



Quality Improvement and Health Equity
Transformation Work Plan 2025

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Reference Guide

#	Metric	Goal	Department		
1	2025 Quality Improvement & Health Equity Transformation (QIHET) Program Description	Update the 2025 QIHET Program Description.	Quality Improvement		
2	2025 Quality Improvement and Health Equity Transformation Work Plan	Update the 2025 QIHET Work Plan	Quality Improvement		
3	2024 Quality Improvement and Health Equity Transformation Program and Work Plan Evaluation	Complete the 2024 QIHET Program and Work Plan Evaluation.	Quality Improvement		
4	2025 Culturally and Linguistically Appropriate Services (CLAS) Work Plan and Program Description	Health Education & Cultural Linguistics			
5	2024 CLAS Program and Work Plan Evaluation	- ·			
6	2025 HEDIS® Compliance Audit™	Quality Improvement			
7	Population Needs Assessment (PNA)	Needs Assessment (PNA) Maintain NCQA compliant PNA as part of the Population Health Strategy Report submitted to DHCS.			
8	Wellth Program Maintain and expand a QI focused programs with Wellth for full-scope Cal members who are 18+ years of age, are taking at least one medica and have multiple care gaps for which GCHP is held to the DHCS MP percentile).		Population Health		
9	Health Risk Assessment	Further develop and expand use of the HRA to meet the CalAIM annual requirement.	Population Health		
10	Utilization Management: Clinical Practice Guidelines Complete annual review and adoption of evidence-based Preventive Health Guidelines (PHG), including the Diabetes and Asthma Clinical Practice Guidelines (CPG).		Utilization Management		
11	Complex Case Management Maintain and monitor a standardized turn-around-time (TAT) process for members identified as eligible for complex case management per NCQA CCM requirements.		Care Management		
12	Care Gap Closure	Implement strategies to close care gaps for MCAS measures.	Care Management		
13	Tobacco Cessation	Increase the rate of tobacco cessation counseling and utilization of tobacco	Health Education /		
		cessation medication in members identified as tobacco users.	Cultural Linguistics		
14	Initial Health Appointment (IHA)	Increase rates of Initial Health Appointment (IHA) completion by providers.	Quality Improvement		

#	Metric	Goal	Department
15	Opioid Utilization Monitoring	Monitor member opioid utilization via pharmacy claims from Medi-Cal Rx and monitor for any trends where the utilization exceeds more than a 5% increase from the prior quarter.	Pharmacy
16	Behavioral Health: Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	Increase the FUM-30 rate to exceed the DHCS MPL (50 th percentile).	Behavioral Health
17	Behavioral Health: Follow-Up After Emergency Department Visit for Substance Use – 30 Days	Increase the FUA-30 rate to exceed DHCS MPL (50th percentile).	Behavioral Health
18	2023-2026 PIP Non-Clinical Topic: Percentage of Provider Notifications for Members with SUD/SMH Diagnoses within 7 Days of an ED Visit	Improve the percentage of provider notifications for members with substance use disorder (SUD) and / or specialty mental health (SMH) diagnoses following or within 7 days of emergency department (ED) visit.	Quality Improvement
19	2024-2025 DHCS/IHI Behavioral Health Collaborative	Behavioral Health	
20	Breast Cancer Screening (BCS)	Increase the percentage of members 50-74 years of age who had a mammogram to screen for breast cancer to meet or exceed the DHCS HPL (90th percentile).	Quality Improvement Health Education/ Cultural Linguistics
21	Cervical Cancer Screening (CCS)	Increase percentage of members 21-64 years of age who were screened for cervical cancer to meet or exceed the DHCS HPL (90 th percentile).	Quality Improvement
22	Colorectal Cancer Screening (COL)	Increase the percentage of members 45 to 75 years of age who had an appropriate screening for colorectal cancer to meet the Medicare 50 th percentile.	Quality Improvement
23	Asthma Medication Ratio (AMR) Increase the AMR rate for members, 5 to 64 years of age, who had a sthma and had a ≥ 0.50 ratio of controller medications to total asthmedications to exceed the DHCS MPL (50th percentile).		Quality Improvement Pharmacy
24	Asthma Medication Ratio (AMR)	Quality Improvement	
25	Health Equity Controlling Blood Pressure (CBP)	Quality Improvement Population Health	
26	Glycemic Status Assessment for Patients with Diabetes >9.0% (GSD-Poor Control	Decrease the percentage of members with diabetes who are 18-75 years of age and have GSD $> 9.0\%$ to meet the DHCS HPL (90^{th} percentile).	Quality Improvement

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#	Metric	Goal	Department
27	Chlamydia Screening in Women (CHL)	Increase the rate of chlamydia screening in members 16 to 24 years of age to meet or exceed the 75 th national Medicaid percentile established by NCQA.	Quality Improvement Health Education / Cultural Linguistics
28	Prenatal and Postpartum Care (PPC)	Increase the percentage of members with live birth deliveries who completed timely prenatal and postpartum exams to meet or exceed the DHCS HPL (90th percentile).	Quality Improvement
29	Childhood Immunization Status – Combo 10 (CIS-10)	Quality Improvement	
30	Immunization Status for Adolescents – Combo 2 (IMA-2)	Quality Improvement	
31	Developmental Screening in the First Three Years of Life (DEV)	Quality Improvement	
32	Lead Screening in Children (LSC) Increase the percentage of members who had one or more capillary or venous blood lead tests for lead poisoning by their 2 nd birthday to meet the 75 th national Medicaid percentile established by NCQA.		Quality Improvement
33			Quality Improvement
34	Well-Child Visits in the First 30 Months of Life (W30)	Increase the percentage of members who had well-child visits with a PCP to exceed the DHCS MPL (50th percentile)	Quality Improvement
35	Child and Adolescent Well-Care Visits (WCV) Increase the percentage of members, 3-21 years of age, who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year to exceed the DHCS MPL (50th percentile).		Quality Improvement
36	2023-2026 PIP Clinical Topic: W30-6+ among Hispanic/Latinx Members	Improve the performance rate for Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) among the Hispanic/Latinx population.	Quality Improvement
37	2024-2025 DHCS Child Health Equity Focused Collaboration on Well-Care Exams	Improve the completion of well-child visits.	Quality Improvement

Gold Coast Health Plan

#	Metric	Goal	Department
38	Cultural and Linguistic Needs & Preferences	 By July 31, 2025, GCHP's Health Education, Cultural and Linguistic (HECL) Services Department shall expand current training modules to include Diversity, Equity, and Inclusion (DEI) training program as per DHCS (APL 23-025) that encompasses sensitivity, diversity, cultural competence and cultural humility, and health equity trainings. By July 31, 2025, GCHP's HECL Department shall conduct three Cultural and Linguistic (C&L)/DEI trainings with Network Provider offices per quarter. By December 31, 2025, GCHP's HECL Department shall report on the number of C&L fulfilment and benchmarks quarterly during the QIHEC meeting. 	Health Education / Cultural Linguistics
39	Primary and Specialty Care Access	Ensure primary and specialty care access standards met for minimum of 80% of providers.	Provider Network Operation
40	Network Adequacy	Assess and improve network adequacy as demonstrated by availability of practitioners.	Provider Network Operations
41	After Hours Availability	vailability Conducts surveys to ensure members are able to reach a provider after hours.	
42	Provider Satisfaction	Field provider survey and develop action plan(s) to improve areas of low performance.	Provider Network Operations
43	Facility Site Review Requirements	Maintain 100% compliance with Facility Site Review (FSR) requirements.	Quality Improvement
44	Physical Accessibility Review Surveys (PARS)	Complete Physical Accessibility Reviews (PARs) 100% on time.	Quality Improvement
45	Credentialing/Recredentialing	Maintain a well-defined credentialing and recredentialing process for evaluating practitioners/ providers to provide care to members.	Provider Network Operations
46			Grievances and Appeals
47			Member Services
48	CAHPS: Surveys	Coordinate with DHCS and HSAG to complete the CAHPS surveys and complete analysis of survey results.	Quality Improvement

#	Metric	Goal	Department
49	CAHPS: Access to Specialty Care	Improve access to specialty care for adults and children.	Operations Strategy /
			External Affairs
			Quality Improvement
50	CAHPS: Improve CAHPS Scores	Improve CAHPS scores based on MY 2024 CAHPS outcomes, including	Operations Strategy /
		Getting Care Quickly and Getting Needed Care.	External Affairs
			Quality Improvement
51	Delegation Oversight	100% of all audits completed at least annually with corrective action plans	Compliance
		(CAPs) closed timely.	

