Board of Directors'

Quality Assurance Committee Meeting

October 8, 2025

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

QIHEC Summary		
QIHEC Chair(s)	Quality Medical Director and Chief Health Equity Officer	
Reporting Period	Quarter 2, 2025	
QIHEC Meeting Dates	April 8, 2025, May 13, 2025, June 10, 2025	
Topics Presented and Discussed in QIHEC or subcommittees during the reporting period	• Access and Availability • Adolescent Care • Adult Wellness and Prevention • Appropriate Testing for Pharyngitis (CWP) and Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) • Behavioral Health Integration (BHI) • Benefit Management Subcommittee (BMSC) • CalAIM • 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)	• Health Education • 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 • Medication Management • 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 • Pharmacy • Plan All Cause Readmission (PCR) • Policy • Population Health Management (PHM) • Potential Quality Issues (PQIs) • Prenatal and Postpartum Care • Preventive and Screening Services • Provider Directory • Maternal Care

	• Depression Screening • Diabetes Care • Diversity, Equity, and Inclusion (DEI) training • Emergency Department Diversion Program • Enhanced Care Management (ECM) • Facility Site Review (FSR)/Medical Record Review (MRR)/Physical Accessibility Review Survey (PARS) • Grievance & Appeals Resolution Services (GARS)	• Quality Compliance Report • Quality Improvement Health Equity Work Plan • Quality Metrics • Student Behavioral Health Incentive Program • Transitional Care Services (TCS) • Utilization Management Committee • Whole Child Model (WCM)

QIHEC Actions in Quarter 2, 2025

QIHEC Approved the Following Items:

- March 11, 2025, meeting minutes; April 28, 2025, meeting minutes; May 13, 2025, meeting minutes
- Three Quality Improvement policies:
  - Policy GG.1620: Quality Improvement Health Equity Committee (QIHEC)
  - Policy GG.1629: Quality Improvement and Health Equity Transformation Program (QIHETP)
  - Policy GG.1655_Reporting Provider Preventable Conditions

Accepted and filed the following items:

- Appendix: National Committee for Quality Assurance (NCQA) Accreditation
- Appendix: Student Behavioral Health Incentive Program (SBHIP)
- 2025 QI Work Plan_Quarter 1 update
- Appendix: Quality Improvement and Credentialing Policies
- PHMC meeting minutes_02.20.25_Final
- GARS meeting minutes_02.19.25_Final
- UMC meeting minutes_01.23.25_Final
- UMC meeting minutes_ 02.20.25_Final
- WCM CAC meeting minutes_02.18.25_Final

QIHEC Quarter 1 2025 Highlights

- Chief Medical Officer (CMO) Updates
  - CMO provided an update on the measles outbreak and immunization rates. High immunization rates in Orange County except in South County.
  - California maintains a 96.5% vaccination rate, but hesitancy is increasing. Emphasis was placed on provider-patient trust to address skepticism.
  - CMO emphasized continued focus on member care despite organizational uncertainties.
- Quality Improvement Compliance Report - Following the compliance issue reported last quarter regarding CalAIM Community Supports authorizations, which failed to meet the 95% benchmark in November and December 2024 due to staff vacancies and an increase in referral volumes, a Corrective Action Plan (CAP) was implemented. This plan included cross-training staff and hiring temporary personnel, leading to improved compliance rates of 99% for both February and March 2025.
- At the March 11, 2025, QIHEC meeting, QIHEC raised concerns about the lack of specificity in CalOptima Health's provider directory and requested an update. Provider Directory enhancements are

QIHEC Quarter 1 2025 Highlights

underway to improve provider data collection and search capabilities, starting with orthopedics. A provider portal link with a specialty spreadsheet is also in development to support clinical staff and referring physicians.

- At the March 11, 2025, meeting, QIHEC discussed member resistance to immunizations, prompting QIHEC to recommend that CalOptima Health send a communication emphasizing the importance of vaccinations. Staff will send member communications using DHCS materials to promote measles, mumps, rubella (MMR) vaccination. Content was submitted for the Fall 2025 newsletter, but the action remains open until publication.
- Prenatal Care Initiative - Staff are developing a women's health text campaign, partnering with community organizations, and planning media outreach to improve early pregnancy identification and prevent delayed prenatal care.
- NCQA Accreditation - Health Equity accreditation submission is due October 7, 2025. Health Plan accreditation is due April 6, 2027. Staff are addressing gaps and preparing documents for submission.
- Comprehensive Community Cancer Screening Program (CCCSP) - A dashboard was developed to track grantee progress. Staff are planning mobile mammography events and refining evaluation scope.
- Behavioral Health Services - Staff focused on improving quality measures such as Follow Up After Emergency Department Visit for Mental Illness (FUM) and Follow Up After Emergency Department Visit for Alcohol and Other Drug Dependance (FUA) by implementing the following: weekly texts and coordinating with a telehealth vendor for follow-up appointments, created a Quick Reference Guide for portal use, and submitted a Fall newsletter article and social media posts.
- Behavioral Health Performance Improvement Projects (PIPs) - The Medi-Cal PIP aims to increase case management enrollment among CalOptima Health Medi-Cal members with specialty mental health diagnoses by 2%. Enrollment declined from 1.71% in 2022 to 1.08% in 2023. PIP data was submitted to DHCS. Staff continue to work with telehealth vendors for member outreach and focus on member data integrity.
- School-Based Mental Health Services - All partners in the DHCS Student Behavioral Health Incentive Program (SBHIP) concluded their program obligations successfully. Key outcomes included increased behavioral health staffing, improved referral and billing systems, and expanded services. Hazel Health now serves 19 districts. CalOptima Health submitted its outcome report and is awaiting DHCS scoring.
- Medication Adherence - Interactive Voice Response (IVR) system to improve medication adherence was implemented, making over 1,000 calls that resulted in 283 prescriptions for 197 members, focusing on triple-weighted Star measures. The 100-Day Supply Conversion Program allowed pharmacists to extend chronic medication supplies with prescriber and member approval, converting 54 prescriptions for 34 members.
- Cultural Responsiveness - Demographic Data Collection - CalOptima Health successfully collected Race/Ethnicity and Language (REL) data for their members; 87% for race/ethnicity and 98% for language. Only 5% of members provided information on their Sexual Orientation and Gender Identity (SOGI) and efforts are focused on increasing data collection in this area.
- Language Services Utilization - Interpreter and translation requests increased in early 2025 due to member awareness and demand. Russian to be added as a threshold language by August 2025.
- Experience with Language Services - CalOptima Health launched two surveys to assess staff and member experience of languages services. The staff survey launched on March 17, 2025, and staff feedback was positive. The member survey is currently being conducted, and results are not yet available

QIHEC Quarter 1 2025 Highlights

- Diversity, Equity, and Inclusion Training - CalOptima Health has developed a new Diversity, Equity, and Inclusion training that covers cultural competency, disability, and unconscious bias. The training was approved by the state and was piloted for new employees and began in April, and a full launch for all employees will be conducted in September.
- Postpartum Depression Screening - At a previous QIHEC meeting, staff were asked to consider postpartum depression screenings during hospital stays. Inpatient screenings do not meet HEDIS criteria. CalOptima Health will continue focusing on outpatient screenings.
- Quality Performance Improvement - Preliminary HEDIS 2024 results for Medi-Cal MCAS measures indicate that measures in the Children and Reproductive Health and Cancer Prevention domains exceeded the Minimum Performance Level (MPL), except Asthma Medication Ratio (AMR) measure. Behavioral Health measures (FUA and FUM) remained below MPL. Preliminary HEDIS 2024 results for Medicare measures indicate Care for Older Adult and Transitions of Care measures are below a 3-Star.
- Value-Based Payment Program - Proposal for the 2026 Pay for Value Program was presented to QIHEC and approved. The proposed program aims to link Medi-Cal incentive eligibility to OneCare STAR performance. Under the proposal, health networks must achieve at least a 3-star rating in OneCare to access the Medi-Cal incentive pool. The proposal is being reviewed in various forums and will be presented to the board's Quality Assurance Committee in October.
- Hospital Quality Program - The program uses a Pay for Value model based on quality, patient experience, and safety, using CMS and Leapfrog data. For non-CMS hospitals, Leapfrog ratings apply. Staff proposed rolling over $12.5M in unearned 2023 funds to 2024, potentially increasing payouts from $18M to $21M. A work group will explore fund use. There was also a request to consider U.S. News rankings to expand participation.
- Special Needs Plan (SNP) Model of Care (MOC) - HRA and ICP completion rates improved; Staff will begin tracking combined initial and renewal HRA rates as requested by the committee.
- Quality Performance Measure Update:
    - Maternal and Child Health: Prenatal (82.16%) and postpartum (59.6%) care rates improved over the previous year, driven by early identification efforts and strong community partnerships. Collaboration with the Equity and Community Health team continues to support these gains.
    - Medication Management: Notable improvements were seen in antibiotic stewardship measures (AAB and CWP). The team is planning targeted provider education and member outreach to close remaining gaps.
    - Pediatric & Adolescent Wellness: Immunization and screening rates are trending upward, though well-child visits remain a challenge. Staff are addressing vaccine hesitancy and expanding access to lead testing equipment.
    - Adult Wellness: Most cancer screening rates improved, except for breast cancer screening, which remains low. Outreach strategies include mobile mammography, culturally tailored messaging, and at-home testing kits.
    - Maternity Care for Black Members: Focused efforts are underway to support Black members through Enhanced Care Management (ECM), doula services, and community outreach. Early engagement shows promise, with 22 members in ECM and 7 receiving doula support.
    - Medi-Cal PIP – Well-Child Visits for Black Members: Outreach continues toward the 55.78% target, despite challenges in member contact.

QIHEC Quarter 1 2025 Highlights

  - OneCare CCIP – Diabetes Emerging Risk: A1C control remains a priority, with the current rate at 21% against a goal of 87%. SMS and phone outreach campaigns are in progress to improve member engagement and outcomes.
- Plan All-Cause Readmission - Medicare rate is at 4 stars. Interventions include discharge summaries, transportation, and text campaigns
- Network Cultural Responsiveness, Provider Demographics – Provider demographic data is being collected and displayed in the provider directories. QIHEC discussed member challenges of obtaining interpreter services and requested staff to investigate interpreter availability concerns, specifically interpreter scheduling process. Staff clarified CalOptima Health's interpreter request process. In-person services require 5–7 business days' notice; phone interpreters are available. Provider and member contact numbers were shared for Cultural and Linguistic Services support.
- Delegation Oversight - In Q1 2025, CalOptima Health conducted audits for Family Choice Medical Group/Family Choice Management Services MSO/Conifer Health Solutions and Children's Hospital of Orange County (CHOC) Health Alliance/Rady's Children MSO, identified multiple findings and issued corrective action plans (CAPs) in the Medi-Cal and OneCare lines of business.
  - FCMG had 1 CAP and 8 findings related to claims processing, provider disputes, and utilization management.
  - CHOC had 1 CAP and 3 findings focused on timely notices, reporting, and pharmaceutical management.
  - Common issues included improper use of decision templates, notification delays, and claims adjudication errors. Most findings are under monitoring, with some already resolved. Committee discussed issues with claims, UM, and notification timelines Remediation with ongoing monitoring and corrective actions.

QIHEC Subcommittee Report Summary in Quarter 1, 2025

Credentialing Peer Review Committee (CPRC)

CPRC met January 12, 2025, February 27, 2025, and March 20, 2025, and approved their previous meeting minutes.

