologuard Campaign Initiate of mobile mammography events Continue Flu Postcard for members TBD Q3/Q4 Relaunch IVR robocall campaign TBD Q3/Q4 Relaunch Texting Campaign TBD Q3/Q4	

					Colorectal Cancer Screening 7. Implement a comprehensive outreach strategy utilizing multiple modalities (e.g. mail, SMS, IVR, email, telephone)					OC Zoster Total: 24.62%	2024 MC Pneumococcal 66+: A 1.5 percent point decrease compared to March 2024 OC Pneumococcal 66+: A 0.26 percent point increase compared to March 2024 MC Tdap Total: A 2.35 percent point decrease compared to March 2024 OC Tdap Total: A 1.69 percent point decrease compared to March 2024 MC Zoster Total: A 1.28 percent point decrease compared to March 2024 OC Zoster Total: A 0.2 percent point increase				

											compared to March 2024				

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33	Quality of Clinical Care		CalOptima Health Comprehensive Community Cancer Screening Program (CCCSP)	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer report key findings and/or activities, analyze barriers, and improvement efforts.	Assess and report the following: 1. Establish the Comprehensive Community Cancer Screening and Support Grants program and monitor Grantees' progress to measure impact 2. Develop and implement a comprehensive plan for other initiatives under CCCSP.	Report Program update to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Chief Medical Officer	Manager of Medical Management	Medical Management	1) Hosted the quarterly grantee meeting on January 21, 2025, to review Q1 (Sep-Nov 2024) progress. 2) Received the Q2 progress reports (Dec 2024 - Feb 2025) from all grantees. 3) Received feedback on the Research and Eval component from both City of Hope and UCI Chao Family Comprehensive Cancer Center. 4) Created a prototype dashboard to view grantees' baseline, goals, and progress toward their goals.	1) Not all grantees reported baseline data for Q1 2024 (Jan 1 - Mar 31, 2024). Several non-health system grantees are unable to report on or connect their outreach efforts to screening measures yet. 2) Need to tailor each grantee's goals and progress into measurable formats. 3) 1-way GCA Results: Total messages sent: 1,276,774 to 215,207 unique members. Delivery rate: 91% Opt-out rate: 4%	Met with individual grantees alongside CalAIM's Director of Program Development to understand their progress and introduce the idea of newly formatted goal/progress reports.	Lack of consistent baseline data and goals displayed as percentages without a clear indication of the numerator and denominator.	1) Conduct the quarterly grantee meeting in April to review Q3 (Mar-May 2025) progress. 2) Release the RFP for the Research & Evaluation component of the program.	

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										5) Started collaborating with CalAIM's Program Development team to enhance the grant management process. 6) Launched the 1-way General Cancer Awareness (GCA) texting campaign on February 18 and 25, 2025. 7) Started working with Alinea to schedule mobile mammography services for CHCN members.					

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34	Quality of Clinical Care	CoC - PPC	Maternal and Child Health: Prenatal and Postpartum Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy). MC Prenatal: Increase from 88.08% to 88.58% by 12/31/2025. MC Postpartum: Increase from 80.00% to 80.23% by 12/31/2025.	Assess and report the following activities: 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored messaging to improve engagement 3. Implement a comprehensive outreach strategy utilizing multiple modalities timed with the member meeting denominator-qualifying criteria 4. Launch an interdepartmental maternal health workgroup focused on improving outcomes and addressing disparities 5. Provide bundled code education to high volume providers	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	Activity 1 is in progress (2024 data 'deep dive'). Preliminary discussions re: activity 6 have been held with the Equity & Community Health team and the Financial Analysis team. File layout / dashboard fields have been drafted.	N/A at this time	Activity 1 is in progress (2024 data 'deep dive'). Preliminary discussions re: activity 6 have been held with the Equity & Community Health team and the Financial Analysis team. File layout / dashboard fields have been drafted.	Lack of time and resources; QA focus in Q1 has been on providing support for prospective rate reporting post Citius transition. Measure-specific reporting is slated for Q2.	Complete activities as listed.	

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					6.Create a comprehensive dashboard / report that refreshes weekly to ensure timely member identification and intervention 7. Collaborate with OBGYN specialty groups to perform member outreach and schedule services 8. Expand on collaborative efforts with community-based organizations, providers, and health networks.										

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35	Quality of Clinical Care	PHM	Maternal and Child Health: Prenatal and Postpartum Depression Screening	Prenatal Depression Screening and Follow-Up (PND-E) MC Screening: Increase from 14.52% to 16.03% by 12/31/2025. MC Follow-up: Increase from 52.80% to 53.33% by 12/31/2025. Postpartum Depression Screening and Follow-Up (PDS-E) MC Screening: Increase from 17.33% to 29.84% by 12/31/2025. MC Follow-up: Increase from 56.84% to 61.70% by 12/31/2025.	PND-E & PDS-E Activities: 1. Provider maternal mental health training 2. Enhance CalOptima Health Maternal Depression Program and support referral to Behavior Health Integration when screened at risk. 3. Conduct or promote depression screening at community events.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director Equity and Community Health	Manager of Equity and Community Health/Manager of Behavioral Health Integration	Equity and Community Health	1. Provided a maternal mental health training through Postpartum Support International to clinics/providers and community-based partners. 58 providers and partners are registered. 2. Conducted maternal mental health screenings at community-based events including Santa Ana College and Maternal Presentations to 45 members.	N/A- work in progress	1. Provided a maternal mental health training opportunity to clinics/providers and community-based partners. 2. Conducted maternal mental health screenings at community-based events. 3. Receive contracted provider list for providers that self-identified as specializing in maternal mental health to assist members with connecting to services. 4. Maternal Health focused TeleMed2U flyer is included in maternal health member mailings.	N/A	1. Implement maternal mental health screenings at stroller walks and other community-based activities.	

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36	Cultural and Linguistic Appropriate Services	PHM CLAS HE	Maternity Care for Black Members	Medi-Cal 1. Increase timeliness of prenatal care (TOPC) for CalOptima's Black members from 75.71% to 84.55% by December 31, 2025. 2. Increase postpartum care (PPC) for CalOptima's Black members from 71.43% to 80.23% by December 31, 2025.	Assess and report the following activities: 1. Connect members to doula, Enhanced Care Management (ECM) services, and Black Infant Health (BIH) programs. 2. Implement community and clinic events that focus on improving prenatal and postpartum appointments. 3. Explore digital methods of providing perinatal assessments, education, and resource navigation for pregnant and postpartum members.	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/20/2025	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics/Manager of CalAIM/Director of Equity and Community Health	Equity and Community Health/ Cal AIM/Quality Analytics	Per data through February 2025, the current compliance rate for the Black or African American population for the Timeliness of Prenatal Care measure is 0.97%, and 0.69% for the Timeliness of Postpartum Care measure. The data source is CitiusTech with non-continuous enrollment applied.	Based on February 2025 data, the Black or African American population is trending lower (in terms of compliance rate for both prenatal and postpartum care) as compared to Asian and White members.	1) 22 Black members with open authorization for Enhanced Care Management (ECM) Birth Equity Population of Focus. 7 Black members received doula services in Jan-Feb 2025, comprising 32% of all members engaged in doula services during the same period, March data to be pulled in Q2. 2) Promoted prenatal/postpartum education and doula services at OC Black History Parade and Unity Festival will be held February 1, 2025. 3) Received presentations from three maternal health digital vendors to identify best practices and features.	Fragmented services and coordination of member care.	1) Continue to promote ECM and doula services to population of focus. Establish data sharing with Black Infant Health program.	