Objective 1: Improve Quality and Safety of Clinical Care Services

1. Quality: 2025 Quality Improvement and Health Equity Transformation (QIHET) Program Description

	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
Progr		Update the 2025 QIHET Program Description.	 Collaborate with business units to review and update the 2025 QIHET Program Description. Prepare and submit for approval to the Quality Improvement & Health Equity Committee (QIHEC). Prepare and submit for approval to the Commission. 	 1. 11/18/24 - 01/15/25 2. 01/21/25 3. 01/27/25 	 Sr. Director, Quality Improvement Sr. QI Manager QI Program Manager III 	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No Next Steps:

2. Quality: 2025 Quality Improvement and Health Equity Transformation Work Plan **Timeframe for Status Update Category** Area of **Goals and Objectives Planned Activities** Responsible Staff / **Completion of Focus Department Activities** Quality **2025 QIHET** Update the 2025 QIHET Work Plan. 1. Collaborate with business units 1. 11/18/24 - 01/15/25 Sr. Director, Annual Goal Met: Yes No No Work Plan to review and update the 2025 2. 01/21/25 Quality Improvement OIHET Work Plan. 3. 01/27/25 Quarterly Updates: 2. Prepare and submit for approval Sr. QI Manager to the QIHEC. QI Program 3. Prepare and submit for approval Manager III to the Commission. Continue Objective: Yes X No D Next Steps: **Evaluation & Barrier Analysis**

3. Quality: 2024 Quality Improvement and Health Equity Transformation Work Plan Evaluation

Category Area Focu	· · · · · · · · · · · · · · · · · · ·	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
Quality 2024 QIHET Work Pla Evaluation		 Collaborate with business units to complete 2024 QIHET Program and Work Plan Evaluation. Evaluate effectiveness of the quality improvement structure and resources. Evaluate the QIHEC subcommittees are occurring according to each subcommittee's charter and cadence. Conduct assessment of Committee Members. Conduct assessment of systems and activities. Conduct assessment of resources dedicated to addressing disparities. Prepare and submit for approval to the QIHEC. Prepare and submit for approval to the Commission. 	Activities 1. 03/01/25 - 06/30/25 2. 03/01/25 - 07/31/25 3. 03/01/25 - 07/31/25 4. 07/31/25 5. 07/31/25 6. 07/31/25 7. 09/16/25 8. 09/23/25	• Sr. Director, Quality Improvement • Sr. QI Manager • QI Program Manager III	Annual Goal Met: Yes No Courterly Updates: Continue Objective: Yes No No Next Steps:

4. Health Equity: 2025 Culturally and Linguistically Appropriate Services (CLAS) Work Plan and Program Description **Goals and Objectives Planned Activities Timeframe for Status Update** Category Area of Responsible Staff / **Completion of Focus Activities** Department 2025 CLAS Health Update the 2025 CLAS Program 1. Update the 2025 CLAS 1. 01/31/25 Sr. Director, Annual Goal Met: Yes No No Equity Program Description and Work Plan. Program Description and Work Health Education Description Plan. and Cultural Quarterly Updates: and Work Linguistics • Sr. Cultural Plan and Linguistics **Specialist** Sr. Health Navigator / Continue Objective: Educator Yes No 🗵 New objective added in 2025. Next Steps: **Evaluation & Barrier Analysis**

5. Health Equity: 2024 Culturally and Linguistically Appropriate Services (CLAS) Work Plan and Program Evaluation

Category Area	· · · · · · · · · · · · · · · · · · ·	ctives Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
Health 2024 Cl Equity Program Work P Evaluation	n and and Work Plan Evaluatio		1. 03/01/25 - 06/30/25 2. 03/01/25 - 07/31/25 3. 07/31/25 4. 07/31/25 5. 07/31/25 6. 09/16/25 7. 09/23/25	 Sr. Director, Health Education and Cultural Linguistics Sr. Cultural and Linguistics Specialist Sr. Health Navigator / Educator 	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No No New objective added in 2025. Next Steps:

6. Quality: 2025 HEDIS[®] Compliance Audit™ **Timeframe for** Category Area of **Goals and Objectives Planned Activities** Responsible **Status Update** Staff / **Completion of Focus** Department **Activities** Quality 2025 HEDIS® Successfully complete and pass the 1. ROADMAP Submission 1. 01/31/25 Sr. Director, Annual Goal Met: Yes No No Compliance annual HEDIS® Compliance Audit™ 2. 03/28/25 2. Non-Standard Supplemental Quality Audit™ 3. 04/25/25 Data Primary Source Validation and receive "reportable" status for all Improvement Quarterly Updates: 3. Preliminary rate review 4. 05/23/25 Sr. QI Manager measures. 5. 06/13/25 4. Medical Record Review (MRR) QI Program Validation 6. 06/13/25 Manager II 7. 06/13/25 5. Final rate review 6. Interactive Data Set Submission 7. Submit ROADMAP Continue Objective: Management Representation Yes X No D Letter Next Steps: **Evaluation & Barrier Analysis**

7. Population Health: Population Needs Assessment (PNA)

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
Population Health	Population Needs Assessment	Maintain NCQA compliant PNA as part of the Population Health Strategy Report submitted to DHCS.	Develop and implement Population Health Management Strategic Objectives.	Activities 1. 12/31/25	 Sr. Manager of Population Health Management Program Analyst of Population Health Management Senior Healthcare Data Analyst 	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No No Next Steps:

8. Populat	ion Health: \	Wellth Program				
Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
Population Health	Wellth Quality Improvement Program	Maintain and expand QI focused programs with Wellth for full-scope Medi-Cal members who are 18+ years of age, are taking at least one medication and have multiple care gaps for which GCHP is held to the DHCS MPL (50 th percentile).	 The PHM team will continue to evaluate the outcomes associated with the Wellth QI program. Implement a provider referral process. Enroll additional members into the Wellth QI program to a total of 10,500. 	1. 01/06/25 - 12/31/25 2. 02/28/25 3. 03/31/25	 Sr. Manager of Population Health Wellness and Prevention Manager 	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No No Next Steps:
Evaluation	& Barrier Ana	lysis				

9. Population Health: Health Risk Assessment

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
Population Health	Health Risk Assessment (HRA)	Further develop and expand use of the HRA to meet the CalAIM annual requirement.	 The PHM team will continue working with Carenet to conduct HRAs at a volume to match capacity for referrals. Implement member HRA outreach via SMS/test through Carenet. Transition HRA outreach from Carenet to the GCHP Call Center. Enable HRA completion online via Customer Relation Management (CRM) software. 	1. 06/30/25 2. 03/31/25 3. 07/01/25 4. 03/31/25	 Sr. Manager of Population Health Wellness and Prevention Manager 	Annual Goal Met: Yes No No Quarterly Updates: Continue Objective: Yes No X New objective added in 2025. Next Steps:

10. Utilization Management: Clinical Practice Guidelines **Category** Area of **Goals and Objectives Planned Activities** Timeframe for Responsible **Status Update** Staff / **Focus Completion of** Department **Activities** Utilization Preventive Complete annual review and 1. Review and approval by the 1. 03/06/25, 06/05/25, Chief Medical Annual Goal Met: Yes No No Credentialing /Peer Review Officer Management Health. adoption of evidence-based 09/04/25. 11/20/25 Sr. Director Clinical Preventive Health Guidelines (PHG), Committee (C/PRC) 2. 01/01/25 - 12/31/25 Quarterly Updates: including the Diabetes and Asthma 2. Post guidelines on the GCHP 3. 01/01/25 - 12/31/25 Practice, and Utilization Utilization Clinical Practice Guidelines (CPG), website and distribute Management and UM Guidelines. guidelines to appropriate • Sr. Director Management Quality Guidelines practitioners, upon request. 3. Ensure alignment of PHG with Improvement Provider Manual and applicable Continue Objective: policies. Yes X No D Next Steps: **Evaluation & Barrier Analysis**