- Approved Policies:
  - GG.1650: Credentialing and Recredentialing of Practitioners
  - GG.1651: Assessment and Reassessment of Organizational Providers
  - GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
  - GG.1607: Monitoring Adverse Actions
  - GG.1611: Potential Quality Issue Review Process
  - GG.1616: Fair Hearing Plan for Practitioners
  - GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting
  - GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network
- Two closed session meetings were held to discuss two individual cases.
- The committee reviewed PQI trends, noting ongoing issues with two Applied Behavior Analysis (ABA) groups and two hospitals. Two preventable provider conditions were reported to DHCS.
- Three PCPs failed MRRs and were terminated.

QIHEC Subcommittee Report Summary in Quarter 1, 2025

- Nursing facility audits increased, and critical incident reporting rose due to improved SNF education and DHCS mandates. Critical incidents in Skilled Nursing Facility (SNF)s increased due to better reporting (46 in 2024 vs. 0 in 2023).
- Credentialing volumes increased in early 2025, especially in Behavioral Health. Delays in initial credentialing were noted, but improvements are underway through a new CVO vendor, staffing, and system upgrades. Staff encouraged providers to use the credentialing updates inbox for status checks. Credentialing delays were improved with CVO vendor, staffing, and system upgrade. Committee asked about credentialing timelines; staff explained the backlog and provided contact email for credentialing status updates and reassured that the credentialing backlog was being addressed.
- One Level 3 PQI was reported in Q1, along with multiple Level 2 issues involving ABA providers. CPRC actions included education and referrals for fraud and abuse.
- Dr. Pitts commended the committee's dedication and long hours in ensuring the quality of physician oversight for CalOptima Health

Grievance & Appeals Resolution Services Committee (GARS)

GARS met May 23, 2025, and approved the February 19, 2025, meeting minutes.

- The committee reviewed Q1 2025 trends. OneCare appeals increased to 59 with a 47% overturn rate, primarily involving inpatient and specialty care. Medi-Cal appeals decreased to 265 with a 26% overturn rate. Grievance rates for both lines of business remained below NCQA thresholds.
- Discrimination-related grievances rose to 53, with most involving race, Americans with Disabilities Act (ADA), and language access. Remediation with internal tracking of overturns; quarterly reviews.
- CalOptima Health continues to monitor transportation-related grievances and provider performance. Staff identified a pattern of appeals related to continuity of care and are educating health networks accordingly. Performance comparing Q1 2024 to Q1 2025 showed overall improvement, with CalOptima Health's grievance rate remaining below the state average.
- Following a request by QIEHC, staff reported Grievance and Appeals rates compared to the benchmark to assess performance. Grievance rates remained below NCQA thresholds.
    - OneCare appeals increased (59 in Q1 vs. 41 in Q4); overturn rate 47%.
    - Medi-Cal appeals decreased (265 in Q1 vs. 346 in Q4); overturn rate 26%.
    - Discrimination grievances rose (53 in Q1 vs. 34 in Q4).
    - Overall grievance rates are below NCQA threshold.
    - Committee closed action item on grievance rate benchmarks.

Member Experience Committee (MemX)

MemX met on April 15, 2025, and approved the July 15, 2025, meeting minutes.

- 14 Medi-Cal Primary Care Physician had closed panels due to hitting member assignment capacity.
- For timely access, CalOptima Health met California Department Health Care Services (DHCS) minimum performance levels (MPL) for non-urgent appointments but not for urgent ones. Corrective action plans (CAPs) were issued to health networks and providers for urgent access, with ongoing reviews.
- The 2023 Annual Network Certification (ANC) gaps were largely resolved, and 2024 assessments are underway. Subcontractor Network Certification CAPs were also issued. Monthly monitoring and weekly termination reports are now in place to support the CMS Triennial Network Adequacy Review.

QIHEC Subcommittee Report Summary in Quarter 1, 2025

- Member experience efforts include a "voice of member" campaign and after-call surveys, with satisfaction scores exceeding 92% for both Medi-Cal and OneCare. Feedback focused on medication access and office visits, helping guide service improvement.
- Member Satisfaction Surveys show >92% satisfaction. Committee discussion with focus on improving survey methodology and enhancing survey tools.

Population Health Management (PHM) Committee

PHMC met on May 15, 2025, and approved February 20, 2025, meeting minutes and the 2025 Population Needs.

- As required by the DHCS and NCQA, CalOptima Health must maintain a robust Complex Case Management (CCM program). CalOptima Health has invested significantly in program enhancements, training, support, and oversight to ensure standardized practices and core competencies across all Health Network partners.
    - CalOptima Health invites feedback and discussion to maintain alignment and continually improve care delivery across all networks
- Carolina Gutierrez-Richau, Director, Behavioral Health & Wellness Department Council on Aging – Southern California, presented on The Aging Divide, including national and local demographic data, older adults' health considerations, an overview of the council and its programs and services.
- Staff focused on expanding Health Education Access and Engagement: gather the committee's input on suggestions to increase access and engagement.
- Ongoing Health Risk Assessments shared with PCP
- Initial Screening/Assessment for Newly Enrolled Medi-Cal Members (within 90 days)
- Complex Case Management Q1 member survey results – 95% reported the program helped meet care goals
    - Next step: Sharing the member satisfaction survey scores with CalOptima Health Community Network **(**CCN) and delegated networks.
- PHMC recommended staff explore opportunities to host community classes within primary care provider (PCP) office spaces and collaborate with local school districts to offer classes on school campuses, increasing accessibility and community engagement
- PHMC suggested revising and shortening the member satisfaction survey to increase response rates. Additionally, they suggested offering the survey via text message, either in place of or alongside telephonic outreach, to enhance accessibility and member engagement.
- Explore additional analysis on data on the hyperlipidemia diagnosis rate amongst the Vietnamese population.

Utilization Management Committee (UMC)

- Benefits Management Subcommittee (BMSC)
- Pharmacy and Therapeutics Committee (P&T)

UMC met on May 22, 2025, and approved February 20, 2025, meeting minutes.

- Committee reviewed Q1 2025 utilization data, including inpatient turnaround times, which met the 95% goal. Prior authorization compliance remained strong. Staff addressed earlier workflow issues with training and updates.
- The committee discussed Emergency Department (ED) utilization, bed days, and readmission rates. The ED Diversion Program at University of California, Irvine (UCI) Medical Center launched in February and is showing increased member engagement. UMC recommended that staff focus on improving the collection of post-discharge contacts.

QIHEC Subcommittee Report Summary in Quarter 1, 2025
• Several workgroups met, including Over/Under Utilization, Gender-Affirming Care, EPSDT, and High-Risk Management. • Pharmacy updates included Centers for Medicare & Medicaid Services (CMS) Star Ratings adherence rates. Behavioral Health is monitoring outpatient trends and investigating increased BHT utilization. • Long-Term Services and Supports (LTSS) regained California Advancing and Innovating Medi-Cal (CalAIM) TAT compliance after staffing and process improvements. • Transitional Care Services (TCS) aims to increase successful post-discharge interactions by 10% in 2025. Staff are now full-time, and outreach efforts include daily calls, support lines, and hospital engagement. Positive feedback has been received from hospitals. • Emergency Department Diversion and Transitional Care Setting are progressing. Benefit Management Subcommittee (BMSC) • The Benefit Management Subcommittee approved removal of 97 codes from the prior authorization list. NEMT/NMT improvements led to a 48% drop in grievances, supported by new scheduling tools and standing orders.
Whole-Child Model Clinical Advisory Committee (WCM CAC)
WCM met May 20, 2025, meeting and approved the February 20, 2025 Meeting Minutes • The committee discussed health network adequacy and Timely Access Survey showed gaps in specialties. While routine appointment compliance was generally good, ENT/otolaryngology, gastroenterology, and infectious disease specialties were non-compliant. The WCM CAC requested that staff address Health Network (HN) Adequacy for specialists serving aging out WCM members, as well as Timely Access issues. As a result, staff will focus on initiative to improve access to identified key specialties. • The committee also raised concerns about care coordination, Enhanced Care Management paperwork, and pediatric formulary changes. • Committee discussed specialist shortages and long wait times for Autism Comprehensive Program at two Health Networks (UCI and CHOC). Remediation with exploring partnerships (e.g., Miller Children's); improve care coordination. CalOptima Health is working with health networks to address specialist shortages and improve access, with updates expected at future meetings.

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

Attachment

Approved at QIHEC throughout Q2 2025: Second Quarter 2025 QIHETP Work Plan 2Q

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	Marsha Choo	Gloria Garcia	Quality Improvement	The 2025 QIHETP Description and Annual Work Plan was presented and approval by the BOD on 04/3/2025.	The 2025 QIHETP Description and Annual Work Plan was adopted by BOD on 4/3/2025	Copy of the document was posted on CalOptima Health Website.	None	Implementation and tracking of the QIHETP Description and Work Plan; QIHEC overisight of actiview through regular updates.	On Target
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	QIHEC: 02/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Marsha Choo	Gloria Garcia	Quality Improvement	2024 QIHETP Description and Work Plan Evaluation was presented and approved at the BOD	Evaluation of the 2024 QIHETP Description and Work Plan was completed and presented to BOD on 4/3/2025	Copy of the document was posted on CalOptima Health Website.	N/A	N/A	On Target

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
					Q4 of 2025 and approved in Q1 2026.					on 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	Kelly Giardina	Stacie Oakley/Jennifer Harlow	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 BOD on 4/3/2025	The 2025 Integrated Uitlization Management and Case Management Program Description was aprpoved by the BOD on 4/3/25	None	N/A	Continue with plan as defined for 2025	On Target

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	Kelly Giardina//Jennifer Harlow	Stacie Oakley	Utilization Management	The 2024 Integrated UM CM Program Description was presented to the Committee's/BOD as idnicated 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	N/A	Continue with plan as defined for 2025	On Target
5	Program Oversight		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	Katie Balderas	Barbara Kidder	Equity and Community Health	2025 PHM Strategy and Work Plan were approved at the April 3, 2025 Board of Directors meeting	Approval was received	Implemented the progression of approvals	N/A	Implementation and tracking of the PHM Strategy and Work Plan	On Target

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		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	Katie Balderas	Barbara Kidder	Equity and Community Health	2024 PHM Evaluation was approved at the April3, 2025 Board of Directors meeting	Approval was received	Implemented the progression of approvals	N/A	N/A	On Target
7	Program Oversight		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	Albert Cardenas	Carlos Soto	Customer Service/Cultural and Linguistic Services	The CLAS Description was approved by QAC and the Board Of Directors on 4/3/25.	The CLAS Description was approved by QAC and the Board Of Directors on 4/3/25.	The QAC bookmarked version was sent to HMA for review and feedback.	No barriers have been identified.	The QAC bookmarked version was sent to HMA for review and feedback.	On Target

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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
8	Program Oversight		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	Albert Cardenas	Carlos Soto	Customer Service/Cultural and Linguistic Services	The CLAS Description was approved by QAC and the Board Of Directors on 4/3/25.	The CLAS Description has been approved by QAC and the Board Of Directors.	The bookmark CLAS Evaluation, will be forward to HMA for review and feedback.	No barriers have been identified.	The bookmark CLAS Evaluation, will be forward to HMA for review and feedback.	On Target
9	Program Oversight		**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	Katie Balderas	Barbara Kidder	Equity and Community Health	1.The Q2 2025 PHM Committee Meeting was held on May 15, 2025 which included both internal CalOptima Health updates on the Health Education, Care Management, and Complex Case Management. 2.Community spotlight presentation was from the Council on Aging. 3.Committee reviewed and	Committee recommended: 1. Exploring opportunities to increase accessibility and community engagement: •Host community classes in PCP offices •Collaborate with local school districts 2. Revising and shortening member satisfaction surveys to increase response rates	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 August 2025.	On Target