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37	Quality of Clinical Care	PHM CoC-EED	Chronic Conditions: Members with Diabetes	Eye Exam for Patients with Diabetes (EED) MC EED 64.06% Increase from 63.52% to 64.06% by 12/31/2025. OC: EED 77.00%; Increase from 75.14% to 77.00% by 12/31/2025. HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates Percentage of members with poor A1C control-lower rate is better) (>9.0%) MC HBD: Decrease from 29.34% to 27.01% by 12/31/2025. OC HBD: 10.00% decrease from 15.30% to 10.00% by 12/31/2025.	Assess and report the following activities (Quality Analytics): 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored messaging to improve engagement 3. Update outreach materials to include personalized content based on individual health needs 4. Explore at-home testing for HBD via lab vendor 5. Implement a comprehensive outreach strategy utilizing multiple modalities (e.g. mail, SMS, IVR, email, telephone) 6. Drive provider participation in the Standing Orders program to place A1c lab orders on behalf of	By December 2025 Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Quality Analytics (Medicare Stars and Quality Initiatives)/Director of Equity and Community Health	Manager of Quality Analytics	Equity and Community Health and Quality Analytics	Eye Exam for Patients with Diabetes (EED) EED MC: 28.42% EED OC: 40.54% HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates Percentage of members with poor A1C control-lower rate is better) (>9.0%) HBD MC: 81.05% HBD OC: 79.01%	EED MC: A 0.08 percent point increase compared to March 2024. EED OC: A 2.46 percent point decrease compated to March 2024. HBD MC: A 3.45 percent point decrease compared to March 2024. (lower is better) HBD OC: A 3.99 percent point decrease compared to March 2024. (lower is better)	Complete build of Ushur Two way text campaign for Diabetes. CareNet Telephonic member outreach VSP Eye Exam mailing reminder		Continue Outreach modalities for EED, HBD (text, IVR, mailing, telephonic, emailing) Update EED/HBD cover letter for member remind mailing. Standing Orders program to place A1c lab orders on behalf of physicians Partner with VSP to educate providers on EED CPT II code submission to capture testing results	

					physicians 7. Collaborate with OPH and OPT providers on member outreach and scheduling of services for EED 8 Regularly review members with evidence of A1c testing but no result and address via supplemental data capture 9. Partner with VSP to educate providers on EED CPT II code submission to capture testing results 10. Explore offering EED testing at community based events Assess and report the following activities: 1. Enhance Diabetes Education: Launch virtual and group education classes to improve member engagement by FY 2025. 2. Leverage Technology: Use digital apps and web-										

					based tools to support diabetes prevention, management, and interactive engagement. 3. Strengthen Support Services: Link members to medically tailored meals, health coaching nutrition services, community/clinic events.										

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38	Quality of Clinical Care	PHM CLAS HE	Chronic Conditions: Members with Heart Health (Hypertension)	Controlling High Blood Pressure (CBP) MC CBP: Maintain the 90th percentile (72.75%) or higher by December 31, 2025. OC CBP: Increase from 74.87% to 80.00% by 12/31/2025. Controlling High Blood Pressure (CBP) - CLAS and Health Disparity for Medi-Cal 1. Increase CBP rate among Black and African American Medi-Cal members from 39.21% to 64.48% by 12/31/2025. 2. Increase CBP rate among Black and African American Medicare members from 47.24% to 77% by 12/31/2025. 3. Increase CBP rate among Korean speaking Medi-Cal members from 24.87% to 64.48% by 12/31/2025. 4. Increase CBP rate among Vietnamese speaking Medicare members from 50.56% to 77% by12/31/2025.	Assess and report the following activities: 1. Expand Hypertension Program to offer both virtual and in-person Hypertension Education.	Report to PHMC: Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	1. Education on blood pressure control were provided at the Black History and Unity parade on 2/1/2025. Over 50 members were screened and received education. Hosted a table with information on high blood pressure at the 2nd Annual Ethiopian Day Celebration hosted by Ethio American Generational Bridge on 3/2. 2. A hypertension class was conducted on 2/28 at the Vietnamese American Cancer Foundation	1)Community events are effective engagement points, particularly those centered around cultural identity and inclusion. 2)Members are receptive to health education when delivered through trusted community organizations. 3)There is an ongoing need to reduce equipment access barriers, such as blood pressure monitors, to support chronic condition management. 4)Internal	1. Identified OC members with CBP health gap to provide targeted outreach for education and blood pressure screening clinics 2. Finalized hypertension class curriculum 3. A standing order was created to increase access to BP monitor for CalOptima members. Training for CalOptima staff will take place in April. 4. Meeting with providers and community based organizations to schedule blood pressure clinics 5. Increased screening opportunities at community events	N/A	Several classes and BP screening are scheduled for Q2.	

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
										. Total attendees: 16 3. A standing order was created to increase access to blood pressure monitors for CalOptima members. Training for CalOptima staff will take place in Q2.	training and protocol implementation are necessary next steps to operationalize expanded member access.				

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
39	Quality of Clinical Care		Chronic Conditions: Osteoporosis	Osteoporosis Management in Women Who Had a Fracture (OMW) OC Total: Increase from 34.67% to 39.00% by 12/31/2025.	1.Case management to collaborate with Quality to identify members who need follow-up. 2.Quality to outreach to noncompliant members via SMS, mail, and/or telephone. 3.Quality to pursue at-home DEXA testing via vendor. 4.Quality to provide timely notifications to the member's PCP via fax. 5.Quality to explore collaboration with the Pharmacy team to provide education on the importance of taking a medication to treat osteoporosis (e.g. bisphosphonate). 6.Quality and Case Management coordinate to provide more timely data and	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Sr. Director Medical Management/Manager of Quality Analytics	Quality Improvement Nurse/Program Manager Quality Analytics	Medical Management (Case Management) /Quality Analytics	Denominator: 48 Numerator: 11 Rate is 22.92% as of 2/28/25 Not applicable due to system upgrade. We currently do not have rates for the first quarter (data through March). The most recent data available is reflective of claims/encounters processed through January 2025.	Rate is 22.92% as of 2/28/25 and reflective of claims/encounters processed through January 2025. Year over year comparison between 2024 and 2025 to be reported as part of quarter 2 updates.	**Member focused:** 1. CM telephonic outreach to CHCN members 2. QA outreach to all members via mail **Provider/Health Network focused:** 1. Notifications to providers via fax 2. Data enhancements to HN and CHCN reports to include insight into the compliance deadline date 3. CalOptima Health collaboration with Health Network Case Management Leadership regarding identified members. **Other:** 1. Exploration of at-home DEXA vendor in progress for CHCN OC members. 2. QA enhancement 3. QA -	Visibility into members for MY2025 Quality Team has partnered with Finance team to create OMW specific reports to allow for visiblity of fractures occurring as of July 1, to allow for enhanced member identification and outreach.	1. Continue to pursue at-home DEXA testing via vendor, or purchase equipment and utilize internal resources to complete test at home. 2. Targeted provider outreach for medical record submission if member is compliant 3. Member education to emphasize the importance of osteoporosis medication 4. Provider Education: Develop provider	