11. Care Management: Complex Case Management

Category Area Foc		Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
Care Complex Management (CM) Manager (CCM)	turn-around-time (TAT) process	 Continue staff training as identified. Review and revise staff auditing tools to align with NCQA and policy HS-058 Care Management including Complex Case Management guidelines associated with TAT for CCM. Strategize with CM, QI, HS analyst on the development of metrics and benchmarks to capture CCM TAT. Monitor CCM TAT dashboard and implement interventions for benchmarks not met. 	Activities 1. 01/01/25 - 12/31/25 2. 01/01/25 - 12/31/25 3. 01/01/25 - 12/31/25 4. 03/01/25 - 12/31/25	 Department Director of CM Sr. Manager, CM & Special Projects CM Managers 	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No No Next Steps:

12. Care Management: Care Gap Closure **Category Goals and Objectives Planned Activities** Timeframe for Responsible **Status Update** Area of Staff / **Focus Completion of Activities Department** Care Care Gap Implement strategies to close care 1. Continue to include utilization 1. 01/01/25 - 12/31/25 Director of CM Annual Goal Met: Yes No No gaps for MCAS measures. Sr. Manager, CM & 2. 04/01/25 - 12/31/25 Management Closure of the MCAS care gaps (CM) dashboard as part of the CM Special Projects 3. 01/01/25 - 12/31/25 Quarterly Updates: CM Managers 4. 01/01/25 - 12/31/25 process. Sr. Ql Manager 2. Review and revise JAM's/ 5. 01/01/25 - 12/31/25 resource tools/to align with care gap report utilization. 3. Review and revise staff auditing tools as identified. Continue Objective: 4. Provide staff with learning Yes 🗵 No 🗖 opportunities related to MCAS care gap report, programs and Next Steps: activities. 5. Strategize with QI and other departments as identified on the development of programs and activities to address identified care gaps. **Evaluation & Barrier Analysis**

13. Advance Prevention: Tobacco Cessation

Category Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
Advance Tobacco Prevention Cessation	Increase rate of tobacco cessation counseling and utilization of tobacco cessation medication in members identified as tobacco users. IHA benchmarks 100% of identified tobacco users receive counseling. 32% of tobacco users receive cessation medication. Admin benchmarks 45% of identified tobacco users receive cessation medication. 10% of tobacco users receive counseling. 10% of tobacco users receive counseling.	 Utilize DHCS methodology to identify tobacco users via data pulls for quarterly analysis and reporting. Create and/or update provider and member education campaigns. Measure tobacco cessation medication dispensing and cessation counseling quarterly via IHA medical record review and administrative data. Report tobacco cessation medication dispensing and cessation counseling semiannually. 	 03/31/25, 06/30/25, 09/30/25, 12/31/25 12/31/25 03/31/25, 06/30/25, 09/30/25, 12/31/25 03/31/25, 09/30/25 03/31/25, 09/30/25 	 QI RN Manager Sr. Director of Health Education and Cultural Linguistics Sr. Health Navigator & Health Educator 	Annual Goal Met: Yes No Continue Objective: Yes No Next Steps:

14. Advance Prevention: Initial Health Appointment (IHA) **Category Goals and Objectives Planned Activities** Timeframe for Responsible **Status Update** Area of Staff / **Focus Completion of Activities Department** Advance Initial Health Increase rates of Initial 1. Distribute new member lists to clinic/health 1. 11th day of each QI RN Manager Annual Goal Met: Yes No No system for member outreach to schedule Health Appointment (IHA) OI RN Prevention Appointment month the IHA visit. completion by providers. 2. 03/31/25, 06/30/25, Quarterly Updates: 2. Monitor claims data for timely IHA 09/30/25, 12/31/25 completion within 120 days by clinic 3. 01/01/25 - 12/3125 system. 4. 01/01/25 - 12/31/25 3. Conduct medical record audits by provider site and provide feedback on opportunities for improvement. 4. Provide ongoing trainings on the IHA and Continue Objective: IHA Outreach Log. Yes X No D Next Steps: **Evaluation & Barrier Analysis**

15. Pharmacy: Reduction in Potential Unsafe Opioid Prescriptions

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
Pharmacy	Opioid Utilization Monitoring	Monitor member opioid utilization via pharmacy claims from Medi-Cal Rx and monitor for any trends where the utilization exceeds more than a 5% increase from the prior quarter.	 Monitor the following statistics related to opioid utilization via pharmacy claims from Medi-Cal Rx in GCHP members: Total number of unique users Concurrent users of opioids and benzodiazepines Concurrent users of opioids and antipsychotics Number of high dose utilizers Number of members who fill opioids at 3 or more pharmacies Number of members who have opioids prescribed by 3 or more prescribers Perform retrospective Drug Utilization Review (DUR) and implement Provider Interventions Related to Opioid Utilization as needed. 	 03/31/25, 06/30/25, 09/30/25, 12/31/25 01/01/25 - 12/31/25 	 Director of Pharmacy Services Clinical Programs Pharmacist 	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No No Next Steps:

16. Behavioral Health: Follow-Up After Emergency Department Visit for Mental Illness – 30 Days **Goals and Objectives Planned Activities** Timeframe for **Status Update Category** Area of Responsible Staff / **Focus Completion of Activities Department** Behavioral Follow-Up Increase the FUM-30 rate 1. Continuously improve and develop new 1. 12/31/25 Director, Annual Goal Met: Yes No No Health After to exceed the DHCS MPL innovative interventions that promote 2. 12/31/25 Behavioral **Emergency** (50th percentile). members' access to behavioral health care 3. 12/31/25 Health and Social Quarterly Updates: Department 4. 12/31/25 services. Programs (ED) Visit for 2. Monitor Carelon Behavioral Health 5. 12/31/25 Manager, Mental Illness 6. 08/15/25 Behavioral Health performance towards the established - 30 days. incentive measure targets within the fully 7. 01/31/25 - 12/31/25 Ol Program 8. 07/31/25 (FUM-30) executed contract to ensure adequate Manager III follow-up care after ED visit. Executive Continue Objective: 3. Improve data exchange to ensure more Director, IT Yes X No complete, accurate, and timely data to Director improve robust capture of follow-up visits. of Medical Next Steps: 4. Include FUM in the Quality Incentive Informatics Provider Pool (QIPP) Program. Sr. Program 5. Evaluate improvements in data collection Analyst (e.g., administrative data sources, coding audits). 6. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 7. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 8. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. **Evaluation & Barrier Analysis**

17. Behavioral Health: Follow-Up After Emergency Department Visit for Substance Use – 30 Days

0 /	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
Health After Emer Department (ED) Subs - 30	er	Increase the FUA-30 rate to exceed DHCS MPL (50th percentile).	 Continuously improve and develop new innovative interventions that promote members' access to behavioral health care services. Monitor Carelon Behavioral Health performance towards the established incentive measure targets within the fully executed contract to ensure adequate follow-up care after ED visit. Improve data exchange to ensure more complete, accurate, and timely data to improve robust capture of follow-up visits. Include FUA in the Quality Incentive Provider Pool (QIPP) Program. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). Provide clinics/providers with the annual MY 2024 MCAS / HEDIS® rate reports. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 	1. 12/31/25 2. 12/31/25 3. 12/31/25 4. 12/31/25 5. 12/31/25 6. 08/15/25 7. 01/31/25 - 12/31/25 8. 07/31/25	 Director, Behavioral Health and Social Programs Manager, Behavioral Health QI Program Manager III Executive Director, IT Director of Medical Informatics Sr. Program Analyst 	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No No Next Steps:

18. Behavioral Health: 2023-2026 PIP Non-Clinical Topic: Percentage of Provider Notifications for Members with SUD/SMH Diagnoses within Seven Days of an ED Visit

Category Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
& Barrier Non-Clinical parallel paralle	Improve the percentage of provider notifications for members with substance use disorder (SUD) and / or specialty mental health (SMH) diagnoses following or within seven days of emergency department (ED) visit.	 Submit PIP Modules as directed by DHCS and HSAG for review and approval. Perform ongoing evaluation of the interventions and identify opportunities to improve. Report updates and results to the QIHEC. 	1. 09/01/25 2. 09/16/25, 11/18/25 3. 03/31/25, 06/30/25, 09/30/25, 12/31/25	 QI Program Manger III Sr. Manager, CM & Special Director of Behavioral Health and Social Program Clinical Care Manager III, LCSW Sr. QI Data Analyst 	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No No Next Steps:

19. Behavioral Health: 2024-2025 DHCS/IHI Behavioral Health Collaborative with VCBH

ategory Area of Goals and Objectives Planned Focus	d Activities Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
HCS IHI / VCBH care coordination & development of Collaborative focused on exchange to increase & development of 2. Enhance care coordination between collaboration & development of 2. Enhance care coordination between collaboration between co	f data sharing mechanism data use framework. rdination in the ED and ating providers. delivery system processes. 1. 01/01/25 - 06/30/25 3. 01/01/25 - 06/30/25	GCHP staff • Director,	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No Next Steps:

20. Cancer Prevention: Breast Cancer Screening (BCS) **Goals and Objectives Planned Activities** Timeframe for **Status Update Category** Area of Responsible Staff / **Focus Completion of Activities Department MCAS Breast Cancer** Increase the percentage 1. Provide clinics/providers with the annual 1. 08/15/25 Sr. Ql Manager Annual Goal Met: Yes No No MY 2024. MCAS/HEDIS® rate reports. Screening of members 50-74 2. 01/31/25 - 12/31/25 QI Program 2. Provide clinics/providers with the years of age who had a 3. 07/31/25 Manager 1 Quarterly Updates: prospective MY 2025 MCAS rate and 4. 12/31/25 OI RN mammogram to screen member gaps in care reporting via 5. 12/31/25 • Sr. Health for breast cancer to meet Converged Data Insights. 6. 12/31/25 or exceed the DHCS HPL Navigator & 3. Evaluate MY 2024 performance to identify (90th percentile). 7. 09/30/25 Health Educator barriers, disparities and opportunities for 8. 06/01/25 - 12/31/25 improvement and interventions. 9. 01/01/25 - 12/31/25 4. Evaluate effectiveness of the breast cancer Continue Objective: 10. 12/31/25 screening member incentive program Yes X No 11.01/01/25 - 12/31/25 and identify program changes and enhancements, as applicable. Next Steps: 5. Expand and evaluate the effectiveness of the point-of-care (POC) member incentive program and identify program changes and enhancements as applicable. 6. Distribute provider member incentive awards annually. 7. Promote and support access to mobile mammography services. 8. Conduct member outreach campaigns to increase preventive screenings and close care gap. 9. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., American Cancer Society, Community Relations Department) to implement interventions, promote best practices and increase awareness.

20. Cancer Prevention: Breast Cancer Screening (BCS)

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
			10. Include BCS in the Quality Incentive Provider Pool (QIPP) Program.11. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).			

21. Cancer Prevention: Cervical Cancer Screening (CCS) **Goals and Objectives Planned Activities** Timeframe for **Status Update Category** Area of Responsible Staff / **Focus Completion of Activities Department MCAS** Cervical Increase percentage of 1. Provide clinics/providers with the annual 1. 08/15/25 Sr. Ql Manager Annual Goal Met: Yes No No Cancer members 21-64 years of MY 2024 MCAS/HEDIS® rate reports. 2. 01/31/25 - 12/31/25 QI Program Screening age who were screened 2. Provide clinics/providers with the 3. 07/31/25 Manager I Quarterly Updates: (CCS) for cervical cancer to meet 4. 01/31/26 OI RN prospective MY 2025 MCAS rate and or exceed the DHCS HPL member gaps in care reporting via 5. 12/31/25 Sr. Health 6. 12/31/25 (90th percentile). Converged Data Insights. Navigator & 3. Evaluate MY2024 performance to identify 7. 04/01/25 - 11/30/25 Health Education barriers, disparities and opportunities for 8. 01/01/25 - 12/31/25 improvement and interventions. 9. 12/31/25 Continue Objective: 4. Evaluate effectiveness of the cervical 10.01/01/25 - 12/31/25 Yes X No cancer screening member incentive program and identify program changes and Next Steps: enhancements, as applicable. 5. Expand and evaluate the effectiveness of the point-of-care (POC) member incentive program and identify program changes and enhancements as applicable. 6. Distribute provider member incentive awards annually. 7. Conduct member outreach campaigns to increase preventive screenings and close care gap. 8. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., American Cancer Society, Community Relations Department) to implement interventions, promote best

practices and increase awareness.

21. Cancer Prevention: Cervical Cancer Screening (CCS)

Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
		9. Include CCS in the Quality Incentive Provider Pool (QIPP) Program core			
		10. Evaluate improvements in data collection (e.g., administrative data sources, coding			
		·	9. Include CCS in the Quality Incentive Provider Pool (QIPP) Program core measures. 10. Evaluate improvements in data collection	9. Include CCS in the Quality Incentive Provider Pool (QIPP) Program core measures. 10. Evaluate improvements in data collection (e.g., administrative data sources, coding	Focus 9. Include CCS in the Quality Incentive Provider Pool (QIPP) Program core measures. 10. Evaluate improvements in data collection (e.g., administrative data sources, coding

22. Cancer Prevention: Colorectal Cancer Screening (COL) **Goals and Objectives Planned Activities** Timeframe for Responsible **Status Update Category** Area of Focus Staff / **Completion of Activities Department MCAS** Colorectal Increase the percentage 1. Provide clinics/providers with the annual 1. 08/15/25 Sr. Ql Manager Annual Goal Met: Yes No No of members 45 to 75 MY 2024 MCAS / HEDIS® rate reports. Cancer 2. 01/31/25 - 12/31/25 OI RN 2. Provide clinics/providers with the Screening years of age who had an 3. 07/31/25 Sr. Director of Quarterly Updates: prospective MY 2025 MCAS rate and (COL-E) 4. 07/31/25 Health Education. appropriate screening member gaps in care reporting via for colorectal cancer to 5. 01/01/25 - 12/31/25 Cultural and Converged Data Insights meet the Medicare 50th 6. 01/01/25 - 12/31/25 Linguistic Services 3. Evaluate MY 2024 performance to identify 7. 06/30/25 · Sr. Health percentile. barriers, disparities and opportunities for 8. 01/01/25 - 12/31/25 Navigator & improvement and interventions. Health Educator 4. Conduct disparities analysis by race and Continue Objective: ethnicity. Yes X No 5. Create and/or update provider and member education campaigns that are Next Steps: culturally and linguistically appropriate to address health disparities with input from external organizations (e.g. Community Advisory Committee). 6. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., American Cancer Society, Community Relations Department) to implement interventions, promote best practices and increase awareness. 7. Partner with lab vendors to pilot home test kits. 8. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). **Evaluation & Barrier Analysis**