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					quarterly meetings 4. Report PHMC activities to the QIHEC quarterly.					approved: • Q1 2025 PHMC Meeting Minutes • 2025 Population Needs Assessment 4.Provided PHM Committee update for QIHEC in May 2025.	3. Explore additional analysis on hyperlipidemia diagnosis amongst Vietnamese population.				
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	CPRC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Laura Guest	Rick Quinones Katy Noyes	Quality Improvement	The Committee met on 04/24/2025, 05/22/2025 and 06/26/2025 .On 04/25/2025, there was a Closed Session meeting for the physicians to meet with a physician as part of the Fair Hearing process.	Three physicians (Ob/Gyn, PM&R & NS) continued under the Fair Hearing process. One physician (PM&R) was changed to Probation after meeting with him. A fourth physician (PM) was started on the Fair Hearing process. Ten PQI cases were presented	PQI and Credentialing implemented plans to reduce it's backlog.	Need to have a new Ob/Gyn physician added to the Committee since an Ob/Gyn was removed from the Committee last year due to his retirement.	A new Provider Life-Cycle system for credentialing will be implemented in Q3.	On Target

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					meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.						to CPRC for leveling and actions; three level 3, seven level 2, no level 1. There were three physicians with issues presented for re-credentialing; three presented for credentialing all for the CCN network.All were recommended for credentialing/recredentialing except for one PM physician who was recommended for termination. Credentialing statistics were presented which showed that close to 1100 providers were credentiale				

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											d in Q1; 3 recreds were > 180 days.The following policies were presented and approved: GG.1605, GG.1607, GG.1611, GG.1616, !!.1651, GG.1657 and GG.1658. The credentialing clean lists and closure lists were presented and approved.				
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	GARS Committee Report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Heather Sedillo	Ismael Bustamante	GARS	1) MC and OC grievances resolved timely 2) MC and OC grievances resolved timely	Grievances: Provider/Staff Attitude related to access for appointments and telephone accesibility. Appeals: Acess to specialty care.	1) Tracking and trending of specific providers quarter over quarter.	No specific barriers identified.	1) Tracking and trending of specific providers quarter over quarter.	On Target

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					results are presented by product time to the committee quarterly. 3. Committee 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	Vacant	Carol Matthews/Helen Syn	Quality Analytics	Committee met on 4/15/2025. Meeting minutes from the 1/28/25 meeting were deferred. Regulatory updates were presented: annual network certification, subcontracted network certification, network adequacy, timely access, UM and CAHPS improvement update.	QIHEC accepted the MemX update without further questions feedback.	Continue as planned.	Low customer service scores	CS identify ways to gather specific individual member feedback for members giving low ratings for customer service	On Target

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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.					A MemX update was provided to QIHEC on 6/10/25.					
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	UMC Committee report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Kelly Giardina//Jennifer Harlow	Stacie Oakley	Utilization Management	The UMC met on 5/22/25 & reviewed Q1 2025 over/under utilization patterns. Meetings minutes are drafted & will be approved at the 8/21/25 meeting. UM Leadership will report Q1 2025 findings to the QIHEC on 9/9/25	Medi-Cal Expansion & TANF18+ readmits above goal. TANF under 18 bed days & admits above goal. ED utilzation across all aid codes remains stable with little change. Inpatient & prior authorizatio n turn around time goals met, above 95% compliant. NEMT - Since April	Continue to monitor, track and trend utilization.	None	Continue with plan as defined for 2025	On Target

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					quarterly. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.						2024 there has been over 2K rides/day.				

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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.	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	Thanh-Tam Nguyen, MD/Hannah Kim	Gloria Garcia	Medical Management	WCM CAC met 5/13/2025. Approved 2/18/25 meeting minutes. Presented follow up on timely Access Data	Met goals for Health Network Adequacy Turn Around Time (TAT) and other Whole Child Model measures except Timely Acess.	Reviewed data and discussed: WCM Network Adequacy,Timely Accesss, Grievances and Appeals, Adverse Childhood Experiences (ACEs), Member Inquiries, Mental Health Utilization, BH Quality Measures, Student Behavioral Health Incentive Program, Pediatric California Advancing & Innovating Medi-Cal, and Pharmacy.	1) Network Adequacy and the lack of certain specialist providers. 2) Whole Child Model case managed members and Enhanced Care Management overlap. 3) Identify challenges related to the reinstitution of prior authorization for Pediatrics	1) Address with CalOptima Health leadership HN Adequacy for specialist serving the aging out WCM members and Timely Access issues. 2) Examine ECM population criteria and Care Coordination; Follow WCM regulatory requirement. 3) Report challenges related to Medi-Cal Rx prior authorization requirement for pediatric Rx. 4) Autism Comprehensive Program	On Target

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														update scheduled for the 8/19/25 meeting.	
15	Program Oversight		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	Megan Dankmyer/Hannah Kim	Sherry Hickman	Medical Management	Report on the following activities: 1. Basic PHM/CM 2. Early and Periodic Screening, Diagnostic and Treatment	Interventions and activities were completed for the quarter.	Report on the following activities: 1. Basic PHM/CM: Ongoing Health Risk Assessments are shared with Primary Care Physician. 2. Early and Periodic	None	Report on the following activities: 1. Basic PHM/CM: Continue sharing Health Risk Assessments with Primary Care	On Target

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										(EPSDT) CM:		Screening, Diagnostic and Treatment (EPSDT) CM: a. Continue meeting in workgroup and review necessary oversight of PSDT services. b. Preparation for texting campaign to members overdue for vision, dental, and hearing screening. c. Ongoing monitoring with Utilization Management and each Health Network to review EPSDT d. Behavioral Health Integration review of depression and developmental screening codes for oversight needs.		Physician. 2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM a. Continue meeting in workgroup and review necessary oversight of PSDT services. b. Texting campaign to members overdue for vision, dental, and hearing screening. c. Ongoing monitoring with Utilization Management and each Health Network to review EPSDT	

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16	Program Oversight	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 all Health Networks 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) 3. Ongoing training and support for new and existing staff. (Goal 2) 4. Continue to gather member feedback to improve outcomes. (Goal 3)	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Hannah Kim	Diana Tep	(1) Seven out of the nine Health Networks achieved a score of 90% or higher (Goal 1). (2) A total of 51 members were surveyed. All questions from the member satisfaction survey met the 85% benchmark (Goal 2). (3) 98% of the members surveyed found the case management process helped them meet their care plan goals (Goal 3).	Goal 1 did not meet for Q2 as two Health Networks did not achieve a score of 90% or higher. Goal 2 and 3 met.	1) Continue training and educational opportunities to staff on 2025 PHM Element D/E and complex conditions/ situations. (Goal 1) a. Element D/E training for WCM CCN on 5/12/2025, 5/14/2025, and 5/20/2025 2) Member Satisfaction s Survey (MSS) scores will be shared with CCN and the health networks to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care,	Goal 1: Staff training needed for Elements D and E.	Conduct and report on the following activities: Goal 1. a. Continue training and provide educational opportunities to all Health Network staff on the 2025 PHM5 Element D and E and complex conditions. Goal 2 a. Member Satisfaction scores will be shared with all Health Networks to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care, and member outcomes, and improve the member experience in CCM program. b. Continue to gather feedback from MSS to strategize on improving outcomes and	Concern	16	Program Oversight

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										member outcomes, and improve the member experience of the CM programs. (Goal 2) a. MSS score shared during the Clinical Ops meeting with the Health Networks on 5/15/2025 and in the CCN CM department meeting on 6/25/2025. b. Ongoing training and support for new and existing staff. (Goal 2) c Continue to gather feedback from MSS to improve outcomes. (Goal 2) d Meeting held with QI Nurse and		share in quarterly meetings with leadership. c. Continue training and support for new and existing staff. Goal 3 a. Continue Member centric care plan training and support for all Health Network staff.			

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										leadership on 5/5/2025 to discuss Q1 MSS results. Additional meeting held on 5/19/2025 with QI Nurse, Data Analyst, MA, and Leadership to discuss ways to improve the survey and engage the members in completing the MSS. 3) Training and education on member centric care plans. (Goal 3) a. Care plan training for CCN conducted on 4/18/2025, 6/25/2025, 6/27/2025.					

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17	Program Oversight		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 3. Collect quarterly progress reports from PHM Work Plan implementation owners	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Katie Balderas/Megan Dankmyer	Barbara Kidder	Equity and Community Health	1. 2025 PNA was presented at the May 15, 2025 PHMC meeting and was approved; submitted 2025 PNA as NCQA accreditation evidence 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. Review and approval of 2025 PNA 2. N/A- work in progress 3. Quarterly reporting and tracking is in progress	N/A	1. Monitor 2025 PNA feedback survey 2. Continue implementing the 2025 PHM work plan 3. Continue monitoring progress	On Target
18	Program Oversight		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	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Katie Balderas	Elisa Mora	Equity and Community Health	1. Two-Way Text Campaign: 18,693 diabetes members and 16,106 asthma members were contacted through two-way text messages. 2.	1. Increased Reach Through Text Campaigns: • Text messages are sent to members with diabetes and asthma, allowing them to opt	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	There have been ongoing issues with staff not being able to launch the text message satisfaction survey. Issue is	Continue to implement activities and monitor outcomes.	On Target

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					Management interventions. 3. Use multimodal methods of outreach to identify members in need of Disease Management services and reduce cold calls. 4. Integrate new methods to measure and improve member satisfaction.					Stratification Criteria Revision to better target low to moderate-risk members and avoid duplicative outreach is in progress. 3. Disease Management Satisfaction Survey: survey is text-based and delivered to members via text after follow-up session. Survey received 119 responses out of 278 texts.	in to health coaching services. This approach has increased enrollment rates compared to traditional cold calls. 2. Real-Time Feedback Improves Response Rate: •The Disease Management Satisfaction survey received responses in just 2 months that accounted for over half of the previous annual total (100), indicating a likely improvement in response rates using this new survey method. Notably, within 4	other departments and improving visibility of care gaps across Disease Management interventions. 3. Expansion of Disease Management Satisfaction Survey: Planning to supplement with a paper survey included in the education packet sent by health coaches following telephonic outreach.	being addressed by vendor. A process has been established to ensure that text messages are not sent to the same members on a monthly basis.		

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											months of implementing the text message-based surveys, the number of responses has already surpassed the total received in previous years, further demonstrating the effectiveness and efficiency of this new approach in engaging participants.				
19	Program Oversight		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.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Katie Balderas	Thanh Mai Dinh	Equity and Community Health	1. 1,536 referrals for health education services were received for Q2. There was as slight drop from 1,566 in Q1. 2. 40 virtual and in person Shape Your Life classes	Pilot results for adult Vietnamese virtual classes yielded no participants despite different days and time options. Virtual classes as a primary referral outcome is not realistic for	1. May: Two-way text campaign inviting members to the new virtual adult hypertension class was launched to 30,799 Medi-Cal members ages 18+ with an email address on file (English-20,657 and Spanish-10,142). 2. Virtual adult classes were scheduled and	Some barriers in referring members to the virtual classes include: •availability of virtual classes are not convenient to some members •some	Pilot 2 text campaign approaches to see which one has a larger engagement rate. In July 2025, 97,000 adult Medi-Cal members will be randomly divided into two	On Target

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					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).					were completed. 188 participants attended sessions successfully. 3. 10 virtual and in person Adult Healthy Living one-time classes were completed in English, Spanish and Khmer. 117 participants attended sessions successfully. 4. 17 virtual and in person Adult Hypertension one-time classes were completed. 89 participants attended classes successfully.	members with low digital literacy.	launched for monthly hypertension and bi-monthly healthy living one-time classes in both English and Spanish, and added to the Events page on the external website. 3. Two in person presentations on healthy living and heart health were provided in Khmer at Cambodian Family Center in April and June in Santa Ana . 4. One in person presentation on hypertension was provided in Vietnamese and Spanish at Southland Integrated Services clinic in Garden Grove. 5. One in person presentation on adult healthy living was provided at Ready Set OC in Los Alamitos. 6. Two mini	members do not have email addresses •digital literacy fluency is low to none for members who do not have home internet service or smart phones	groups. One group will receive a text with the Zoom link to an adult healthy living virtual one-time class in English or Spanish. The other will receive a two way text inviting them to click the next screen in order to get the link for the virtual class.	