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
					insight to the member's compliance deadline date to Health Network partners.							Standing Orders Program for DEXA		tip sheet/ explore CE/CME for osteoporosis screening and treatment. 5. Add pharmacy component to member outreach and/or member communication materials. 6. Continued CM follow-up with appropriate HN Case Management Leadership regarding identified members. 7. Continued CM telephonic outreach to CHCN members 8. Year over year comparison	

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
														between 2024 and 2025 to be reported as part of quarter 2 updates.	
40	Quality of Clinical Care	CoC - FMC	Chronic Conditions: Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) OC Total: Increase from 51.27% to 53.00% by 12/31/2025.	1. Review and update the Key Events for Emergency Visits 2. Continue to share Emergency Visits with Health Networks through Key Event reporting.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director Medical Management	Quality Improvement Nurse	Case Management	Denominator: 307 Numerator: 116 Rate is 37.79% as of 2/28/25	Rate is 37.79% as of 2/28/25	1. Key Event logic reviewed and reshared with Health Networks. 2. Daily Key Event Reporting. 3. CM outreach to all members	1. Ability to differentiate on key event report for ER visits those members who qualify for FMC so networks may prioritize. 2. short turn-around time for visit 7 days	1. Continue Daily Key Event Reporting. 2. Continue CM outreach to all member	

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
41	Quality of Clinical Care		Behavioral Health Services: Child and Adolescent Health on Antipsychotics	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) MC Glucose and Cholesterol Combined-All Ages: Increase from 36.76% to 41.41% by December 31, 2025.	Goal not met. Continue to assess and report the following activities: 1) Monthly review of metabolic monitoring data to identify prescribing providers and Primary Care Providers (PCP) for members in need of metabolic monitoring. 2) Work collaboratively with provider relations to conduct monthly face to face provider outreach to the top 10 prescribing providers to remind of best practices for members in need of screening. 3) Monthly mailing to prescribing providers to remind of best practices for members in need of screening. 4) Send	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	Not applicable due to system upgrade, we currently do not have rates for the first quarter and unable to analyze any findings.	Not applicable due to system upgrade, we currently do not have rates for the first quarter and unable to analyze any findings.	1) Created a draft to update the Prescriber tip tool sheet. 2) Updated the Best Practices Prescriber letter-pending management approval. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation for Providers and staff on how to use the Provider Portal. Pending report availability. 4) Created Social media post for this HEDIS measure. 5) Created article for Fall Member Newsletter.	1) Due to lack of the Prospective Rate report we are unable to track and trend any analysis for this measure. 2) Unable to send text messages to members due to system upgrade.	1) If data is received, Disseminate prescriber letter. 2) If data is received, Disseminate prescriber tip tool sheet. 3) If data is received, resume Text message campaign. 4) If data is received, resume mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to providers on a monthly basis. 5) If data is received, resume collaborati	

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
					monthly reminder text message to members (approx 600 mbrs). 5) Information sharing via provider portal to PCP on best practices.									on with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis. 6) Schedule listening sessions with Providers to educate/train on how to obtain BH data upon BH reports are availability.	

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
42	Quality of Clinical Care	PHM	Behavioral Health Services: Depression	Antidepressant Medication Management (AMM) MC Acute Phase - 63.35% Increase from 68.06% to 68.35% by December 31, 2025. MC Continuation Phase - Increase from 48.06% to 48.16% by December 31, 2025. OC Acute Phase - 63.35% Increase from 75.52% to 78.39% by December 31, 2025. OC Continuation Phase - Increase from 60.77% to 62.58% by December 31, 2025. Depression Screening and Follow-up for Adolescents and Adults (DSF-E) MC Screening Total: Increase from 6.57% to 16.22% by December 31, 2025. OC Screening Total: Maintain the 90th percentile (54.28%) or higher by December 31, 2025.	AMM Goal not met. Continue to assess and report the following activities: 1) Educate providers on the importance of medication adherence through outreach. 2) Educate members on the importance of medication adherence through newsletters/outreach. 3) Track number of educational events on depression treatment adherence. DSF-E Goal not met. Continue to assess and report the following activities: 1) Educate providers on the importance of screenings and follow-up care after positive screenings. 2) Educate	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	**AMM/DSF-E:** Not applicable due to system upgrade, we currently do not have rates for the first quarter and unable to analyze any findings.	**AMM/DSF_E:** Not applicable due to system upgrade, we currently do not have rates for the first quarter and unable to analyze any findings.	**AMM** 1) Created a draft to update the Prescriber tip tool sheet. 2) Updated Best Practices Prescriber letter-Pending management approval. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation for Providers and staff on how to use the Provider Portal. Pending report availability. 4) Created Social media post for this HEDIS measure. 5) Created article for Fall Member Newsletter. DSF-E: 1) Created a draft to update the Prescriber tip tool sheet. 2) Updated Prescriber letter-pending management approval. 3) Created a Quick	AMM/DSF-E: 1) Due to lack of the Prospective Rate report we are unable to track and trend any analysis for this measure. 2) Unable to send text messages to members due to system upgrade.	AMM/DSF-E: 1) If data is received, Disseminate prescriber letter. 2) If data is received, Disseminate prescriber tip tool sheet. 3) If data is received, resume Text message campaign. 4) If data is received, , resume mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to providers on a monthly basis. 5) If data is received,	

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
					members on the importance of screenings through newsletters/outreach and increase follow up appointments after positive screenings.							Reference Guide (QRG) & Power Point Presentation for Providers and staff on how to use the Provider Portal. Pending report availability.		resume collaboration with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis. 6) Schedule listening sessions with Providers to educate/train on how to obtain BH data upon BH reports availability.	