23. Chronic Disease Management: Asthma Medication Ratio (AMR)

Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
Increase the AMR rate for members, 5 to 64 years of age, who had persistent asthma and had a ≥ 0.50 ratio of controller medications to total asthma medications to exceed the DHCS MPL (50th percentile).	 Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. Retrospective Drug Utilization Review and Provider Interventions Related to Asthma Medication Use. Explore development of community health workers (CHW) home visiting program in collaboration with Health Education. Include AMR in the Quality Incentive Provider Pool (QIPP) Program. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). Conduct member outreach campaigns to members identify with <50% asthma medication ration. Implement the asthma spacer member incentive program. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., American Cancer Society, Community Relations Department) to implement interventions, promote best practices and increase awareness. 	1. 08/15/25 2. 01/31/25 - 12/31/25 3. 07/31/25 4. 09/30/25 5. 09/30/25 6. 12/31/25 7. 12/31/25 8. 09/30/25 9. 06/30/25 10.01/01/25 - 12/31/25 11.01/01/25 - 12/31/25	Director of	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No Next Steps:
	Increase the AMR rate for members, 5 to 64 years of age, who had persistent asthma and had a ≥ 0.50 ratio of controller medications to total asthma medications to exceed the DHCS MPL	Increase the AMR rate for members, 5 to 64 years of age, who had persistent asthma and had a ≥ 0.50 ratio of controller medications to total asthma medications to exceed the DHCS MPL (50th percentile). 1. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Retrospective Drug Utilization Review and Provider Interventions Related to Asthma Medication Use. 5. Explore development of community health workers (CHW) home visiting program in collaboration with Health Education. 6. Include AMR in the Quality Incentive Provider Pool (QIPP) Program. 7. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 8. Conduct member outreach campaigns to members identify with <50% asthma medication ration. 9. Implement the asthma spacer member incentive program. 10. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., American Cancer Society, Community Relations Department) to implement interventions, promote best	Increase the AMR rate for members, 5 to 64 years of age, who had persistent asthma and had a ≥ 0.50 ratio of controller medications to total asthma medications to exceed the DHCS MPL (50th percentile). 3. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Retrospective Drug Utilization Review and Provider Interventions Related to Asthma Medication Use. 5. Explore development of community health workers (CHW) home visiting program in collaboration with Health Education. 6. Include AMR in the Quality Incentive Provider Pool (QIPP) Program. 7. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 8. Conduct member outreach campaigns to members identify with <50% asthma medication ration. 9. Implement the asthma spacer member incentive program. 10. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., American Cancer Society, Community Relations Department) to implement interventions, promote best	Increase the AMR rate for members, 5 to 64 years of age, who had persistent asthma and had a ≥ 0.50 ratio of controller medications to total asthma medications to exceed the DHCS MPL (50 th percentile). 4. Retrospective Mry 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Retrospective Drug Utilization Review and Provider Interventions Related to Asthma Medication Use. 5. Explore development of community health workers (CHW) home visiting program in collaboration with Health Education. 6. Include AMR in the Quality Incentive Provider Pool (QIPP) Program. 7. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 8. Conduct member outreach campaigns to members identify with <50% asthma medication ration. 9. Implement the asthma spacer member incentive program. 10. Engage in partnerships with internal department 1. 08/15/25 2. 01/31/25 - 12/31/25 3. 07/31/25 - 5. 09/30/25 5. 09/30/25 7. 12/31/25 8. 09/30/25 9. 06/30/25 9. 06/30/25 11. 0.01/01/25 - 12/31/25 11. 0.01/01/25 - 12/31/25 12. Olirical Programs Pharmacist A copy and member of 12/31/25 12. Olirical Programs Pharmacist Str. QI Program Anager III Outlon/125 - 12/31/25 11. 0.01/01/25 - 12/31/25 12. Olirical Programs Pharmacist Str. QI Program Anager III Outlon/125 - 12/31/25 11. 0.01/01/25 - 12/31/25 11. 0.01/01/25 - 12/31/25 11. 0.01/01/25 - 12/31/25 12. Olirical Programs Pharmacist Str. QI Program Anager III Outlon/125 - 12/31/25 12. Olirical Programs Pharmacist Str. QI Program Anager III Outlon/125 - 12/31/25 12. Olirical Programs Pharmacist Str. QI Program Anager III Outlon/125 - 12/31/25 12. Olirical Programs Pharmacist Str. QI Program Outlon/125 - 12/31/25 12. Olirical Programs Pharmacist Str. QI Program Anager III Outlon/125 - 12/31/25 12. Olirical Programs In 10.01/01/25 - 12/31/25 12. Olirical Programs Pharmacist Str. QI Program Anager Outlon/125 - 12/31/25 12. Olirical Program Outlon/125 - 12/31/25 12. Olirical Program Out

23. Chronic Disease Management: Asthma Medication Ratio (AMR)

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
			11. Create and/or update provider and			
			member education campaigns that are			
			culturally and linguistically appropriate to			
			address health disparities with input from			
			external organizations (e.g. Community			
			Advisory Committee).			

24. Chronic Disease Management: 2025 DHCS Lean Quality Improvement and Health Equity Improvement Project

Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
thma dication tio	Implement multi- disciplinary continuous quality improvement activities to improve the Asthma Medication Ratio	 Submit the lean quality improvement and health equity process form. Submit the initial progress form with SMART goals, run charts, and interventions. Submit the final progress form. 	1. 02/10/25 2. 06/10/25 3. 10/10/25	QI Program Manager III	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No No New objective added in 2025. Next Steps:

25. Chronic Disease Management: Health Equity Controlling Blood Pressure (CBP)

			inty Controlling Blood Fressure (CBF)		I	D	
Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities		Responsible Staff / Department	Status Update
	Controlling Blood Pressure	Increase the percentage of members with hypertension who are 21-44 years of age and have a blood pressure rate of <140/90 to exceed the DHCS MPL (50th percentile).	 Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. Conduct disparities analysis by race and ethnicity. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities with input from external organizations (e.g. Community Advisory Committee). Notify members and providers of the Medi-Cal Rx blood pressure cuff benefits. Monitor and promote member utilization of the blood pressure devices to improve self-monitoring and reporting of blood pressure. Collaborate with Care Management to promote the blood pressure cuff benefit. Utilize the Wellth Program to collect blood pressure data. Conduct community health fairs to collect blood pressure data and refer members with hypertension to care management. 	1. 08/15/25 2. 01/01/25 - 12/31/25 3. 07/31/25 4. 07/31/25 5. 01/01/25 - 12/31/25 6. 03/31/25 7. 03/01/25 - 12/31/25 8. 09/01/25 9. 01/01/25 - 12/31/25 10. 12/31/25 11. 12/31/25 12. 12/31/25 13. 12/31/25		Sr. QI Manager QI Program Manager II QI RN Manager, Care Management and Special Programs Sr. Manager of Population Health Wellness and Prevention Manager HEDIS® Data Master	Annual Goal Met: Yes No Continue Objective: Yes No No Next Steps:

25. Chronic Disease Management: Health Equity Controlling Blood Pressure (CBP)

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
			11. Utilize the Chronic Disease Self-			
			Management Program to educate members			
			with hypertension care gaps on self-			
			management skills.			
			12. Include CBP in the Quality Incentive			
			Provider Pool (QIPP) Program.			
			13. Evaluate improvements in data collection			
			to capture BP through administrative data			
			(e.g., EMR, HIE).			

26. Chronic Disease Management: Glycemic Status Assessment for Patients with Diabetes (>9.0%) (GSD)

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities		Responsible Staff / Department	Status Update
MCAS	Glycemic Status Assessment for Patients with Diabetes >9.0% (GSD- Poor Control	Decrease the percentage of members with diabetes who are 18-75 years of age and have GSD > 9.0% to meet the DHCS HPL (90 th percentile).	 Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. Conduct disparities analysis by race and ethnicity. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities with input from external organizations (e.g. Community Advisory Committee). Launch program to distribute at-home HbA1c screenings kits. Include in the Quality Incentive Provider Pool (QIPP) Program Evaluate improvements in data collection (e.g., administrative data sources, coding audits). Continue community program to utilize test screenings: Health Fairs Pop-Clinics Launch the new Arine Diabetes Management Program 	1. 08/15/25 2. 01/31/25 - 12/31/25 3. 07/31/25 4. 07/31/25 5. 01/01/25 - 12/31/25 6. 01/01/25 - 12/31/25 7. 12/31/25 8. 12/31/25 9. 01/01/25 - 12/31/25 10.09/01/25 11.01/01/25 - 12/31/25	•	Sr. QI Manager QI Program Manager III QI RN Sr. Director of Health Education, Cultural and Linguistic Services Sr. Health Navigator & Health Education	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No No Next Steps:

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26. Chronic Disease Management: Glycemic Status Assessment for Patients with Diabetes (>9.0%) (GSD)

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
			11. Continue to promote Chronic Disease Self-			
			Management Program to members with			
			diabetes care gap and other co-morbidities.			