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												hypertension presentations were provided at our May BP Screening event at PACE in English and Spanish.			
20	Program Oversight		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	Mia Arias	Andrew Kilgust	Medi-Cal and CalAIM	1. The CalAIM Team is currently in the process up creating audit templates for the Housing trio of community supports. Most recently, the team created program templates for these services which are required to be utilized as of 7/1. These templates will assist in	No findings to report.	Activities included reasearching and developing a housing assessment and housing support plan template. A draft of these documents were provided to contracted housing providers to collect feedback and input. Much of the feedback was incorporated into the final templates. In addition, the 3rd Cohort of the ECM Academy launched in April 2025 with	None.	Continue to research and develop documents and tools for implemetation of the audit of housing community supports. Use feedback from providers on implementation of the new housing templates to continue to refine	On Target

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										monitoring and auditing these services. 2. From January 1, 2025 - May 31, 2025, 6,984 members have received ECM services.		12 providers which will be contracted in December 2025 to provide ECM services.		and update those documents if neccessary.	

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21	Program Oversight		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	Nicole Garcia	None	Medi-Cal and CalAIM		a. MSS score shared during the Clinical Ops meeting with the Health Networks on 5/15/2025 and in the CCN CM department meeting on 6/25/2025.	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 delivery. ▪ Document all encounters. Goal 3: ▪ Outreach to	While all goals were met, affordable, permanent housing opportunities continue to be scarce.	Continue to offer street medicine services in the three identfied service areas.	On Target

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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							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			

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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	Scott Robinson	Cathy Osborn	Long Term Support Services	CalAim TAT: 99.28%, CBAS Inquiry to Detrmination: 100%, CBAS TAT 99.76%, LTC TAT 99.40%	All programs are compliant	Continuous monitoring of daily staff capacity and productivity. Workloads are shifted to staff with capacity as needed.	None	Continue daily stand-up meeting to assess and intervene workloads as needed.	On Target
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	Stacy Baker	Zulema Gomez John Robertson	Delegation Oversight	Annual oversight audit completed (April 14, 2025) for Children's Hospital Orange County (CHOC)/Rady's Children MSO	Delegate monitored: Children's Hospital Orange County (CHOC)/Rady's Children MSO Areas Assessed: • Case Management • Claims • Compliance • Credentialing	Delegate: • Children's Hospital Orange County (CHOC)/Rady's Children MSO Corrective Action Plan(s) Issued: * Utilization Management (Medi-Cal): Status - Accepted	None	Focused Monitoring for three months until CAP is closed	On Target

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											• Customer Service • Provider Network Contracting • Provider Relations • Sub-Contractual •Utilization Management				
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	Marsha Choo	Veronica Gomez Guy Todd Britney Warren	Quality Improvement	**1) Health Plan Accreditation:** **QI:** 2025 QI program ready for submission ; Q1 of QI Work Plan completed (Q2 will be available 8/1), 2024 QI Eval is ready for submission **UM**: We received and approved 2025 UM/CM Program descriptions, 2024 UM Evaluation, 2024 IRR analysis reports, reviewed	Health Equity and Health Plan accreditation document collections are currently underway, with look-back periods starting on April 6, 2025 (HPA) and April 7, 2025 (HEA). 1) **HPA Accreditation:** There are 6 domains (QI1A-QI4D), UM (UM1A-UM13D), NET (NET1A-NET6D), PHM	**1) Health Plan Accreditation:** - Continue collecting documents due in 3Q2025. - QI/Consultants: We will conduct CR training with our delegates on July 11, 2025and a second training will be held for those who can't attend. - Perform another internal BH denials mock audit to determine if the findings from the 2024 audit have been addressed. - The Quality	A current barrier has been identified for both Health Equity and Health Plan Accreditation. There may be a minor point loss if this issue is not addressed. Specifically, the Delegation Agreem	**1) Health Plan Accreditation (HPA):** - Continue collecting documents required for Year One (April 2025 - April 2026). - Conduct CR training with our delegates on July 11, 2025. A second training will be held for those who can't attend. - Perform another	On Target

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										and approved articles scheduled to go out in 4Q on Annual Member newsletter, Policies reviewed by consultant, 2Q2025 external board certification consultant review cases, April 2025 CalOptima Health dated screenshots were completed by end of April. **NET:** Report templates and training with stakeholders were held before the start of the look-back period. Several reports were written in June and	(PHM1A-PHM7D), CR (CR1A-CR9D), MEM (ME1A-ME8D). A total of 29 policies are required to meet specific domains for HPA accreditation. All policies have been reviewed by a consultant and are on track to meet the year-one look-back period (April 2025 to April 2026). Required programs, including Quality Improvement (QI), Utilization Management (UM), Care Management (CM), and Population Health Manageme	Improvement Department, Contractingand Customer Service are working with Contracting and consultants to address the delegation of interpreter services and translation services in the delegation agreements. Policies may need to be updated to fill gaps. 2) **Health Equity Accreditation:** - Continue to work with stakeholders to finalize a few open items. - We will review each domain/area with executive leadership and start uploading final approved documents via the NCQA Submission Tool. Our scheduled submission date is October 7th. - The Quality Improvement	ents are missing provisions for the delegation of Interpreter Services and Translation of Written Materials (Sight). The Quality Improvement team is collaborating with Contracting, Customer Service, and a consultant to make the necessary edits before the Health Equity submission deadline on	internal BH denials mock audit to determine whether the findings from the 2024 audit have been addressed by the end of August 2025. - The 2026 HPA Standards are scheduled to be released in August 2025. Will conduct a webinar to go over changes from 2025 to 2026. **2) Health Equity Accreditation (HEA):** - Close out any open deliverables before the October	

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										are currently going through final revisions. Policies were reviewed by the consultant and the April 2025 CalOptima Health dated screenshots were completed by the end of April. PHM: PHM strategy approved, Multiple Chronic Conditions Program Approved, Population Assessment Approved, Health Appraisals & Managment Tools Approved. Pending delegation currently at 80% completion. **CR:** HMA reviewed and	nt (PHM) Strategy, have been reviewed by a consultant and received final approval by the Board in April 2025. NCQA Program Managers are collaborating with stakeholders to collect the necessary documents to fulfill year one of the look-back period, including reports, DTPand communications for both members and providers. We have several reports that are due by the end of June. 2) HEA Accreditatio	Department, Contracting, and Customer Service are working with Contracting and consultants to address the delegation of interpreter services and translation services on the delegation agreements. Policies may need to be updated to fill gaps.	October 7th.	submission. - HEA submission is scheduled for October 7, 2025. The final review and document loading should be completed by the end of August 2025 - Introductory call with the Accreditation Survey Coordinator (ASC) is scheduled for July 22, 2025. - Submission of the delegation worksheet, and introductory call form	

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										approved required policies, ongoing monitoring Grid approved by consultant, April CPRC meeting minutes approved by consultant. **MEM: Pending 9 documents & delegation docuements currently completion rate is at 70%** Consultants received 49 additional documents, all of which were reviewed in a timely manner. **2) Health Equity Accreditation:** HE1: Ready for submission; HE2: Pending HEDIS	n: Health Equity Accreditation has seven domains (HE1-HE7). We have a few domains with open items (HE2B/C, HE6 A, and D). HE 2 and HE 3 are almost complete; the HE6 team is waiting for reports in June (HEDIS reports and member and staff surveys).				

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										Reporting. then will be ready for submission ; HE3: Ready for submission . HE3C waiting on one deliverable which is currently under consultant review; HE4: Ready final executive leadership review and submission .; HE5: Ready final executive leadership review and submission ; HE6:Pending HEDIS Reporting. then will be ready for submission ; HE7:Delegation agreements is being reviewed, meeting with consultant, Customer service,					

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										and Contracting to align evidence with the delegation of Interpreter/ Language assistance delegation. The total number of documents reviewed as of June is 79, and the consultant received one additional inquiry. **As of today our NCQA Score is 70.97% out of possible 100%, we must meet 80% be be accredited .**					

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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	By December 2025 Report program update to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 05/13/2025 Q3: 07/08/2025 Q4: 10/07/2025 11/04/2025	Paul Jiang / Vacant	Kelli Glynn	Quality Analytics	1. Prospective rate reports are generated monthly for overall CalOptima Health, CCN-specific performance, for all HN partners, and for CHCN providers. 3. The QA Strategy team reviews changes in rates at the measure level for both lines of business after each monthly refresh and identifies new improvement activities as needed, or collaborates with the HEDIS team if there are suspected data issues.	PJ: FUA-30day is at the 25th percentile and it is at the risk for not meeting the MPL. FUM-30day is at the 25th percentile and it is at the risk for not meeting the MPL. PPC-postpartum is below the 25th percentile and it is at the risk for not meeting the MPL.	Continue with plan as listed	Lack of automation of prospective rate report process, and some delays with CitiusTech refreshing (e.g. May 2025 data not available until July 2025).	Automation of the prospective rate report process. Implementation of Hyperlift to monitor Stars performance.	On Target

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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	Linda Lee	Paul Jiang	Quality Analytics	1. Monthly prospective rate reports provided to all HN partners via email. Member-measure level gap in care reports provided monthly to all HN partners via sFTP.	data collection in progress	Automation of monthly reports in development	1. Lack of automation of HN summary reports requires manual formatting and submission; this process takes one business day to complete across multiple FTEs.	Complete reporting of annual audited plan-level rates. Prepare HN and CHCN provider-level rates.	On Target
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	Marsha Choo	Katy Noyes	Quality Improvement	Site Review, PARS, Community-based Adult Services (CBAS), and Nursing Facilities (NF) Oversight: A. FSR: Initials FSRs=11; Periodic FSRs=47; On-site Interims=2	FSR/MRR: The number of Periodic and Initial FSRs completed increased slightly from Q1 2025 to Q2 2025. The number of Periodic FSRs completed timely increased slightly from 92% in Q1 2025	Provide extensive educational support and technical assistance to sites. This includes but is not limited to review of DHCS FSR and MRR Tools and Standards, U.S. Preventive Services Task Force (USPSTF) A&B recommendati	N/A	Continue to implement work plan.	On Target

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										9; Failed FSRs=2 B. MRR: Initial MRRs=4; Periodic MRRs=42; Failed MRRs=6 C. CAPs: Critical Element (CE)=42; FSR=51; MRR=55 D. PARS: Completed PARS=63; Basic Access=28 (44%); Limited Access=35 E. CBAS Oversight: Critical Incidents=20 (14 COVID); Non-Critical Incidents=8; Falls=12; Audits Completed =11; CAPs Issued=8; Unannounced Visits=0 F. NF Oversight: Critical Incidents=; On-Site Visits=21;	to 93% in Q2 2025. The number of Periodic and Initial MRRs completed decreased from Q1 2025 and Q2 2025. The number of failed FSRs decreased from 3 in Q1 2025 to 0 in Q2 2025. The number of failed MRRs decreased significantly from 19 in Q1 2025 to 6 in Q2 2025. CAPs: The number of CE CAPs issued increased from 33 in Q1 2025 to 42 in Q2 2025. The number of FSR CAPs issued increased from 43 in Q1 2025 to 51 in Q2 2025. The	ons, the American Acedemy of Pediatrics (AAP) periodicity schedule, most current adult and childhood vaccination recommendations from Advisory Committee on Immunization Practices (ACIP). Additionally, a hard copy provider audit packet it sent out to sites before every periodic audit. The packet includes resources to help providers achieve a safe and effective provision of primary care services, to ensure and support the quality of care and documentation of appropriate clinical services, and to improve overall member health outcomes.			