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
43	Quality of Clinical Care	CoC-SSD	Behavioral Health Services: Schizophrenia	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) MC SSD: Increase from 74.96% to 79.51% by 12/31/2025. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) MC: Increase from 70.19% to 74.83% by 12/31/2025. OC: Increase from 77.37% to 77.93% by 12/31/2025.	SSD Goal not met. Continue to assess and report the following activities: 1) Identify members in need of diabetes screening. 2) Conduct provider outreach, work collaboratively with the communications department to fax blast best practice and provide list of members still in need of screening to prescribing providers and/or Primary Care Physician (PCP). 3) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening. 4) Send monthly reminder text message to members (approx 1100 mbrs)	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	**SSD\SAA:** Not applicable due to system upgrade, we currently do not have rates for the first quarter and unable to analyze any findings.	**SSD\SAA:** Not applicable due to system upgrade, we currently do not have rates for the first quarter and unable to analyze any findings.	**SSD:** 1) Updated prescribing provider letter. 2) Created new provider tool tip sheet. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider Portal. Pending report availability. 4) Created Social Media Posts for members to receive a diabetic screening. 5) Created an article for the Fall Member Newsletter. SAA: 1) Created new Prescribing Provider Letter. 2) Created a Provider Too Ttip sheet. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation	**SSD\SAA:** 1) Due to lack of the Prospective Rate report we are unable to track and trend any analysis for these measures. 2) Unable to send text messages to members due to system upgrade.	**SSD:** 1) Continue tracking members in need of glucose screening test as soon as we're able to receive data. 2) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 3) Continue to follow up on data pull for text messaging campaign. 4) Mail out member health rewards flyer to eligible members. 5) Mail out to all prescribing provider	

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
					5) Member Health Reward Program. SAA Assess and report the following activities: 1) Educate providers on the importance of medication adherence through outreach. 2) Educate members on the importance of medication adherence through newsletters/outreach.							for Providers & Staff on how to use the Provider Portal. Pending report availability. 4) Created an article for the Fall Member Newsletter.		offices the following: a.)Prescribing Provider Letter b.)Provider Tool Tip Sheet c.)Member Reward Flyer 6)Schedule listening sessions with Providers to educate/train on how to obtain BH data. Pending report availability. **SAA:** 1) Will use provider portal to communicate best practices and guidelines for medication adherence and member	

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
														follow-up. 2) Discussion of implementing a text messaging campaign. 3) Begin mail out to all prescribing provider offices the following: a.) Prescribing Provider letter b.) Provider Tool Tip Sheet 4) Schedule listening sessions with providers to educate/train on how to obtain BH data. Pending report avialability.	

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44	Quality of Clinical Care	PHM CoC-FUM; FUA; FUI	Behavioral Health Services: Care Coordination and Follow-up Care	Follow-Up After Emergency Department Visit for Mental Illness (FUM) MC 30-Day: Increase from 35.76% to 53.82% by 12/31/2025. MC 7-day: Increase from 21.38% to 33.01% by 12/31/2025. Follow-Up After Emergency Department Visit for Substance Use (FUA) MC 30-Day: Increase from 21.12% to 36.18% by 12/31/2025. MC 7-Day: Increase from 11.23% to 18.76% by 12/31/2025. Follow-up After High-Intensity Care for Substance Use Disorder (FUI) MC 30-Day: Increase from 20.25% to 44.53% by 12/31/2025. MC 7-Day: Increase from 7.99% to 26.90% by 12/31/2025.	FUM Goal not met. Continue to assess and report the following activities: 1. Share real-time ED data with our health networks on a secured FTP site. 2. Participate in provider educational events related to follow-up visits. 3. Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4. Bi-Weekly Member Text Messaging (approx. 500 mbrs) 5. IVR calls to members who fall under the FUM measure FUA Goal not met. Continue to assess and report the following activities: 1. IVR calls to members who fall under the FUA measure 2. Continue weekly	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	**FUM/FUA/ FUI:** Not applicable due to system upgrade, we currently do not have rates for the first quarter and unable to analyze any findings.	**FUM/FUA/ FUI:** Not applicable due to system upgrade, we currently do not have rates for the first quarter and unable to analyze any findings.	**FUM:** 1) Member text messages sent weekly. 2) Member outreach via BH Telehealth vendor to assist with scheduling Follow up appointments. Outreach based on daily ED data feed. 3) Reminders regarding importance of FUM/FUA sent in monthly HN Communication. 4) Continued sharing FUM data with HN Networks via sFTP. 5) Attend HN Quality meetings to educate on importance of FUM/FUA measures. 6) Collaboration with OC HCA regarding 837 data exchange 7) Created HEDIS Provider Tip Sheet. FUA: 1) Weekly member text messages. 2) Sharing FUA data with Health Networks via	**FUM/FUA/FUI:** Due to lack of the Prospective Rate report we are unable to track and trend any analysis for this measure.	**FUM:** 1) Start IVR calls for members who meet FUM criteria to remind them of the importance of scheduling a follow up appointment after an ED visit. 2) Continue following up with OC HCA regarding data exchange. 3) Meet with High volume ED's to ensure members are connected to services before they leave the hospital by introducing Telemed2U/NAMI By Your Side. 4) Share FUM data	

					member text messaging 3. Share FUA data with providers through the Provider Portal. 4. Sharing FUA data with Health Networks via sFTP. FUI: This measure was added for monitoring purposes. Opportunities for improvement and/or interventions will be considered upon the ability to obtain data from the Orange County Health Care Agency.							the sFTP. 3) Participate in Quality update meetings with Health Networks to educate the importance of the FUA measure. 4) Send reminders regarding the importance of FUA measure in monthly HN communication. 5) Created HEDIS Provider Tip Sheet. 6) Member outreach via BH Telehealth vendor to assist with scheduling Follow up appointments. Outreach based on daily ED data feed. **FUI:** 1) Opportunities for improvement and/or interventions are being considered upon the ability to obtain data from the Orange County Health Care Agency. 2) Created a HEDIS		via Provider portal. Pending report availability. 5) Schedule listening sessions regarding how to use data from Provider portal. FUA: 1) Continue weekly text messages. 2) Continue sharing data with Health Networks via the sFTP. 3) Continue to collaborate in Quality update meetings with Health Networks. 4) Start IVR calls for members who meet FUA criteria to remind	

													Provider Tool Tip Sheet.		them of the importance of scheduling a follow up appointment after an ED visit. 5) Continue following up with OC HCA regarding data exchange. 6) Share FUA data via the Provider Portal. FUI: 1) Continue to monitor measure on a monthly basis. 2) Continue collaborative meetings between teams to identify best practices to implement.	

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
45	Quality of Clinical Care	CoC - APP	Behavioral Health Services: Medication Management	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) MC Total: Increase from 28.95% to 54.55% by 12/31/2025. Pharmacotherapy for Opioid Use Disorder (POD) MC Total: 21.36% Increase from 7.79% to 21.36% by 12/31/2025.	Assess and report on the following activities: 1) Educate providers on measure and best practice guidelines.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Manager of Behavioral Health Integration	Behavioral Health Integration	**APP/POD:** Not applicable due to system upgrade, we currently do not have rates for the first quarter and unable to analyze any findings.	**APP/POD:** Not applicable due to system upgrade, we currently do not have rates for the first quarter and unable to analyze any findings.	**APP:** 1) Created HEDIS Provider Tip Sheet. 2) Created Provider Best Practice Letter **POD:** 1) Met with Pharmacy on 02/24/25 to discuss collaboration with this measure. Both BH and Pharmacy agreed that data will be needed from Orange County Health Care Agency for tracking purposes.	**APP/POD:** Due to lack of the Prospective Rate report we are unable to track and trend any analysis for this measure	**APP:** 1) Use provider portal to communicate best practices and guidelines. 2) Discuss implementing a text messaging campaign. 3) Plan to mail out to all prescribing provider offices the following: a.) Best Practice Provider letter b.) Provider HEDIS Tool Tip Sheet **POD:** 1) Establish steps to obtain data from OCHA.	