27. Women's Health: Chlamydia Screening in Women (CHL) **Goals and Objectives Planned Activities** Timeframe for Responsible **Status Update Category** Area of Staff / **Focus Completion of Activities Department MCAS** Chlamydia Increase the rate of 1. Provide clinics/providers with the annual 1. 08/15/25 OI RN Manager Annual Goal Met: Yes No No MY 2024 MCAS / HEDIS® rate reports. Screening in chlamydia screening in 2. 01/31/25 - 12/31/25 QI Program 2. Provide clinics/providers with prospective Women members 16 to 24 years 3. 07/31/25 Manager II Quarterly Updates: MY 2025 MCAS rate and gaps in care 4. 01/01/25 - 12/31/25 OI RN of age to meet or exceed reporting via Converged Data Insights. the 75th national Medicaid 5. 04/30/25 • Sr. Health 3. Identify low performing providers and 6. 06/30/25 percentile established by Navigator & conduct best practices presentations. NCQA. 7. 12/31/25 Health Educator 4. Evaluate MY 2024 performance to identify 8. 01/01/25 - 12/31/25 barriers, disparities and opportunities for 9. 01/01/25 - 12/31/25 improvement and interventions. Continue Objective: 5. Engage in partnerships with internal Yes X No departments, clinic systems, and external organizations, (e.g., Community Relations Next Steps: Department, Planned Parenthood, VCPH, VCOE) to implement interventions to increase access to care, promote best practices and increase awareness. 6. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities Trainings for low performing providers. 7. Include CHL in the Quality Incentive Provider Pool (QIPP) Program. 8. Evaluate programs to utilize chlamydia screenings test kits. Health Fair

Home Test Kits

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27. Women's Health: Chlamydia Screening in Women (CHL)

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
			9. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).			

28. Women's Health: Prenatal and Postpartum Care (PPC) **Goals and Objectives Planned Activities** Timeframe for Responsible **Status Update** Category Area of **Focus Completion of** Staff / **Activities Department MCAS** Prenatal and Increase the percentage 1. Provide clinics/providers with the annual 1. 08/15/25 OI RN Manager Annual Goal Met: Yes No No MY 2024 MCAS / HEDIS® rate reports. Postpartum of members with live 2. 01/31/25 - 12/31/25 OI RN 2. Provide clinics/providers with the Care birth deliveries who 3. 07/31/25 HECL/Sr. Health Quarterly Updates: prospective MY 2025 MCAS rate and 4. 07/31/25 completed timely prenatal Navigator & member gaps in care reporting via 5. 01/01/25 - 12/31/25 Health Educator and postpartum exams to Converged Data Insights. 6. 03/01/25 - 12/31/25 meet or exceed the DHCS Population Health 3. Evaluate MY 2024 performance to identify HPL (90th percentile). 7. 12/31/25 Analyst barriers, disparities and opportunities for 8. 03/01/25 Members who received improvement and interventions. a prenatal care visit 9. 06/30/25 4. Conduct disparities analysis by race and Continue Objective: during the first 10.09/30/25 ethnicity. Yes X No trimester, on or before 5. Create and/or update provider and the enrollment start member education campaigns that are Next Steps: date, or within 42 days culturally and linguistically appropriate to of enrollment. address health disparities with input from Members who external organizations (e.g. Community Advisory Committee). completed a 6. Conduct member outreach campaigns to postpartum exam increase postpartum screenings and close completed with 7 to 84 gaps in care. days after a live-birth 7. Include PPC in the Quality Incentive delivery. Provider Pool (QIPP) Program. 8. Continue monthly reports to improve early identification of members who are due for prenatal and postpartum visits. 9. Evaluate effectiveness of the Doula Pilot Program, 10. Provide Pregnancy and Postpartum packets with resources for providers to distribute to members. **Evaluation & Barrier Analysis**

29. Children's Health: Childhood Immunization Status – Combo 10 (CIS-10)

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
MCAS		Increase the percentage of members who completed all Combo-10 immunizations by their 2nd birthday to exceed the 75th national Medicaid percentile established by NCQA.	 Provide clinics/providers with the annual MY 2024 MCAS / HEDIS® rate reports. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Care Management, Community Relations Department, VCPH, VCOE, VFC) to implement interventions to increase access to care, promote best practices and increase awareness. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities. Conduct member outreach campaigns to increase immunizations and close care gaps. Include CIS-10 in the Quality Incentive 	Completion of	Staff /	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No No Next Steps:
			Provider Pool (QIPP) Program. 8. Continue the flu vaccine workgroup to improve the CIS-10 rate. 9. Evaluate effectiveness of the flu vaccine member incentive program.			

29. Children's Health: Childhood Immunization Status – Combo 10 (CIS-10)

Category Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
		10. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).			

30. Children's Health: Immunizations for Adolescents – Combo 2 (IMA-2)

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
MCAS	Immunizations for Adolescents – Combo 2 (IMA-2)	Increase the percentage of adolescents who completed all IMA-2 immunizations by their 13th birthday to exceed the 75th national Medicaid percentile established by NCQA.	 Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Care Management, Community Relations Department, VCPH, VCOE, VFC) to implement interventions, improve access to care, promote best practices and increase awareness. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities. Conduct member outreach campaigns to increase immunizations and close care gap. Evaluate effectiveness of the HPV immunization member incentive program and identify program changes/enhancements, as applicable. Expand and evaluate the effectiveness of the POC member incentive program and identify program changes/enhancements as applicable. 	1. 08/15/25 2. 01/31/25 - 12/31/25 3. 07/31/25 4. 01/01/25 - 12/31/25 5. 01/01/25 - 12/31/25 6. 03/0125 - 12/31/25 7. 12/31/25 8. 12/31/25 9. 12/31/25 10.01/01/25 - 12/31/25	 QI RN Manager QI Program Manager II QI RN Sr. Health Navigator & Health Educator 	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No Next Steps:

30. Children's Health: Immunizations for Adolescents – Combo 2 (IMA-2)

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
			9. Include IMA-2 in the Quality Incentive Provider Pool (QIPP) Program.10. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).			

31. Children's Health: Developmental Screening in the First Three Years of Life (DEV)

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
MCAS	Developmental Screening in the First Three Years of Life	Increase the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding, or on, their first, second or third birthday, by 3% compared to the prior measurement year.	 Provide clinics/providers with the annual MY 2024 MCAS / HEDIS® rate reports. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Community Relations Department, Help Me Grow/First 5, VCPH, VCOE) to implement interventions to improve access to care, promote best practices and increase awareness. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). Include in the Quality Incentive Provider Pool (QIPP) Program. Conduct member outreach campaigns to increase preventive screenings and close care gap. 	1. 08/15/25 2. 01/31/25 - 12/31/25 3. 07/31/25 4. 01/01/25 - 12/31/25 5. 09/30/25 6. 12/31/25 7. 12/31/25 8. 03/15/25 - 11/30/25	 QI RN Manager QI Program Manager II QI RN 	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No Next Steps:

32. Children's Health: Lead Screening in Children (LSC)

32. Children's Health: Lead Screening in Children (LSC)			
Focus	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
in Children (LSC) of children who had one or more capillary or venous blood lead tests for lead poisoning by their 2nd birthday to meet the 75th national Medicaid percentile established by NCQA. MY 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Engage in partnerships with internal departments, clinic systems, and external	08/15/25 01/31/25 - 12/31/25 07/31/25 01/01/25 - 12/31/25 01/01/25 - 12/31/25 05/31/25, 12/31/25 03/15/25 - 11/30/25 03/01/25 - 12/31/25 12/31/25 01/01/25 - 12/31/25	 QI RN Manager QI Program Manger II QI RN Sr. Health Navigator & Health Educator 	Annual Goal Met: Yes No Cuarterly Updates: Continue Objective: Yes No No Next Steps:

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32. Children's Health: Lead Screening in Children (LSC)

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
			9. Evaluate effectiveness of the LSC member			
			incentive program and identify program			
			changes/enhancements, as applicable.			
			10. Increase adherence to the DHCS APL (20-			
			016) in the areas of anticipatory guidance			
			and lead screening refusal forms.			
			11. Evaluate improvements in data collection			
			(e.g., administrative data sources, coding			
			audits).			

33. Children's Health: Topical Fluoride Varnish (TFL) **Goals and Objectives Planned Activities** Timeframe for **Status Update** Category Area of Responsible Focus Staff / **Completion of Activities Department MCAS Topical** Increase the percentage of 1. Provide clinics/providers with the annual 1. 08/15/25 OI RN Manager Annual Goal Met: Yes No No Fluoride members, ages 1 through MY 2024 MCAS / HEDIS® rate reports. 2. 01/31/25 - 12/31/25 QI Program Varnish (TFL) 20, who received at least 2. Provide clinics/providers with the 3. 07/31/25 Manager II Quarterly Updates: two topical fluoride 4. 01/01/25 - 12/31/25 • OI RN prospective MY 2025 MCAS rate and member gaps in care reporting via 5. 12/31/25 applications during the Converged Data Insights. measurement year to 6. 12/31/25 exceed the DHCS MPL 3. Evaluate MY 2024 performance to identify 7. 01/01/25 - 12/31/25 8. 01/01/25 - 12/31/25 $(50^{th}).$ barriers, disparities and opportunities for improvement and interventions. Continue Objective: 4. Engage in partnerships with internal Yes X No departments, clinic systems, and external organizations, (e.g., Community Relations Next Steps: Department, Help Me Grow/First 5, VCPH, VCOE, United Way) to implement interventions to improve access to care, promote best practices and increase awareness. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities. 6. Include TFL in the Quality Incentive Provider Pool (QIPP) Program. 7. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).