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										Unannounced Visits=0	number of MRR CAPs decreased from 61 in Q1 2025 to 55 in Q2 2025. PARS: The number of PARS completed increased significantly from 74 in Q1 2025 to 169 in Q2 2025. The number of PARS with BASIC access decreased from 51% in Q1 2025 to 40% Q2 2025. CBAS Oversight: The number of Critical Incidents reported increased significantly from 1 in Q1 2025 to 20 in Q2 2025. The number of Non-Critical Incidents reported decreased greatly from 42 in				

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											Q1 2025 to 20 in Q2 2025. The number of Falls reported decreased slightly from 15 in Q1 2025 to 12 Q2 2025. The number of audits completed increased from 8 in Q1 2025 to 11 in Q2 2025. The number of CAPs issued increased from 6 in Q1 2025 to 8 in Q2 2025. NF Oversight: The number of Critical Incidents reports received increased from 7 in Q1 2025 to 20 in Q2 2025. The number on on-site visits completed increased				

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											from 16 in Q1 2025 to 21 in Q2 2025.				
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	Marsha Choo	Laura Guest	Quality Improvement	Ten PQI cases were presented to CPRC for leveling and actions; three level 3, seven level 2, no level 1. We closed 321 PQIs in Q2, opened 185 cases and have a total of 363 cases open at the end of Q2.	The number of PQI's closed in Q2 increased significantly due to the PQI Backlog Project in collaboration with the medical directors. We had a higher number (99) of cases opened in April due to Customer Service finding more declined grievances and nursing facilities submitting critical incident	Changes implemented as a result of updates to policy GG.1611 and the Backlog Project: 1)Two nurses may close a PQI to QOS, 2)Nurses are reviewing the provider response to QOC grievances and determining if it is QOS at that time, 3)Nurses are waiting 2 weeks after the grievance closes for the provider's response before opening a PQI, 4)We had the first meeting of the Provider Action Workgroup to address service issues	1)The Provider Action Workgroup is still in development so no actions have been initated as yet, 2)There are still 363 PQIs opened; we'd like to get that number under 200.	1)Hold monthly meetings of the Provider Action Workgroup to develop policy, charter and implement actions on providers reviewed. 2)Implement a nurse in GARS to review grievances when received to determine if QOC to further help to reduce the volume of PQIs	Concern

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											reports in mass.	organizationally. 5)We began presenting a report of all PQIs closed in previous month.		being opened.	
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	Marsha Choo	Rick Quinones	Quality Improvement	Initial BH Credentialing Q2 = 2291 Initial CCN Credentialing Q2 = 282 BH Recredentialing Q2 = 56 CCN Recredentialing Q2 = 122	Initial/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 have also contracted wiith Salesforce, a vendor to support the end to end functions of multiple	We implemented a Backlog project from Feb-June which required help from other depts per leadership's request.	N/A	Hired two FTEs (Program Specialist and Program Coordinator)	Concern

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											departments.				
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 Face interactions	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Megan Dankmyer	Sherry Hickman	Medical Management	Percent of Members with Completed HRA through 6/30/2025: 49.01% Percent of Members with ICP through 6/30/2025: Initial ICP 73.6% Annual ICP 95.2% DHCS ICP reporting for Q12025 at 79.3%	1. Identified 62 OC members from Q3 2024 through Q2 2025 who did not have ICP completed timely due to	Assess and report the following activities: 1. Network communications: Revised layout for monthly communication Implemented in June 2025. 2. DCHS Reporting: a. DHCS HRA1--This DHCS reporting has been sunset and no longer reported in 2025. b. DHCS ICP1-Q1 2025: 772 of 973 members had ICP developed within 90 days of eligibility for	2. Members who are unable to contact or decline both the HRA and the ICP.	Assess and report the following activities: 1. Ongoing communication with Health Networks on ICP development. 2. Ongoing assessment and reporting of DHCS quarterly ICP reporting (Q2 2025) 3. Ongoing assessment and reporting	Concern

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												79.3% 3. HRA Star Status: Percent of Members with Completed HRA days through 6/30/2025: 49.01% 4. MOC Updates: No updates 5. Face to Face Interactions with PCP or specialist: 67% at end of Q2.		on HRA Star Status. 4. Ongoing assessment and reporting for MOC updates. 5.Ongoing assessment and reporting for Face to Face interactions.	

31	Quality of Clinical Care		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	Vacant	Kelli Glynn/Leslie Vasquez	Quality Analytics	Data through May 2025: CIS: 24.6% IMA: 40.7% W30 (6 or more visits): 29.03% W30 (2 or more visits): 64.12% WCV: 19.03% LSC: 66.58%	CIS: already achieved the 33rd %ile and performing significantly higher as compared to same point in time last year (19.52% in May 2024) IMA: already achieved the 50th %ile and performing higher as compared to same point in time last year (37.66% in May 2024) W30: both sub measures are performing higher as compared to same point in time last year (28.1% and 61.31% respectively, in May 2024) WCV: performing higher as compared	Ongoing outreach to parents / guardians / members via Carenet (telephonic) and Ushur (SMS). Creation of a personalized pediatric mailer. One-time telephonic outreach via Carenet to members that are aging in. Vaccine hesitancy presentation to MAC/PAC.	HEDIS engine does not provide all necessary data elements for personalized outreach; creating in-house reporting with Financial Analysis.	Continue with plan as listed and pursue automation where possible. Leverage the upcoming Cozeva PayerOne solution to provide HN and CHCN provider partners with more detailed data for CIS and W30.	On Target

					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						to same point in time last year (17.43% in May 2024) LSC: already achieved the 50th %ile and performing higher as compared to same point in time last year (63.28% in May 2024)				

					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	Vacant	Melissa Morales/Dexter Dizon/Kelli Glynn	Quality Analytics	Cervical Cancer Screening (CCS) MC:43.97 % Colorectal Cancer Screening (COL) OC: 59% Breast Cancer Screening (BCS) MC: 47.21% OC:57% Immunization Status - Flu, Pneu, Tdap, Zoster (AIS-E) MC Flu Total: 17.12% OC Flu Total: 42.39% MC Pneumococcal 66+: 38.05% OC Pneumococcal 66+: 47.31% MC Tdap Total: 37.99% OC Tdap Total: 42.84% MC Zoster Total: 17.69% OC Zoster	CCS MC: A 5.7 percent point increase compared to May 2024 COL OC: A 7 percent point increase compared to May 2024 BCS MC: A 34.6 percent point increase compared to May 2024 BCS OC: A 1 percent point increase compared to May 2024 MC Flu Total: A 2.79 percent point increase compared to May 2024 OC Flu Total: A 3.14 percent point increase compared to May 2024	Breast Cancer Screening Text Campaign (MC: 75,000) Cervical Cancer Screening Text Campaign (MC 90,000) Colorectal Cancer Screening Text Campaign (MC 90,000) CareNet Live Call campaign for CCS, MC and OC BCS, MC and OC COL Mobile Mammography Events Flu Thank You Postcard Care gap member outreach to commence Q3 and Q4	None identified.	Continue Mobile Mammography Events Continue CareNet Live Call Campaign Q3/Q4 Initiate 2025 Cologuard Campaign Standing Order telephonic and mailing member outreach for BCS Continue Flu Postcard for members TBD Q3/Q4 Relaunch IVR robocall campaign TBD Q3/Q4 Relaunch Texting Campaign TBD Q3/Q4	On Target

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					Colorectal Cancer Screening 7. Implement a comprehensive outreach strategy utilizing multiple modalities (e.g. mail, SMS, IVR, email, telephone)					Total: 25.81%	MC Pneumococcal 66+: A 7.37 percent point increase compared to May 2024 OC Pneumococcal 66+: A 0.33 percent point decrease compared to May 2024 MC Tdap Total: A 19.55 percent point increase compared to May 2024 OC Tdap Total: A 21.89 percent point increase compared to May 2024 MC Zoster Total: A 5.42 percent point increase compared to May 2024				

											OC Zoster Total: A 7.56 percent point increase compared to May 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	Dr. Richard Pitts	Joanne Ku	Medical Management	1. Conducted an in-person grantee meeting to review Progress Report #2. 2. With the new HEDIS engine implemented, developed the FQ grantee dashboard showing baseline, progress during the current reporting period, and the number of additional members they need to screen to achieve their grant goal (using prospective data). 3. mPulse (texting campaign): Launched the 2-way texting campaigns: -Breast Cancer Screening	Based on observations and feedback from grantees, the workgroup identified the following challenges: 1. Need to account for "ramp up" and hiring. 2. Most payments are in arrears. 3. Frequent reporting and out of sync with calendar year. 4. Challenge in using HEDIS metrics to evaluate success throughout the process.	Worked with the Senior Director of Grant Programs to identify areas of opportunity and initiated grant amendments to better align with the program's scope: 1. Added a 6-month no-cost extension to the grant program. 2. Increased frequency of payments. 3. Decreased number of reports and sync with calendar year. 4. Added volume of screenings objectives based on attempted HEDIS improvements. Distributed the dashboard to the FQ grantees for monitoring and reference purposes.	1. Identified a data discrepancy during the amendment process. Need to determine the root cause and find a solution to ensure data accuracy. 2. While the workgroup actively worked on refining the scope of work for the Research & Evaluation initiative, the focus has shifted significa	1. Execute grant amendments with all 13 grantees, including a benchmarking table. 2. Conduct an in-person grantee meeting in August 2025 to review the grantees' progress using the newly formatted progress report template. 3. Meet with KCS and the internal Quality Analytics team to resolve the data discrepancy issue. 4. Continue working on the Research & Evaluatio	On Target

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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
										(unique members: 55,536 | Engagement rate: 22%) -Cervical Cancer Screening (unique members: 81,013 | Engagement rate: 14%) -Colorectal Cancer Screening (unique members: 59,521 | Engagement rate: 14%) Translated trigger responses into threshold languages to obtain more meaningful data.			ntly from the time the initial plan was presented to the Board.	n initiative scope of work and determine the best time to release the RFP.	

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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
34	Quality of Clinical Care		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	Kelli Glynn	Leslie Vasquez	Quality Analytics	PPC Postpartum Care: 65.39% (data through May 2025) PPC Prenatal Care: 81.86% (data through May 2025)	Both measures are performing higher as compared to same point in time last year (May MY2024)	All planned activities are still in progress.	Resource constraints	Continue to partner with the Maternal Health Team.	Concern

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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.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.										

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
35	Quality of Clinical Care		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	Katie Balderas	Ann Mino	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. 3. Implemented stroller walks to include mental health	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.	1. Community Events due to immediate needs when completing mental health screenings that are very difficult in that situation. 2. Community events due to the current community environment and low attendance at events.	N/A	On Target

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										preventative care (physical activity, social interactions, breath work, etc.).					
36	Cultural and Linguistic Appropriate Services		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	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/20/2025	Vacant	Kelli Glynn/Katie Balderas	Equity and Community Health/ Cal AIM/Quality Analytics	PPC Postpartum Care: 57.53% compliance rate for Black members compared to 64.41% compliance rate for the entire PPC population (data through May 2025) PPC Prenatal Care: 78.08% compliance rate for Black members compared to 81.06% compliance	Based on May 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) 24 Black members have open authorization for Enhanced Care Management (ECM) within the Birth Equity Population of Focus in Q2. In that quarter, 3 Black members received doula services, making up 9% of all members who received doula services during the same period. This shows a decrease in utilization compared to Quarter 1 (17.5%). Approval was	1) Limited promotion of Doula Benefit 2) Barriers to data sharing with Black Infant Health and community resources	1) Developing strategy for doula promotion to members. 2) Developing manual workaround until automated data sharing solution is available.	On Target

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
					resource navigation for pregnant and postpartum members.					rate for the entire PPC population (data through May 2025)		obtained from the CalOptima Health Privacy and Security teams to establish member-level data sharing, which will help OC Black Infant Health program with outreach to eligible members. 2) No activities for this quarter. 3) No activities for this quarter.			