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
46	Quality of Clinical Care		Behavioral Health Services: School-Based Services Mental Health Services	Report on activities to improve access to preventive, early intervention, and BH services by school-affiliated BH providers.	Assess and report the following Student Behavioral Health Incentive Program (SBHIP) activities/school base mental health services 1 . SBHIP Program Outcome Reporting 2. DHCS CYBHI multi-Payer Fee Schedule	Report program update to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Project Manager of Behavioral Health Integration	Behavioral Health Integration	NA	NA	1) Waiting for DHCS' approval letter for the December submitted project outcome reports. 2) Final two WellSpaces installed March 2025. 3) The Autism Comprehensive Program designed by CHOC through SBHIP launched in March 2025.	NA	1) For the CYBHI Fee Schedule, Carelon Behavioral Health conducting an implementation kick-off meeting for the ASO claims payment process - April 2025.	
47	Quality of Clinical Care		Medication Management	Appropriate Testing for Pharyngitis (CWP) MC Total: Increase from 43.66% to 76.71% by 12/31/2025. OC Total: Increase from 15.77% to 72.50% by 12/31/2025. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) MC Total: Increase from 47.55% to 56.73% by 12/31/2025. OC Total: Increase from 68.97% to 47.50% by 12/31/2025.	1) Identify top 5-10 providers that prescribed antibiotics to members and provide targeted provider education via provider updates/provider newsletter. 2) Provide members with general education on antibiotic avoidance.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Medicare Stars and Quality Initiatives	Program Manager of Quality Analytics	Quality Analytics	Appropriate Testing for Pharyngitis (CWP) MC Total: 52.8% OC Total: 17.22% Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis (AAB) MC Total: 37.16% OC Total: 24.82%	CWP MC: A 0.53 percent point increase compared to March 2024 CWP OC: A 7.58 percent point increase compared to March 2024 AAB MC: A 2.51 percent point decrease compared to March 2024	Create provider material on antibiotics avoidance. Identify top 10 lower performing providers	N/A	COH to finalize provider communication plan	

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
											AAB OC: A 1.60 percent point decrease compared to March 2024				
48	Quality of Clinical Care		Medication Adherence	Improve medication adherence for Cholesterol (Statins), Hypertension (RAS Antagonists) and Diabetes	1) Member IVR, member education, provider education, PDC report to Health Networks.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Pharmacy Management	Manager of Pharmacy Management	Pharmacy Management	1Q25 Overview: Count of Member adherence IVRs: 4,473 Count of Member: 1,088 interventions (pharmacies, members and providers); 283 prescriptions filled (26%) which resulted in successful refills for	CY2025 Star Measure reports unavailable from Acumen for 1Q25. Results of interventions documented in column O.	1) Adherence IVRs 2) Adherence outreach calls to members, pharmacies and providers 3) Health network coaching 4) PDC report enhancements 5) 100-day supply conversion program	1) Members picking up their medications 2) Limited providers signing collaborative practice agreement for 100-day supply program	Continue all interventions outlined.	

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										197 members Report distribution Health Networks via provider portal (daily refresh); actionable report for networks to conduct outreach Distribution of best practices document to health networks to assist in intervention design 100-day supply conversion program (19 contracted providers); 54 prescriptions converted for 34 members					

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49	Cultural and Linguistic Appropriate Services	CLAS HE	Performance Improvement Projects (PIPs) Medi-Cal	Increase well-child visit appointments for Black/African American members (0-15 months) from (final rate TBD) to 55.78% by 12/31/2025.	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP – Increasing W30 6+ measure rate among Black/African American Population	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/20/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Manager of Quality Analytics / Manager of Quality Analytics	Quality Analytics	Denominator: 38 Numerator: 4 Rate is 10.53% as of 2/28/25 Not applicable due to system upgrade. We currently do not have rates for the first quarter (data through March). The most recent data available is reflective of claims/encounters processed through January 2025.	Count of Member IVRs: 4,473	1. PIP Call Campaign to coordinate well-child visit with PCP.	1. Contact Information: bad or disconnected phone numbers poses additional challenges in the ability to contact members and subsequntly coordinate care.	1. Following up with PCP offices to identify alternative contact information for members.	

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50	Quality of Clinical Care		Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals) FUM and FUA for complex case management.	Non Clinical PIP: Improve the percentage of members enrolled into care management, CalOptima Health community network (CCN) members, complex care management (CCM), or enhanced care management (ECM), within 14-days of a ED visit where the member was diagnosed with SMH/SUD.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration/ Quality Analytics	NA	Count of Member: 1,088 interventions (pharmacies, members and providers); 283 prescriptions filled (26%) which resulted in successful refills for 197 members	1) Receiving daily ED report from vendor which contains Real-Time ED data for CCN and COD members. 2) Collaborate with telehealth provider, Telemed2U, and internal ITS team to develop implementation plan for Member Outreach. Vendor to provide information about case management including ECM and referrals	1) Data integrity has been an issue. Proposed changes may threaten validity of baseline data.	1) Continue collaboration with Case Management and Financial Analysis depts to ensure accuracy of internal data and reports. 2) Continue to conduct barrier analysis 3) Continue Telehealth member outreach.	

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51	Quality of Clinical Care		Chronic Care Improvement Projects (CCIPs) OneCare: Diabetes Emerging Risk	By December 31, 2025, 5% of members identified as emerging risk* and who participated in program will lower HbA1c to less than 8.0%. *Emerging risk is defined as members with a result of A1C 8.0% to A1C 9.0% who were previously in good control A1C less than 8.0% in previous 12 months.	Conduct quarterly/Annual oversight of specific goals for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study - Comprehensive Diabetes Monitoring and Management Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Manager of Quality Analytics	Quality Analytics	HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates Percentage of members with poor A1C control- lower rate is better) (>9.0%) HBD OC: 79.01%	Report distribution Health Networks via provider portal (daily refresh); actionable report for networks to conduct outreach	Telephonic outreach via Disease Management department staff for those identified as emerging risk	Data refresh issue due to the HEDIS vendor transition	Case Management and Equity & Community Health teams are currently discussing the approach to Q2-Q4 outreach	
52	Quality of Service: Access		Improve Network Adequacy: Reducing Gaps In Provider Network	Increase provider network to meet regulatory access goals	Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network	Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/21/2025	Director of Provider Operations	Sr. Program Manager, Provider Operations/Program Specialist	Provider Data Operations	1.Gap analysis showed Plan level meets standards except for PMR, which shows gaps in LMFT, Gastroente	Distribution of best practices document to health networks to assist in intervention design	1. PDO curated target lists for R,U,N and PR Recruitment Outreach is in progress 2. Research to see what caused the new Plan - count gap in Opthalmology	South County is always an area where it's hard to find providers (CCN gaps)	1. Review the results of the outreach and identify next steps 2. Review HN CAP response submission	