8. Work with vendors to administer topical

fluoride varnish at health fairs.

34. Children's Health: Well-Child Visits in the First 30 Months of Life (W30)

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
	Well-Child Visits in the First 30 Months of Life	Increase the percentage of children who had well-child visits with a PCP to exceed the DHCS MPL (50th percentile) for the following submeasures. • Well-child visits in the first 15 months of life: Increase the percentage of children with six or more well-care exams within the first 15 months of life. • Well-child visits between 15 and 30 months of age: Increase the percentage of 30-month-old children who had two or more well-child exams between 15 and 30 months of age.	 Provide clinics/providers with the annual MY 2024 MCAS / HEDIS® rate reports. Provide clinics/providers with monthly prospective MY 2025 MCAS rate and gaps in care reporting via Converged Data Insights. Evaluate MY 2024performance to identify barriers, disparities and opportunities for improvement and interventions. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Care Management, Health Education, Population Health, Community Relations, Help Me Grow/First 5, CHDP, VCPH, VCOE, WIC) to implement interventions, promote best practices and increase awareness. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities. 	1. 08/15/25 2. 01/31/25 - 12/31/25 3. 07/31/25 4. 01/01/25 - 12/31/25 5. 01/01/25 - 12/31/25 6. 03/01/25 - 11/30/25 7. 12/31/25 8. 01/01/25 - 12/31/25	 Sr. QI Manager QI Program Manager II QI RN Sr. Health Navigator & Health Educator 	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No Next Steps:

34. Children's Health: Well-Child Visits in the First 30 Months of Life (W30)

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
			6. Conduct member outreach campaigns to increase well-child			
			preventive care screenings and			
			close gaps in care. 7. Include W30 in the Quality			
			Incentive Provider Pool (QIPP) Program			
			8. Evaluate improvements in data			
			collection (e.g., administrative data sources, coding audits).			

35. Children's Health: Child and Adolescent Well-Care Visits (WCV)

	1		ven-care visits (vvcv)			
Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
MCAS	Child and Incre	Increase the percentage	1. Provide clinics/providers with prospective	1. 07/31/25	Sr. QI Manager	Annual Goal Met:
	Adolescent	of members, 3-21 years	MY 2025 MCAS rate and gaps in care	2. 01/01/25 - 12/31/25	 QI Program 	Yes No
	Well-Care	one comprehensive	reporting via Converged Data Insights.	3. 07/31/25	Manager II	Quarterly Updates:
	Visits		2. Provide clinics/providers with the annual	4. 07/31/25	• QI RN	Quarterly Opdates.
		well-care visit with a PCP	MY 2024 MCAS/HEDIS® rate reports.	5. 01/01/25 - 12/31/25	Sr. Health	
		measurement year to exceed the DHCS MPL (50th percentile).	3. Evaluate MY 2024 performance to identify	6. 01/01/25 - 12/31/25	Navigator &	
			barriers, disparities and opportunities for	7. 01/31/25	Health Educator	
			improvement and interventions.	8. 01/01/25 - 12/31/25		
			4. Conduct disparities analysis by race and	9. 12/31/25		
			ethnicity	10. 03/01/25 - 10/31/25		Continue Objective: Yes X No
			5. Create and/or update provider and	11. 12/31/25		ies 🖾 ino 🗖
			member education campaigns that are			
			culturally and linguistically appropriate to			Next Steps:
			address health disparities with input from			
			external organizations (e.g. Community			
			Advisory Committee).			
			6. Engage in partnerships with internal			
			departments, clinic systems, and external			
			organizations, (e.g., Care Management,			
			Community Relations Department, Help			
			Me Grow/First 5, CDR, CLPPP, VCPH,			
			VCOE) to implement interventions to			
			increase access to care, promote best			
			practices and increase awareness.			
			7. Evaluate effectiveness of the well care			
			member incentive program and identify			
			program changes/enhancements, as			
			applicable.			

35. Children's Health: Child and Adolescent Well-Care Visits (WCV)

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
			8. Expand and evaluate the effectiveness of			
			the point-of-care (POC) member incentive			
			program and identify program changes/			
			enhancements as applicable.			
			9. Distribute provider member incentive			
			awards quarterly.			
			10. Conduct member outreach campaigns to			
			increase preventive care screenings and			
			close gaps in care.			
			11. Include WCV in the Quality Incentive			
			Provider Pool (QIPP) Program.			

36. Children's Health: 2023-2026 PIP Clinical Topic: W30-6+ among Hispanic/Latinx Members

Category Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
Quality / 2023-2026 DHCS PIP Clinical Topic: W30-6+ among Hispanic/Latinx Members	Increase the rate of members among the Hispanic/Latinx community for completing six or more Well-Child visits by 15 months of life by 14.37% to meet the 75th percentile nationally established NCQA benchmark.	 Submit Modules as directed by DHCS / HSAG for approval. Report updates/results to QIHEC. 	1. 09/01/25 2. 09/16/25, 11/18/25	QI Program Manager II	Annual Goal Met: Yes No Continue Objective: Yes No Next Steps:

37. Children's Health: 2024-2025 DHCS/IHI Child Health Equity Collaborative **Status Update Category** Area of **Goals and Objectives Planned Activities** Timeframe for Responsible Staff / **Completion of** Focus **Department Activities** Quality / **DHCS** Child Increase the number of 1. Complete Interventions 4: Actor mapping 1. 01/16/2025 • QI Program Annual Goal Met: Yes No No well-child visits completed & Community Partnership. Manager I DHCS Health Equity 2. 01/16/2025 by members assigned to 2. Complete Intervention 5: Partnering for Focused 03/20/2025 QI RN Quarterly Updates: Collaboration CDCR KRB clinic, who Effective Education and Communication. Senior Health on Well-Care are English speaking and Navigator between 12 and 17 years Exams Manager, of age, from 38.42% to Community 43.22% by December 31, Relations 2024. Continue Objective: Yes X No D Next Steps: **Evaluation & Barrier Analysis**

Objective 2: Improve Quality and Safety of Non-Clinical Care Services

38. Cultural and Linguistic Needs & Preferences

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
Improve Quality & Safety of Non- Clinical Care Services	Cultural and Linguistic Needs & Preferences	 By July 31, 2025, GCHP's Health Education, Cultural and Linguistic (HECL) Services Department shall expand current training modules to include Diversity, Equity, and Inclusion (DEI) training program curriculum as per DHCS (APL 23-025) that encompasses sensitivity, diversity, cultural competence and cultural humility, and health equity trainings. By July 31, 2025, GCHP's HECL Department shall conduct three Cultural and Linguistic (C&L) / DEI trainings with three Network Provider offices per quarter. 	 Develop an action plan to evaluate existing C&L / DEI training modules on the GCHP website and develop a process to increase C&L / DEI trainings. Engage various departments on the C&L / DEI training modules and solicit feedback. Engage Community-Based Organizations on the C&L / DEI training modules and solicit feedback. Engage Members on the C&L / DEI training modules for Providers and solicit their recommendations to ensure the Providers trainings are inclusive of GCHP membership. Identify three Providers to conduct three C&L / DEI trainings. Evaluate C&L / DEI trainings and prepare summary report of findings. Prepare QIC dashboard summarizing the total number of C&L / DEI trainings and services at the quarterly QIHEC meetings. 	1. 01/01/25 - 07/31/25 2. 08/01/25 - 12/31/25 3. 12/31/25 4. 12/31/25 5. 12/31/25 6. 12/31/25 7. 03/31/25, 06/30/25, 09/30/25, 12/31/25	 Sr. Director of Health Education and Cultural Linguistics Sr. C&L Specialist Sr. Director, Network Operations Manager, Provider Contracting & Regulatory 	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No No Next Steps:

38. Cultural and Linguistic Needs & Preferences

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
		By December 31, 2025, GCHP's HECL Department shall report on the number of C&L fulfilment and benchmarks quarterly during the QIHEC meeting.				