37	Quality of Clinical Care		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	Vacant/Katie Balderas	Melissa Morales/Kelli Glynn/ Elisa Mora	Equity and Community Health and Quality Analytics	Eye Exam for Patients with Diabetes (EED) MC:37.64 % OC: 52% Glycemic Status Assessment for Patients with Diabetes (GSD): HbA1c Poor Control (>9%) MC Poorly Controlled (Glycemic Status >9%): 62.73% OC Controlled (Glycemic Status <8%):40%	EED MC: A 2.28 percent point increase compared to May 2024 EED OC: A 1 percent point increase compared to May 2024 GSD MC: A 14.61 percent point decrease compared to x 2024 (lower is better) GSD OC: A 5 percent point increase compared to May 2024	Diabetes Member Outreach text campaign (MC, OC approx. 45,000) CareNet Live Call Campaign for MC and OC HbA1c VSP Eye Exam mailing reminder	None identified.	Continue CareNet Live Call Campaign Q3/Q4 Relaunch Diabetes Texting Campaign Q3/Q4 Exploration of at-home A1c testing with lab partners such as Quest	On Target

					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.										

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
38	Quality of Clinical Care		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	Katie Balderas	Elisa Mora/Joanna Hoffnagle	Equity and Community Health	1. In Q2, 345 members were screened for blood pressure and received education on blood pressure management, including how to measure it properly, through various community events. Of these, 160 were OneCare members. 2. Eleven hypertension classes were held in Q2, with a total attendance of 150 members. 3. A standing order process was implemented to increase access to blood pressure	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.Ongoing training, data	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	A1 Pharmacy initially did not carry the XL blood pressure cuff covered under the medical prescription benefit. To ensure continued support for our members, they established a contract with a different manufacturer that provides the XL cuff under medical Rx coverage.	Continue to track and monitor the use the standing order by CalOptima Health staff.	On Target

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										monitors for CalOptima Health members. A total of 173 CalOptima Health staff were trained on the new process. 4. Since the implementation of the standing order process, a total of 168 blood pressure monitors have been ordered. 5. A presentation on the CBP STAR measure and how to increase blood pressure monitor access for members through the pharmacy and DME benefits took place on 5/1 at the CalOptima	tracking and protocol implementation are necessary steps to operationalize expanded member access.				

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										Health Clinical Ops 2025 Health Network Series (UM/CM) 75 attendees.					

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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
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.Case Management to outreach to noncompliant members via SMS, mail, and/or telephone. 3.ECH 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	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Megan Dankmyer/Kelli Glynn	Sherry Hickman Mahmoud Elaraby	Medical Management (Case Management) /Quality Analytics	The OMW measure is performing signficiantly higher as compared to same point in time last year (May 2025: 37% vs. May 2024: 9%).	The OMW measure is performing signficiantly higher as compared to same point in time last year (May 2025: 37% vs. May 2024: 9%).	1.Case management to collaborate with Quality to identify members who need follow-up: a. Members with OMW will be added to Key Event report through Point Click Care Data. IT TIcket/RITM0043625 2.Case Management to outreach to noncompliant members via SMS, mail, and/or telephone. 3.Quality to pursue at-home DEXA testing via vendor: a. ECH researched in home vendors during quarter 2. 4.Quality to provide timely notifications to the member's PCP via fax. 5.Quality to explore collaboration with the Pharmacy team to provide	1. Some in-home vendors do not meet diagnostic criteria for the Star Measure.	1. Case management will continue to collaborate with Quality to identify members who need follow-up: a. Pending Members with OMW to be added to Key Event report through Point Click Care Data. IT Ticket/RITM0043625 2.Case Managementwill continue to outreach to noncompliant members via SMS, mail, and/or telephone. 3. Quality to	On Target

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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
					timely data and insight to the member's compliance deadline date to Health Network partners.							education on the importance of taking a medication to treat osteoporosis (e.g. bisphosphonate). Discussion in Stars Workstream Workgroup. 6.Quality and Case Management coordinate to provide more timely data and insight to the member's compliance deadline date to Health Network partner: Ongoing in member - measure level files to Health Networks monthly.		continue timely notifications to the member's PCP via fax. 4. Exploration for education on the importance of taking a medication to treat osteoporosis (e.g. bisphosphonate) is currently on hold. Quality will continue to explore potential pharmaceutical intervention in support of OMW. 5. Quality and Case Management will continue to coordinate to provide more timely data and	

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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
														insight to the member's compliance deadline date to Health Network partners	
40	Quality of Clinical Care		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	Megan Dankmyer	Sherry Hickman	Case Management	The FMC measure is performing higher compared to same point in time last year (May 2025 48% vs May 2024 40%)	The FMC measure is performing higher compared to same point in time last year (May 2025 48% vs May 2024 40%)	1. Review and update the Key Events for Emergency Visits: a. IT Ticket RITM0043625 created for additional identification of members who meet chronic condition criteria to be identified as a Key EventType. 2. Continue to share Emergency Visits with Health Networks through Key Event	Key Event reporting lacked visibility for members who met FMC chronic care condition critiera.	1. Review and update the Key Events for Emergency Visits: a. Pending addition of Members who meet FMC criteria as Key Event Type. IT Ticket RITM0043625. 2. Continue to share Emergency Visits with	On Target

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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
												reporting: Ongoing.		Health Networks through Key Event reporting.	
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	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Behavioral Health Integration	APM PR HEDIS Rates Q2 (April): MC: 13.08%	APM PR increased from Q1 (March) to Q2 (April) by 1.67%	APM: 1) Prescribing provider letter finalized 06/09/2025. 2) HEDIS Provider tool tip sheet finalized 06/06/2025. 3) Social Media Post, posted on 04/14/2025. 4) Article for the Fall Member Newsletter approved and going through MMA process. 5) Text Campaign sent out a.) 4/10/2025 - 75 texts sent b.) 5/8/2025 - 52 texts sent 6) Created a Quick Reference Guide (QRG) & Power Point	Barriers include: 1) Unable to do provider outreach due to lack/delayed data.	APM: 1) Continue Text message campaign. 2) Resume mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to providers on a monthly basis. 3) Resume collaboration with Provider Relations to conduct in-person provider outreach	At Risk

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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
					need of screening. 3) Monthly mailing to prescribing providers to remind of best practices for members in need of screening. 4) Send monthly reminder text message to members (approx 600 mbrs). 5) Information sharing via provider portal to PCP on best practices.							Presentation for providers and staff on how to use the Provider Portal. Pending report availability		with top 10 providers on a monthly basis. 4) 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		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	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Behavioral Health Integration	**AMM-Measure retired for MY2025 and MY2026.** DSF-E PR HEDIS Rates Q2 (April): MC: 2.06% OC: 2.48%	**AMM-Measure retired for MY2025 and MY2026.** DSF-E PR increased from Q1 (March) to Q2 (April) by 0.02% for MC and for OC there is no data from Q1 to compare findings for Q2.	**AMM-Measure retired for MY2025 and MY2026.** DSF-E: 1) HEDIS Provider tool tip sheet finalized 06/06/2025. 2) Prescribing provider letter finalized 06/09/2025. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider Portal. Pending report availability	Barriers include: 1) Unable to do provider outreach due to lack/delayed data.	**AMM-Measure retired for MY2025 and MY2026.** DSF-E: 1) Share updated draft of prescriber letter with BHQI workgroup If data is received: a.) Disseminate prescriber tip tool sheet, once Prescriber letter is approved b.) Send out a text message campaign. c.) Resume mailings of Provider materials (Best Practices letter and Provider tip tool	At Risk

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.									sheet) to providers on a monthly basis. d.) Resume collaboration with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis. 2) Schedule listening sessions with Providers to educate/train on how to obtain BH data upon BH reports availability.	

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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
43	Quality of Clinical Care		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	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Behavioral Health Integration	SSD PR HEDIS Q2 (April): MC 42.4% SAA PR HEDIS Q2 April PR: MC 0.52% OC 1.70%	SSD PR increased from Q1 to Q2 by 3.39% SAA PR increased from Q1 to Q2 for: MC by 0.52% OC by 1.70%	SSD: 1) Prescribing provider letter finalized through CAR process on 06/09/2025. 2) Provider tool tip sheet Finalized through CAR process on 06/06/2025. 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) Article for the Fall Member Newsletter approved and going through MMA process. SAA: 1) Prescribing provider letter finalized through CAR process on 06/09/2025. 2) Provider tool tip sheet Finalized through CAR	Barriers include: 1) Member compliance is a challenge with this population 2) Unable to do member mail out due to lack/delayed data.	SSD: 1) Continue tracking members in need of glucose screening test. 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 offices the following: a.) Prescribin	At Risk

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					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.							process on 06/06/2025.. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation for Providers & Staff on how to use the Provider Portal. Pending report availability. 4) Article for the Fall Member Newsletter approved and going through MMA process.		g 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 follow-up. 2) Discussio	

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
														n 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.	

44	Quality of Clinical Care		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	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz / Valerie Venegas	Behavioral Health Integration	FUM PR HEDIS Rates Q2 (April): 30 day-49.6%, 7 day-29.21% FUA PR HEDIS RATES Q2 (April): 30-day: 29.16%%, 7-day:16.17 % FUI PR HEDIS Rates Q2 (April): 30-day: 26.26% 7-day: 8.42%	FUM PR increased from Q1 (March) to Q2 (April) for 30-day by 30.67% and for the 7-day the rate increased by 19.13%. FUA PR increased from Q1 (March) to Q2 (April) for 30-day by 6.74% and for the 7-day the rate increased by 4.32%. FUI PR increased from Q1(March) to Q2 (April) for 30-day by 6.56% and for the 7-day the rate increased by 1.85%.	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) Collaboration with OC HCA and CalOptima IT regarding 837 data exchange 6) Continued Pilot Program with Providence 7) Identified Top ED's based on claiims and encounter report pulled Dec. 2024. 8) Met with High volume ED's. BHI leadership w/ Michelle Evans (UM) co-presented with	1) Delay in receiving supplemental 837 data from OC HCA 2) Member engagement is a challenge with this population.	FUM: 1) IVR calls for members who meet FUM criteria to remind them of the importnace of schedling a follow up appointment after an ED visit. 2) Continue Text Campaign 3) Continue to 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 HEDIS report data via Provider	Concern

					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.							NAMI (NAMI By Your Side)/ Telemed2U to ensure members are connected to services before they are discharged from the ED. Meeting Date Facility 5/8/2025 KPC 5/21/2025 Prime 9) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider Portal. Pending report availability. FUA: 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.		portal. (Pending report availability). 5) Schedule listening sessions regarding how to use data from Provider portal. FUA: 1) IVR and text campaign Pilot will replace the current text campaign in July 2025, this will expand member out reach to include landlines 2) Continue Text Campaign 3) Continue to meet with High volume ED's to ensure members are connected to services before they leave	

												4) Continued sharing FUA data with HN Networks via sFTP. 5) Collaboration with OC HCA and CalOptima IT regarding 837 data exchange 6) Continued Pilot Program with Providence 7) Identified Top ED's based on claiims and encounter report pulled Dec. 2024. 8) Met with High volume ED's. BHI leadership w/ Michelle Evans (UM) co-presented with NAMI (NAMI By Your Side)/ Telemed2U to ensure members are connected to services before they are discharged from the ED. Meeting Date Facility 5/8/2025 KPC 5/21/2025 Prime 9) Created a Quick Reference Guide (QRG) & Power Point Presentation		the hospital by introducing Telemed2U/NAMI By Your Side. 4) Share FUM HEDIS report data via Provider portal. (Pending report availability). 5) Schedule listening sessions regarding how to use data from Provider portal. FUI: 1) Continue to monitor measure on a monthly basis. 2) Continue collaborative meetings between teams to identify best practices to implement.	

												for providers and staff on how to use the Provider Portal. Pending report availability. FUI: 1) Monitoring this measure. 2) Created a HEDIS Provider Tool Tip Sheet.06/06/2025. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider Portal. Pending report availability.			