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					2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members					rology, Ortho Surgery & LMFT 2.CCN met all requirements except for Time or Distance - Q1 showed 3 gaps 3. HNs all had Time or Distance gaps, with some having PMR gaps		3. HNs are to provide CAP response on or before 4/4 to address gaps			
53	Quality of Service: Access		Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	Goal not met. Continue to assess and report the following activities: 1) Conduct an evaluation of appointment and telephone access 2) Issue corrective action for areas of noncompliance 3) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions to improve timely	Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/21/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Manager of Quality Analytics / Project Manager of Quality Analytics	Quality Analytics	Timely Access CAPs issued to 9 HNs in December 2024, and all networks submitted a response in Q1. Response Rate: 100% As of Q1, 64% of the provider CAPs (109) issued in June-2024 have been closed.	HN CAP submissions for MY-2023 data are currently under review. High level findings noted attributing to non-compliance includes but not limited to: staffing shortages, lack of walk-in availability, and scheduling. MY-2024 Timely	In February issued an RFP for Timely Access Survey and received 6 submission. Selection process is underway. Timely Access workgroup members are working on streamlining the survey process and reviewing standards to ensure they are a regulatory requirement Will continue to collaborate with providers	Vendor issues with data integrity and quality control issues has caused significant delays in releasing results timely to providers and health networks over the last several years.	-2025 Timely Access Survey (MY-2024) non-compliance/CAP notifications to be issued to providers by mid-June. -Continue to educate and collaborate with providers and HNs on Access. -Re-evaluate	

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					access. 4) Continue to educate providers on timely access standards 5) Develop and/or share tools to assist with improving access to services.						Access Survey concluded December 2024, and QA is in the process of receiving and QC'ng data from the vendor.	to learn more about their challenges and to share best practices.		MPL threshold per DHCS Timely Access recommendations	
54	Quality of Service: Access		Network Adequacy Regulatory Submission and Audits	Comply with regulatory requirements • Annual Network Certification (ANC) • Subdelegate Network Certification (SNC) • Network Adequacy Validation (NAV) Audit	1) Annual participation of ANC, SNC and NAV to DHCS with AAS or CAP 2) Implement improvement efforts 3) Monitor for Improvement 4) Communicate results and remediation process to HN	Submission: 1) By end of January 15, 2025 2) By end of Q2 2025 3) By end of Q3 2025 Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/21/2025	Director of Provider Operations	Sr. Program Manager, Provider Operations	Provider Data Operations	1. ANC - 2023 ANC approved AAS website posting in process - 2024 ANC from DHCS showed 21 gaps. - COH submitted completed 2024 ANC submission 3/18 inclusive of revised AAS request for 21 gaps (down from 43 in 2023) 2. SNC - RAC requested update for 2023 CAPs	2024 SNC (HN) found all Health Networks did not meet Network Adequacy Standards based on Q4 Network Adequacy Assessments	1. 2024 ANC Package - PDO and PR performed outreach recruiting efforts and Contracting completed requested information regarding provider network. 2. 2024 SNC - COH issued HN CAPs for Time or Distance and PMR	1. ANC - DHCS FFS database show providers with inaccurate practice locations - DHCS and CalOptima Health do not use the same geomapping software, leading to different assessment	1. COH working on upgrading Quest geomapping software to increase TorD assessment accuracy 2. HN CAP submissions due to COH 4/4/2025 for contracting efforts to close SNC gaps	

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										issued, submitted document stating COH has closed all CAPS issued to HNs, and found no deficiencies, officially closing out 2023 SNC. 3. RAC has not heard from DHCS regarding 2024 NAV Audit			results for Tor D		
55	Quality of Service: Access	PHM	Increase Primary Care Utilization - Initial Health Appointment	Increase the IHA completion rate for all new Medi-Cal members from 33% to 50% by December 31, 2025.	Assess and report the following activities: 1) Enhance methods of informing members of the importance of IHA and preventive screenings. 2) Collaborate with delegation oversight to improve IHA compliance by Health Network.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Equity and Community Health	Manager of Equity and Community Health/Program Manager Equity and Community Health	Equity and Community Health	1) Member communication: - Member text message campaign went live in December 2024 and is sent to new members monthly. 2) DO Collaboration for HN compliance improvement	N/A- work in progress	Presentations: - PHMC 2/20/25 - CLCHC CalOptima Quality Meeting 2/20/25 - SOS Clinic Quarterly Mtg (held by PR) 3/18/25 - HN Forum 3/20/25 - CHCN Virtual Meeting 3/25/25 - DOC Meeting 3/26/25	N/A	1) Member communication: -Continue text campaign along with existing member outreach efforts 2) DO Collaboration for HN compliance improvement	

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					3) Provider and HN education to support new member screening for SDOH screening within 120 days.					-Under DO guidance, ECH is working with HNs to obtain additional information from their submitted DODR Forms - ECH participation in the monthly Delegate Health Network Dashboard Monitoring Workgroup 3) Provider/HN education ECH presented IHA updates at 6 meetings in Q1, listed in Column Q.				- A follow up meeting with ECH/DO will be held to decide the next step to take with HNs not meeting or improving their rates. 3) Provider/ HN education Continue educating and supporting HNs and Providers with IHA requirements through various presentations.	

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56	Quality of Service: Member Experience		Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal OC: One Star ImprovementMC: One Star Improvement	Assess and report on the following activities: 1) JIT: Conduct outreach to members in advance of 2025 CAHPS survey (Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively).2) Launch 8 Listening Post campaigns via two-way Ushur SMS and provide year-round service recovery in collaboration with multiple departments. 3) Launch a recurring meeting series with Health Network partners dedicated to member experience improvement strategy.4) Propose mapping of member responses to CAHPS	Report to MemX Q1: 01/28/2025Q2: 04/15/2025Q3: 07/15/2025Q4: 10/21/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Project Manager of Quality Analytics / Manage of Quality Analytics	Quality Analytics	1) Just In Time outreach completed2) 3 of the 8 listening posts have been implemented.3) 2 health network meetings have been held focusing on improving member experience. 4) Mapping of CAHPS responses is in progress.5) Meeting was held with one department to review the DPI platform.	1) Average NPS score is > 92) Members would like refill reminders3) health networks vary in member experience improvement efforts	1) Just in Time mailer and calls completed for OneCare in February. Calls will be completed for MediCal in mid-April.2) 3 of 8 Listening Post campaigns are live (missed medication refill, first time medication for med adherence measures, post office visit).3) Meetings launched with HNs in late Q1.4) Mapping in progress for multiple channels.5) Discussed with the Case Managment team on 3/17/25.	Lack of time and resources	Continue with plan as listed	

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					categories in support of the organization adopting a Voice of Member reporting system.5) Train member-facing roles to the Decision Point Insights platform to review and address CAHPS risk during member discussions.										

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57	Quality of Service: Member Experience		Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process and report key findings and/or activities, analyze barriers, and improvement efforts. Maintain the grievance and appeals and resolution process while meeting all regulatory requirements for timely processing of appeals and grievances at a target goal of 95%.	Track and trend member and provider grievances and appeals for opportunities for improvement. Maintain business for current programs. Improve process of handling member and provider grievance and appeals Identify trends in grievances quarterly to address member needs and systemic issues within the Plan. Utilize feedback provided in our quarterly GARS Committee Meetings to improve overall member experience and plan operations.	Report progress to GARS Q1 02/19/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/13/2025 Q1: 02/10/2026	Director of Grievance and Appeals	Manager of Grievance and Appeals	GARS	1) MC and OC grievances resolved timely 2) MC and OC appeals resolved timely	1) Grievance trends: Provider/Staff Attitude, Timely Access, Treatment Concerns 2) Appeal Trends- Modifications to In-Network who cannot treat, Integrated Medicare and Medi-Cal criteria not utilized during initial UM decision.	1) Tracking and trending of specific providers quarter over quarter	1) Tracking and trending of specific providers quarter over quarter	1) Tracking and trending of specific providers quarter over quarter	

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58	Quality of Service: Member Experience		Customer Service Call Center	Implement customer service process and monitor against the following standards: OC Call Center Abandonment Rate 5% or lower OC Call Center Average Speed of Answer 2 minutes or lower MC Call Center Average Speed of Answer 10 minutes or lower Report key findings and/or activities, analyze barriers, and improvement efforts.	Track and trend customer service call center data Comply with regulatory standards Improve process for handling customer service calls	Report progress to QIHEC Q1: 01/14/2025 Report to MemX Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/21/2025	Director of Customer Services	Manager of Customer Service	Customer Service	OneCare Call Center Abandonment Rate: 3.6% OneCare Call Center Average Speed of Answer: 49 seconds Medi-Cal Call Center Average Speed of Answer: 2 minutes and 56 seconds	None noted.	Hired additional staff, collaborate with various departments to stagger their member engagement campaigns, leveraging call back capabilities for inbound calling members opting in.	None noted.	Continue with plan as listed	
59	Safety of Clinical Care		Plan All Cause Readmission	Plan All-Cause Readmissions 18-64 (PCR) MC: Decrease from 0.8983 to 0.8937 by 12/31/2025. OC: Decrease from 10.00% to 8.00% by 12/31/2025.	1. Collaborate with Quality /Data analytics to identify top 5-10 readmission DX – consider adding in top 5-10 member readmission data for targeted education and outreach for member/provider. 2. review of ambulatory Follow up	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director Medical Management	None	Case Management	1. MC readmission: 0.087 2. OC readmission (pending as current report only pulls not pulling data for q1 2025 yet)	MC: Readmission Rate with slight downward trend.	1)Report in progress by Data analytics for top 5-10 readmission DX.members. 2) Provider education for E/M's post discharge (99495 & 99496)in process to share @ HN/facility JOMS' and clinical OPs outreach, provider	Member engagement. Limited reporting functionality for visibility into member readmission details for targeted outreach.	Continue planned activities	

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					within 7 days of DC for HN and discharging facilities. 3. Provider education for E/M's post discharge appt's within 7 days: 99495 and 99496. 3. Collaborate with other departments (UM/CM/TCS) for targeted outreach for member outreach for							relations outreach through PR channels. 3) Member resources at HN and Hospital JOM's. 4)TCS (MC) calling members when admitted as IP to make connections for support after discharge 5)HN outreach on ways to impact readmission.			
60	Safety of Clinical Care		Emergency Department Member Support	Launch the Emergency Department (ED) Program in 2025 and track utilization of services and report key findings and/or activities, analyze barriers, and improvement efforts.	Assess and report the following activities: 1) Promoting communication and member access across all CalOptima Networks 2) Increase CalAIM Community Supports Referrals 3) Increase PCP follow-up visit within 30 days of an ED visit 4) Decrease inappropriate ED Utilization	Report to UMC Q1: 02/20/2025 Q2: 05/22/2025 Q3: 08/21/2025 Q4: 11/20/2025	Director of Long Term Support Services	Manager of Long Term Support Services	Long Term Support Services	The UCI embedded ED program launched on 2/5/2025 with one RN and MSW in the ED.	February and March had minimal in person Member enagement . Ten members were engaged with and 250 members were followed up telephonically.	An ED workgroup was was established to review barriers to member in person engagement	Staff not located in the ED due to lack of space. Can only make rounds. No full epic access. Needed for epic chat and admission board.	Locate work space in the ED to facilitate case management coordination with members. Get full epic access for chat and admission information. Implement point click care.	

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61	Safety of Clinical Care		Transitional Care Services (TCS)	UM/CM/LTC to improve care coordination by increasing successful interactions for TCS high-risk members within 7 days of their discharge by 10% by end of December 31,2025. [New goal will be established Q1 2025]	1) Use of Ushur platform to outreach to members post discharge. 2) Implementation of TCS support line. 3) Ongoing audits for completion of outreach for High-Risk Members in need of TCS. 4) Ongoing monthly validation process for Health Network TCS files used for oversight and DHCS reporting.	Report to UMC Q2: 05/22/2025 Q3: 08/21/2025 Q4: 11/20/2025	Sr. Director of Utilization Management	Project Manager, Medical Management	Utilization Management	1) Usher text campaign for 2/weekly text to members admitted to hospital 2) TCS support line moved to be managed by all TCS staff. 3) Ongoing audits for outreach for high risk members 4) Creating JIVA report for transarency into successful outreach within 7 days- currently no report- manual sample audit process.	Manual audit finding for successful outreach within 7 days is 49.15% with random sample audit completed monthly. Need reporting into TCS support line for visibility into volume/handled calls.	1) Moved TSC phone support to all TCS staff support 2) Creating TSC phone audit log (transparency into type of calls) and support ability to return missed calls. 3) Report in Jiva in process. 4) Continue random sample audits. 5) Sharing TCS flyer to HN and Hospital JOM's. 6) Creating TCS phone line reporting for visbility and opportunities.	Member engagement. Limited reporting functionality.	Continue planned activities	

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62	Cultural and Linguistic Appropriate Services	CLAS	Language Services: Cultural and Linguistics and Language Accessibility	Implement interpreter and translation services and report key findings and/or activities, analyze barriers, and improvement. For translation services, by August 1st, 2025, CalOptima Health will expand the threshold languages to include Russian to meet requirements established by the California Department of Health Care Services (DHCS).	Track and trend interpreter and translation services utilization data and analysis for language needs. Comply with regulatory standards, including Member Material requirements Launch Russian as new threshold language.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	Cultural and Linguistic Services continually tracks and trends interpreter and translation services utilization data while analyzing and identifying language needs, as an ongoing process. Cultural and Linguistic Services continually to complies with regulatory standards, including Member Material requirements for all threshold languages. Cultural and Linguistic Services will lead the launch of Russian as new	In preparation of the Russian threshold language implementation on August 11, 2025. The following preparations are currently underway for the August launch. • Member facing documents are currently being translated into Russian. • Interviews are underway to identify and onboard a full-time Russian translator.	No interventions or activities planned at this time.	No barriers have been identified for both Health Equity and Health Plan accreditation.	Cultural and Linguistic Services will lead the launch of Russian as new threshold language on August 11, 2025.	