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45	Quality of Clinical Care		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	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jaylene Ramirez	Behavioral Health Integration	APP HEDIS Rates Q2 (April): MC: 43.94% POD HEDIS RATES Q2 (April): MC:3.62%	APP increased from Q1 (March) to Q2 (April) by 16.46%. POD PR increased from Q1 (March) to Q2 (April) by 0.03%.	APP: 1) HEDIS Provider Tool Tip Sheet Finalized on 06/06/2025. 2) Prescribing provider letter finalized 06/09/2025. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider Portal. Pending report availability POD: 1) HEDIS Provider Tool Tip Sheet Finalized on 06/06/2025. 2) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider Portal. Pending report availability.	APP: 1) We are not able to send out the provider letters, as we are still awaiting their approval. 2) We are also waiting for Citius to display provider data such as address, so that we can begin to send out letters once approved. POD: 1) The barrier with POD is that pharmacy claims data for Medi-Cal	APP: 1) Send out the provider letters. 2) Work on text message to send out to members, possible barrier new APL regarding minor consent. POD: 1) Meet with county to disscus POD data gap issue at the next county collaboration meeting on July 16, 2025.	At Risk

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													members comes through the state; the state pays for those prescriptions. Sometime the claims are not being billed through the state, so if the member is getting their prescription at county, CalOptima Health does not know the process for members to get thier prescription outside of the states coverage.		

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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	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Sherie Hopson	Behavioral Health Integration	N/A	N/A	1) There are no activities to report. SBHIP implementation activities and deliverables are all completed; the last incentive payment was received on April 24, 2025. CalOptima Health earned the entire $25M DHCS allotted incentive funding for Orange County.	N/A	1) At this time there are no follow-up actions.	On Target
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	Kelli Glynn	Dexter Dizon	Quality Analytics	Appropriate Testing for Pharyngitis (CWP) MC Total: 52.67% OC Total: 15.82% Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis (AAB) MC Total: 37.34% OC Total: 25.32%	CWP: A 1.72 percent point increase compared to May 2024 AAB: A 3.03 percent point decrease compared to May 2024	Create provider material on antibiotics avoidance. Identify top 10 lower performing providers.	N/A	Finalize provider communication plan in collaboration with the Quality Medical Director.	On Target

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
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	Dr. Nicki Ghazanfarpour	Dr. Susan Vigil	Pharmacy Management	2Q25 Overview: -Count of Member adherence IVRs: 4,473 -Adherence intervention calls to providers, members and pharmacies (ongoing) from January 2025 to date: 2,114 (42.8%) of the 4,938 prescriptions intervened on were filled after the intervention -Report distribution Health Networks via provider portal (daily refresh); actionable report for networks to conduct outreach Distribution of best practices document to health	CY2025 Star Measure reports unavailable from Acumen for 2Q25. 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.	Concern

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										networks to assist in intervention design -100-day supply conversion program : 230 prescribers outreached , 52 prescribers signed collaborative practice agreement; 67 prescriptions for 42 unique members converted					
49	Cultural and Linguistic Appropriate Services		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	Vacant	Leslie Vasquez/Kelli Glynn	Quality Analytics	10.20% compliance rate for Black members compared to 26.79% compliance rate for the entire W30 population (first 15 months of life) (data through May 2025)	A significant difference in compliance exists for Black members as compared to the performance for the overall population	Telephonic outreach to parents / guardians	1. Contact Information: Bad or disconnected phone numbers continues to be a challenge in the ability to contact members and coordinate care.	To address contact information challenges, outreach staff outreach to the member's assigned primary care doctor and obtain updated contact information, where	Concern

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														feasible. Continue telephonic outreach and explore additional initiatives, such as targeted outreach to pediatricians. Will do so in partnership with health networks and/or primary care providers.	
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	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz/Mary Barranco	Behavioral Health Integration/ Quality Analytics	Baseline Measurement: 01/01/2023 - 12/31/2023 -1.08% Remeasurment 1: 01/01/2024 - 12/31/2024 -2.32%	Percentage has increased by 1.24% during Remeasurment Period 1	1) Continued to receive daily ED report from vendor which contains Real-Time ED data for CCN and COD members. 2) Continue collaboration with telehealth vendor. Vendor to continue ED member outreach and to provide information regarding case managment including ECM and referrals.	1) Coordinating/Engaging internal stakeholder departments due to competing priorities. 2) Given the diagnosis there is difficulty in connecti	1) Continue collaboration with Case Managemnt and Financial Analysis depts to ensure accuracy of internal data and reports. 2) Continue to conduct barrier analysis. 3)	On Target

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					with SMH/SUD.							3) Collaboration with OC HCA and CalOptima Health IT regarding 837 data exchange.	ng with this member populati on. 3) PHI Data Sharing with commun ity partners , for coordina tion of care and outreac h. 4) Lack of data exchang e with the County Mental Health System.	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	Vacant	Melissa Morales/Kelli Glynn	Quality Analytics	Glycemic Status Assessment for Patients with Diabetes (GSD): HbA1c Poor Control (>9%) OC Controlled (Glycemic Status <8%):40%	GSD OC: A 5 percent point increase compared to May 2024	Diabetes Member Outreach text campaign CareNet Live Call Campaign OC HbA1c Report distribution Health Networks via provider portal (daily refresh); actionable report for networks to conduct outreach	None identified.	Continue Emerging Risk project in collaboration with Elisa Mora's team. Exploration of at-home A1c testing with lab partners such as Quest.	Concern
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: 10/07/2025	Quynh Nguyen	Cathy Dela Cruz/ Monair Thith	Provider Data Operations	1. Gap analysis showed Plan level met time or distance standards. It also closed gastroenterology PMR gap. meets	1. Recruiting outreach for Rheumatology, Urology and Neurology coincides already addressed the new	1. PR completed new provider outreach for Rheumatology, Urology, Neurology outreach. 2. PDO launched a new outreach with PR to connect with	1. PR outreach trended on providers either not interested or no longer at the location	1. Review the results of the CCN contracted groups for specified specialties 2. Review/Approved	On Target

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					2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members					standards except for PMR, which shows gaps in Orthopedic Surgery, LMFT and Urology 2. CCN remains the same at 3 gaps for Time/Distance requirements 3. HNs all had time/distance gaps, and 7 new HNs now have 1 PMR gap in Urology	gap in Urology. The results of the outreach did not yield as many new contracted providers as originally hoped. 2. Urology is a new high volume specialty based on 2024 utilization data which is why it's a new PMR gap at the Plan level and 7 of 10 HNs (includes CCN in the count) 3. PMR Gap trended upward with the inclusion of Urology as a new high volume specialty, therefore creating new standard. Time or	all CCN contracted groups to verify that all providers within the group has been submitted to COH for inclusion 3. COH audited and reviewed all HN CAP responses and opened AAS request/ Telehealth to expand member access to care for the purpose of SNC certification.	listed per DHCS FFS database 2. Network Adequacy Workgroup has identified that certain specialties are seeing COH's rates to be lower and therefore not interested in contracting 3. Contracting new providers take multiple months, therefore HNs are not always able to close the gap within 1 quarter.	AAS/Telehealth request from HNs 3. Network Adequacy Workgroup to discuss other solutions to explanding provider network to address gaps	

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											Distance gap trended downward with HNs decreasing gaps from Q1 to Q2, as a direct result of HNs completing CAPs issued for 2024 SNC.				
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 access. 4) Continue to educate providers on	Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/07/2025	Vacant	Helen Syn/Karen Jenkins	Quality Analytics	MY-2024 Appointment Access Results: •One-Care Plan- All provider types met MPL •Medi-Cal Plan- All provider types met the MPL with the exception of Psychiatry ○ Urgent at 55% ○Follow-up at 56%:	2024 non-compliance notifications distributed in Q2-2025: •4 HNs were issued a CAP for not meeting 70% MPL •184 Providers were issued a notice of Non-Compliance •74 Providers were issued a CAP (CAP indicates non-compliance of two or more measures)	CareNet Live Call Campaign for MC and OC HbA1c	•Vendor issues with 2024 data quality and reporting •Threshold too high and monitoring of non-regulatory measures •Timely Access analyst resigned at begging of year	Planning for 2025 Timely Access Survey underway. •Targeting initial fielding to start in August •Currently interviewing for new analyst. •Offering access and appointment training to providers and HNs through our contracted vendor, the SullivanL	On Target

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					timely access standards 5) Develop and/or share tools to assist with improving access to services.									uallin Group	
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: 10/07/2025	Quynh Nguyen	Cathy Dela Cruz/ Monair Thith	Provider Data Operations	1. 2024 ANC - DHCS approved and found COH in full compliance with the following requirements: - MPT, Hospital, Cancer Treatment Validation - MPT, LTSS, OB/GYN P7Ps - Provider to Member Ratio (PCP, Total Physician, Outpatient NSMHS) 2. 2024 SNC - All	1. 2024 ANC - the only item remaining to be certified is the outcome of AAS Request for Time or Distance which is still under review 2. 2024 SNC - COH reviewed all HN CAP submissions in April and June. The CAPs closed a considerable amount of gaps across the network	1. 2024 SNC - Telehealth/Alternative Access Request has been authorized to be used by HNs to close remaining gaps and be certified. COH provided office hours to provider an overview and address any questions the HNs may have in completing this step in the SNC process. 2. NAV: PDO operations implemented a workplan to complete the network adequacy validation	1. 2024 SNC - it takes months to recruit providers, which is why some gaps continue to remain open for HNs under Time or Distance requirement. The use of Telehealth/AAS will allow member	1. 2024 SNC - Telehealth /AAS requests are due to COH in July with the goal of certifying all HNs in Q3 to complete this regulatory requirement 2. 2024 NAV Audit package is due to HSAG on 7/17 and Virtual Audit is scheduled for 8/18/25	On Target

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										HNs completed corrective action plan. COH closed the PMR CAP that were issued. Since this is not a DHCS requirements, COH will no longer include it as part of SNC moving forward. Instead it will continue as an internal monitoring standard for NCQA purposes. 3. DHCS retained HSAG for 2024 NAV Audit and HSAG has kicked off the NAV audit process with COH.	however, no HN closed all Time or Distance gaps to be fully certified. All HNs remain with gaps for Time or Distance. 3. NAV - Review of the NAV package showed that the majority of the questions remained the same compared to last year.	package across multiple departments.	s to gain access to care while the HNs continue their contracting efforts to completion.		