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										threshold language on August 11, 2025. The following preparations are currently underway for the August launch. • Member facing documents are currently being translated into Russian. • Interviews are underway to identify and onboard a full-time Russian translator.					

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63	Cultural and Linguistic Appropriate Services	CLAS	Network Cultural Responsiveness: Data Collection on Member Demographic Information	By Dec. 31st, 2025, CalOptima Health will increase the collection of sexual orientation gender identify (SOGI) data by 10% through focused outreach and education, ensuring better representation and inclusion of members.	1) Field a survey to collect the Member's Sexual Orientation and Gender Identity (SOGI) information from members (18+ years of age). 2) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks. 3) Develop and implement a survey via the Member Portal, mail to new members and other methods. 4) Share member demographic information with practitioners.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	CalOptima staff continues to collect SOGI data from members through various methods in Quarter 1: > Continue to mail survey's to new members 18+ years of age. > Member Portal > Community Events > New Member Orientation Meetings	Collection of data continues to be a challenge as overall, we have collected 5% of members surveyed.	Expanding SOGI Collection methods > April 2025: Mailing surveys to 186,000+ existing members 18+ years of age. >April 2025: Survey members during the New Member Orientation meetings.	Lack of response to the member surveys	Continue monitoring the collection rate. For now, this goal is on target but will re-evaluate in the next quarter after we assess the collection rate of the 186,000 surveys mailed on April 30th 2025. Collaborate with IT to implement a process to share the data collected with the Health Networks. Target Q3 2025	

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64	Cultural and Linguistic Appropriate Services	CLAS	Network Cultural Responsiveness: Data Collection on Practitioner Demographic Information	By Dec. 31st, 2025, CalOptima Health will increase the collection of race/ethnicity/languages (REL) data by 10% through focused outreach and education, ensuring better representation and inclusion of providers.	1) Add REL questions to routine forms, including credentialing, provider relations LOI, and provider demographic forms. 2) Enter REL data into the provider data system to ensure it can be retrieved and used for CLAS improvement. 3) Share data on the provider network's capacity to meet the language needs of CalOptima Health members. 4) Assess the provider network's ability to meet CalOptima Health's culturally diverse member needs. 5) Collaborate with other CalOptima Health departments to share SOGI data with	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/20/2025	Director of Provider Operations	Program Manger Provider Data Operations	Provider Data Management Services	1. The REL data collection is embedded into the routine workflow. REL questions are integrated into the Addition, Change, Termination (ACT) form, Provider Relations LOI, and credentialing forms. 2. PR and Health Networks submit REL data via ACT forms, LOIs, and rosters. This information is routed to Provider Data Operations, where it is stored and maintained within the Facets database for use and reporting. 3-5. Data on provider	REL questions have been integrated into routine forms, including ACT and credentialing forms. REL data submission workflows are routed to PR or PDMS via Provideronline@caloptima.org. The data entry process allows REL information to be stored and retrieved for analysis and CLAS reporting. Language and demographic data are visible in the provider directory when shared by providers.	Addition/Change/Termination (ACT), initial credentialing application, Letter of Intent (LOI), and the Language Supplemental Form now capture race/ethnicity, language fluency, and language-service capability.	Provider disclosure of language fluency and race/ethnicity data remains voluntary, resulting in low response rates. Many providers opt not to share this information, limiting the completeness of data available for analysis and reporting.	Continue collecting REL data through ongoing integration in standard forms, ensuring providers are consistently prompted to submit this information during credentialing, updates, and demographic reviews.	

Domain abbreviations: PHM = Population Health Management Strategy; CoC = Continuity of Care; HE = Health Equity; CLAS = Cultural and Linguistically Appropriate Services

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					Health Networks.					language capacity and cultural demographics is displayed in CalOptima Health's online provider directory when shared by the provider. This information is available to CalOptima Health PR and Health Networks upon request; however, no formal requests have been made to date.					

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65	Cultural and Linguistic Appropriate Services	CLAS	Experience with Language Services	Evaluate language services experience from member and staff by implementing at language services survey to member and staff by March 31, 2025. By Dec. 31st, 2025, CalOptima Health will evaluate language services experience by collecting feedback from at least 10% of members and 80% of staff using surveys and will analyze the results to identify improvements to language services.	Goal not met. Continue to assess and report the following activities: 1) Develop and implement a survey to evaluate the effectiveness related to cultural and linguistic services. 2) Analyze data and identify opportunities for improvement.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	1) Develop and implement a survey to evaluate the effectiveness related to cultural and linguistic services. Cultural and Linguistic Services developed and launched a Staff and a Member survey in March 2025, to assess the satisfaction level of the language assistance service experience of CalOptima Health staff and members. • Staff survey – C&L received 72 responses from CalOptima Health staff as of the end of April	• Member survey – C&L received 642 responses as of the end of April 2025, via U.S. Mail, from the 32,480, that were mailed. The responses are still being sorted and tallied. 2) Analyze data and identify opportunities for improvement. • Since the surveys are still in progress, and the responses from the Member survey are still being sorted and tallied, opportunities for improvement will be identified in the following quarters.	No interventions or activities planned at this time.	No barriers have been identified for both Health Equity and Health Plan accreditation.	The responses for the Member Survey are still being sorted and tallied an update will be provided in the following quarters.	

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										2025. The survey results were positive responses, with only 3 un-favorable responses. • Member survey – C&L received 642 responses as of the end of April 2025, via U.S. Mail, from the 32,480, that were mailed. The responses are still being sorted and tallied. 2) Analyze data and identify opportunities for improvement. • Since the surveys are still in progress, and the responses from the Member survey are					

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										still being sorted and tallied, opportunities for improvement will be identified in the following quarters.					
66	Cultural and Linguistic Appropriate Services	CLAS	Network Cultural Responsiveness: Diversity, Equity and Inclusion Training	By Dec. 31st, 2025, CalOptima Health will implement and train 90% of staff, health networks, and providers on Diversity, Equity and Inclusion (DEI) training, ensuring compliance with DHCS All Plan Letter (APL) 24-016.	1. Develop a DEI Training and launch pilot training by July 31, 2025	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Chief Health Equity Officer	Manager Human Resources and Provider Relations	HR and Provider Relations	1) DEI and Health Equity Training approved by DHCS (2/14/25) 2) DEI and Health Equity Training to replace other related trainings such as: - Cultural Competency - Disability - DEI-	-Internal Regulatory and Compliance Team confirmed DHCS approval. -Approval marks a key milestone for moving forward with implementation	Submitted DEI and Health Equity training materials to DHCS in December 2024. Received and reviewed approval notification from DHCS. Planning activities began for pilot testing and full-scale rollout.	N/A	Quarter 2, 2025 (April 2025) 1) Pilot launch for CalOptima Health staff (new employees). 2) Pilot launch for Providers via the provider portal. 3) Brief survey to	

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										Unconciou s Bias				be administe red post-training for feedback collection. 4) Begin evaluating pilot feedback to prepare for full launch.	

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