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55	Quality of Service: Access		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. 3) Provider and HN education to support new member screening for SDOH screening within 120 days.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Katie Balderas	Anna Safari/Stephanie Johnson	Equity and Community Health	1) Member communication: •New member text message campaign went live in December 2024 and is sent monthly. •Interactive Voice Response (IVR) campaign goes out to new members twice monthly. 2) Delegation Oversight (DO) Collaboration for HN Compliance Improvement: •ECH & DO Internal Stakeholder Collaborative Meetings: Provider relations and customer service to	1) For April and May 2025, text message campaign member engagement and response rates were both at approximately 10%. 2) N/A; In progress. 3) N/A; In progress.	Presentations: •PHMC 5/15/25 •CLCHC CalOptima Health Quality Meeting: 5/20/25, 6/17/25 •CHCN Virtual Meeting:6/26/25 •DOC Meetings: 5/28/25, 6/24/25 •JOMs: 4/28/25, 5/8/25,6/17/25 •Quality Update Meetings: 5/1/25, 5/6/25, 5/7/25, 5/20/25, 5/22/25 (2), 6/3/25, 6/17/25 •Ad Hoc Meeting with Providence for IHA Onboarding: 6/23/25 •Delegate Health Network Dashboard Monitoring -BU Workgroup: 5/8/25, 7/8/25	N/A	1) Member communication: •Continue with existing member outreach efforts 2) DO Collaboration for HN compliance improvement •Steven Chin, Sr. Director, Provider Relations, to review current IHA interventions and explore best practices to improve the HN IHA completion rate 3) Provider/ HN education Continue educating and supportin	On Target

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										review auto-assignment policies and discuss reducing the timeframe for members to be assigned to HN • ECH participation in the monthly Delegation Oversight Committee (DOC) meetings and Delegate Health Network Dashboard Monitoring Workgroup •ECH participates in DO's monthly Delegate Health Network Dashboard Monitoring -Business Unit Workgroup (listed in Column Q) •ECH provides an				g HNs and Providers with IHA requirements through various presentations. IHA CME scheduled for 8/6/25.	

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										IHA data monitoring slide to DO monthly for the DOC 3) Provider/HN Education: ECH presented IHA updates at 18 meetings in Q2, listed in Column Q					

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56	Quality of Service: Member Experience		Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal OC: One Star Improvement MC: 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	Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/07/2025	Vacant	Carol Matthews/Helen Syn	Quality Analytics	1. Closed 2. 2/8 listenting posts active 3. Health Network meetings pending receipt of CAHPS results. 4. Mapping of CAHPS categories is in process. 5. Internal training to CalOptima staff about the DPI platform.	1. 2025 HN CAHPS performance varies for member experience. 2. GARS data difficult to map to one CAHPS meausure for voice of member.	1. Medi-Cal calls were completed in April. 2. Listening posts implementation updates: medication fill within the last month (4/16/2025) and post office visit visit (4/16/2025 and 6/11/2025) 3. HN meetings will be held in Q3 to discuss individual MC HN CAHPS results. 4. Behavioral health categories and GARS data being mapped to CAHPS 5. Training session held July 9.	Lack of time and staffing resources.	Continue with plan as listed.	At Risk

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					responses to CAHPS 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 03/11/2025 Q2: 05/13/2025 Q3 08/12/2025 Q4 11/13/2025 Q1: 02/10/2026	Heather Sedillo	Ismael Bustamante	GARS	1) MC and OC grievances resolved timely 2) MC and OC grievances resolved timely	Grievances: Provider/Staff Attitude related to access for appointments and telephone accesibility. Appeals: Acess to specialty care.	1) Tracking and trending of specific providers quarter over quarter.	No specific barriers identified.	1) Tracking and trending of specific providers quarter over quarter.	On Target

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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: 10/07/2025	Andrew Tse	Mike Erbe	Customer Service	OneCare Call Center Abandonment Rate: 2.4% OneCare Call Center Average Speed of Answer: 24 seconds Medi-Cal Call Center Average Speed of Answer: 1 minute and 34 seconds		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	On Target
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. Review of ambulatory Follow up within 7 days of DC for HN and discharging facilities. 2.. Provider education for E/M's post discharge appt's within 7 days: 99495 and 99496. 3. Collaborate with other departments	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Michelle Evans	None	Case Management	1st Qtr: MC 1.1440 OC: 15.91% 2nd Qtr: MC Pending data OC: not avail yet-MY2025 Current performance with Data processed through April 2025 is 2 stars. Decrease	MC readmission rates trending upward. OC readmission rate trending down from 17.88% Q4 2024	1) Readmission best practices shared with HN and Facility JOM's 2)Review of ambulatory Follow up within 7 days of DC for HN and discharging facilities. 3)Creating education for 99495 and 99496-TCS codes post	Member engagement; Limited visibility into readmission details - manual readmission audits	**Continue planned activities** 1) Sharing readmission best practices with HN, Facility JOM's, SNF qtrly meetings 2) Sharing TCS flyer and OC PCC flyers for	Concern

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					(UM/CM/TCS) for targeted outreach for member outreach					from 3 stars in March 2025		discharge- higher reimbursement for providers 4) Point Click Care- PAC module added for OneCare- access to Continuing care document, Vital sign, progress notes at SNF partners 5) Impacting readmission and Discharge planning tipsshared at Qtlry SNF meeting and Discharge 6) Shared OC PCC contact flyer for all HN		HN for increased awarenes s how to contact with HN/Facilit y JOM's, SNF qtrly meetings. 3) Provide education for 99495 and 99496 when created with HN/Facilit y JOM's supportin g follow-up after Discharge . 4) Review MC and OC readmissi ons with high risk workgrou p-identify opportunit ies	

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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	Michelle Evans	None	Long Term Support Services	Member engagement shows qtrly improvement. 1st Qtr: 9 members engagement. 2nd Qtr: 101 members engaged with 28 in delegated networks.Successful communication with Member HN with member outreach (27% of members from delegated networks)	Increased member engagement from from first Qtr.	1) Continue onsite activities 2) Weekly workgroup identify trends/opportunities/barriers 3) Program enhancements supporting increased member engagement 4) Warm Handoff to delegated HN/CM/TCS/ECM providers 5) Member resources and referrals (CalAim, housing, TCS, CM)	Decreased engagement from Facility Staff	**Continue planned activities** 1) Weekly onsite resources provided to UCI ED team 2) Continue onsite activities 3) Evaluate Assessement in Jiva as reporting enhancement and workflow enhancement 4) Continue refining workflows and processes 5) Expand into additional ED for support to mitigate barriers from ED discharge	On Target

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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. 5) Successful outreach with TCS members within 7 days of outreach.	Report to UMC Q2: 05/22/2025 Q3: 08/21/2025 Q4: 11/20/2025	Michelle Evans	Mimi Cheung	Utilization Management	Internal audit results of total volume of cases and successful outreach w/in 7 days: 1st Qtr audit with 60.69% successful outreach within 7 days. 2nd Qtr audit with 68.27% successful outreach within 7 days.	Results of random sample audit completed monthly showed a 7.58% improvement from first quarter.	1) ContinueTCS Texting campaign. 2) Established TCS phone audit log to capture any missed opportunities to outreach to members 3) Designated staff for TCS maternal health outreach 4) Promotion TCS services at Facility/Hospital JOM's & SNF facilities quarterly meetings. 5) IT support for Jiva Report	Manual audit for successful outreach within 7 days-pending Jiva report.	**Continue planned activities** 1) Usher Text TCS discharge text: Developing a quarterly TCS Ushur report. 2) Continue random sample audits and update KPI report for oversight and monitoring and to address manual audit barrier. 3) Developing Jiva reports for TCS. 4) Continue updating workflows and processes 5) Continue the promotion of TCS	On Target

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														services at the facility and HN JOMs.	
62	Cultural and Linguistic Appropriate Services		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	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services	During Quarter 2 of 2025, Cultural and Linguistic Services continued to provide interpreter and translation services for members. The utilization data of interpretations and translations were analyzed, tracked and trended, identified and adjusted when	During Q2 Cultural and Linguistic Services continued to provide interpreter and translation services for members, which experienced an increase in translation and interpreter requests from members.	Throughout Quarter 2, all Member Material were translated accurately and on time to comply with regulatory standards.	Barriers previously identified in Quarter 4 for interpreter services were the shortage/lack of interpreters in various languages such as Khmer/ Cambodian. However, C&L vendors have onboarded more Khmer/	Cultural and Linguistic Services will continued to provide interpreter and translation services for members.	On Target

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										necessary to ensure members received timely and adequate interpreter and translation services. The following is the data for Telephonic and Face-to-Face interpreter requests for Quarter 2 of 2025: • Quarter 2 – 22,759 Telephonic interpreter requests • Quarter 2 – 4,020 Face-to-Face interpreter requests To follow is the translation total for Quarter 2 of 2025: • Quarter 2 – 4,320 Translations			Cambodian interpreters to support this language.		

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63	Cultural and Linguistic Appropriate Services		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	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services	1) Conducted a mailing of 186,000+ existing members 18+ years of age yielded low response. • The mailing resulted in a 1.2% response rate, as of July 15th, we have received 2,245 surveys as a result of the mailing. 2) In May 2025, began offering survey to members during the in-person New Member Orientation meetings. • Response rate is 13% (7 responses of 56 surveys offered).	1) Response rate continues to be low. • Our overall response rate, based on members surveyed, decreased from 5% to 2.8% due to the low response rate from the mailing. • Our average number of mailing surveys to new members is about 10,000 per month and our average return is 490 so about 5% return rate. • Staff reported members were reluctant to complete the survey due to the type of questions.	1) Conducted a mailing of 186,000+ existing members 18+ years of age yielded low response 2) In May 2025, began offering survey to members during the in-person New Member Orientation meetings.	Members reluctant to respond e to the survey.Feedback from staff conducting the New Member Orientations is that members are hesitant to complete the survey stating they do not wish to share this information and possibly and indictation on the reason for the low response rate from the mailing activities.	Continue to monitor and track the collection of all member demographic data and continue to explore additional methods of collection.	Concern

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64	Cultural and Linguistic Appropriate Services		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	Quynh Nguyen	Linda Huynh	Provider Data Management Services	REL data collection is embedded in standard workflows (ACT, LOI, credentialing). No measurable increase in REL data was noted for Q2 because most providers do not submit this information.	No significant increase in REL data was observed in Q2. The 10% goal is an ambitious benchmark, and provider participation remains voluntary. Progress continues through the integration of REL fields into standard workflows, and tracking mechanisms are in place to support ongoing improvement. Continued outreach and education efforts are expected to help drive gradual increases over time.	Standard forms continue to include REL fields. Developed trending report to track provider to member ratio.	Provider submission of race/ethnicity and language fluency data remains voluntary, this limits the completeness of demographic data collection.	1. Implement outreach and reminders to Providers to encourage REL submission. 2. Continue to track response rates.	Concern

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					Health Networks.										

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65	Cultural and Linguistic Appropriate Services		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	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services	Cultural and Linguistic Services drafted and initiated a Staff and a Member survey to evaluate language services experience from member and staff. The Staff survey resulted in an overall total of 72 responses from CalOptima Health staff. The responses were positive, with only 3 un-favorable responses. CalOptima Health mailed 32,480 member surveys to members via U.S. mail. As of June 30, 2025, we received 1,878	• The Staff survey resulted in an overall total of 72 responses from CalOptima Health staff. The responses were positive responses, with only 3 un-favorable responses. • Out of the 32,480 member surveys mailed to members via U.S. mail, we received 1,878 completed surveys from members. C&L staff are currently logging in the surveys and translating some of the responses to assess the satisfaction	• Some of the responses from members are in other CalOptima Health threshold languages and need to be translated to assess the satisfaction level of the members.	Lack of response to the member surveys.	Will re-evaluate to determine if an additional survey should be mailed to members in the 3rd or 4th quarter.	On Target

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										completed surveys from members. C&L staff are currently logging in the surveys and translating some of the responses to assess the satisfaction level of the members. The target completion date to have a full report/detailed analysis of both the Staff and Member surveys is set for July 24, 2025.	level of the members.				

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66	Cultural and Linguistic Appropriate Services		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 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	Michaell Rose	Greta Rice/Adriana Ramos	HR and Provider Relations	No new updates	N/A	N/A	Per the CalOptima Health legal team – CalOptima is a Federal Contractor. We are reviewing our requirements under state and federal law	Per the CalOptima Health legal team – CalOptima is a Federal Contractor. We are reviewing our requirements under state and federal law	On Target

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