39. Primary and Specialty Care Access

Category Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
Improve Quality Specialty Care & Safety of Non-Clinical Care Services	Ensure standards met for minimum of 80% of providers. Primary Care Access Members are offered: Non-urgent primary care within 10 business days of request Urgent care within 24 hours Specialty Care Access Members are offered: Non-urgent specialty care appointment within 15 business days Non-urgent ancillary services within 15 business days	 Conduct survey and evaluate results. Develop and implement corrective action plans when timely access standards are not met. Report quarterly performance to QIHEC. Monitor complaints and potential quality issues (PQIs), relating to the member access for appointments and/or referrals, and take action as appropriate. 	 09/30/2025 01/01/25 - 12/31/25 03/31/25, 06/30/25, 09/30/25, 12/31/25 01/01/25 - 12/31/25 	 Sr. Director, Network Operations Sr. Manager, Provider Network Operations – Program & Policy Manager, Provider Relations QI RN Manager 	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No No Next Steps:

40. Network Adequacy

Category Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
Improve Quality improve Safety of Non- Clinical Care Services Assess and improve network adequacy as demonstrated by services availability of practitioners.	PCP and Provider Ratios: 1 PCP 1:2000 Total Physicians 1: 1200 Physician Supervision to Non-Physician Practitioner Ratios: Nurse Practitioners 1:4 Physician Assistants 1:4 Network maintained PCP located within 10 miles or 30 minutes from members residence. Network maintained DHCS Core specialists located within 30 miles or 60 minutes from members residence. Develop process for network certification (with ratios). Hospitals 15 miles or 30 minutes from members residence.	 Conduct ratio analysis for primary care and high-volume specialties. Monitor progress toward action plans to maintain or improve GeoAccess standards for Network maintained PCP Monitor progress toward action plans to maintain or improve GeoAccess standards for Network maintained DHCS Core Specialists. Develop process for network certification (with ratios). Report biannual ratio analysis and annual GeoAccess findings to the QIHEC. 	1. 03/31/25, 06/30/25, 09/30/25, 12/31/25 2. 01/01/25 - 12/31/25 3. 01/01/25 - 12/31/25 4. 12/31/25 5. 03/31/25, 06/30/25, 09/30/25, 12/31/25	 Sr. Director, Network Operations Sr. Manager, Provider Network Operations – Program & Policy Executive Director, Delivery System Operations and Strategies 	Annual Goal Met: Yes No Courterly Updates: Continue Objective: Yes No No Next Steps:

41. After Hours Availability

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
Improve Quality & Safety of Non- Clinical Care Services	After Hours Availability	Conducts surveys to ensure members are able to reach a provider after hours.	 Conduct surveys and evaluate results. Develop and implement action plans when timely access standards are not met. Report quarterly performance to the QIHEC. 	1. 09/30/25 2. 01/01/25 - 12/31/25 3. 03/31/25, 06/30/25, 09/30/25, 12/31/25	 Sr. Director, Network Operations Sr. Manager, Provider Network Operations – Program & Policy Manager, Provider Relations Executive Director, Delivery System Operations and Strategies 	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No Next Steps:

42. Provider Satisfaction **Goals and Objectives Timeframe for Status Update** Category **Planned Activities** Responsible Area of Staff / **Completion of** Focus **Department Activities** Field provider survey and Improve Provider 1. Analyze results and identify opportunities 1. 10/31/25 • Sr. Director, Annual Goal Met: Yes No No develop action plan(s) for improvement. Network Quality Satisfaction 2. 01/01/25 - 12/31/25 to improve areas of low 2. Implement interventions as needed to **Operations** & Safety Survey Quarterly Updates: of Nonperformance. improve satisfaction. · Manager, Provider Clinical Relations • Sr. Manager, Care Provider Network Services Operations – Program & Policy Continue Objective: Executive Yes 🗵 No 🗖 Director. Delivery System Next Steps: Operations and Strategies **Evaluation & Barrier Analysis**

43. Facility Site Review Requirements

Category Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
Improve Member Review Safety Requirements	Maintain 100% compliance with Facility Site Review (FSR) requirements.	 Complete and document Initial, Interim, and Tri-annual Facility Site Reviews 100 % timely. Issue and monitor corrective action plans (CAPs) as needed to facilitate clinic compliance and improvement on identified deficiencies. Collaborate with PNO, Legal, and CMO on sites not meeting requirements. Monitor member complaints / grievances and potential quality issues (PQIs) involving quality of care and safety concerns. Submit biannual FSR data to DHCS: January – June July – December 	1. 01/01/25 - 12/31/25 2. 01/01/25 - 12/31/25 3. 01/01/25 - 12/31/25 4. 01/01/25 - 12/31/25 5. 07/31/25, 12/31/25	QI RN Manager QI RN	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No No Next Steps:

44. Physical Accessibility Review Surveys (PARS) **Goals and Objectives Timeframe for Status Update** Category Area of **Planned Activities** Responsible Staff / **Completion of Focus Activities Department** Complete Physical Annual Goal Met: Improve Physical 1. Compile reports for high volume / ancillary 1. 01/31/25 QI RN Manager Yes No No Accessibility Reviews specialist visits for the Seniors and Persons Member 2. 12/31/5 OI RN Accessibility Safety Review Surveys (PARs) 100% on time. with Disabilities (SPD) population and 3. 01/01/25 - 12/31/25 Quarterly Updates: submit PAR reports to DHCS. 2. Complete and document PARs for identified high volume / ancillary specialist provider sites. 3. Complete and document PARs as indicated during the Initial and Periodic FSRs Continue Objective: Yes X No D Next Steps: **Evaluation & Barrier Analysis**

45. Credentialing / Recredentialing

Category	Area of	Goals and Objectives	Planned Activities	Timeframe for	Responsible	Status Update
Category	Focus	Goals and Objectives	Flaimed Activities	Completion of Activities	Staff / Department	Status Opuate
	Credentialing / Recredentialing	Maintain a well-defined credentialing and recredentialing process for evaluating practitioners / providers to provide care to members.	 Perform timely verification of all required credentialing elements to ensure current, accurate and complete files for credentialing decisions. Perform timely recredentialing within 36 months of last approval date. Perform ongoing monitoring of sanctions and adverse events timely. Collaborate with Symplr on software configuration and automation to achieve efficiency in the credentialing process. 	1. 01/01/25 - 12/31/25 2. 01/01/25 - 12/31/25 3. 01/01/25 - 12/31/25 4. 01/01/25 - 12/31/25	 Senior Director, Network Operations Credentialing Specialist III Credentialing Specialist II 	Annual Goal Met: Yes No Continue Objective: Yes No No Next Steps:

Objective 3: Improve Quality of Service

46. Grievances and Appeals						
Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
Assess and improve member experience	Grievances and appeals	Monitor all member grievances and appeals to identify trending issues. Communicate these trends to relevant departments to develop actionable plans aimed at addressing highly reported concerns and improving the overall member experience.	 Conduct quarterly assessment of grievances and appeals. Identify opportunities for improvement. Create and implement action plans for improvement. 	1. 03/31/25, 06/30/25, 09/30/25, 12/31/25 2. 01/01/25 - 12/31/25 3. 01/01/25 - 12/31/25	 Director of Operations Operations Manager 	Annual Goal Met: Yes No Courterly Updates: Continue Objective: Yes No No Next Steps:
:valuation	& Barrier Anal	lysis				

47. Call Center Monitoring

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
	Call Center Monitoring	Meet call center benchmarks to ensure members have timely access to call center staff and implement interventions on any deficient benchmarks. • ASA: 30 seconds or less • Abandonment Rate: 5% or less • Phone Quality Results: ≥ 95%.	 Report Member Services Telephone Access Analysis Monitor Average Speed of Answer (ASA) Monitor Abandonment Rate Phone Quality Results Identify opportunities for improvement based on data analysis. 	1. 03/31/25, 06/30/25, 09/30/25, 12/31/25 2. 01/01/25 - 12/31/25	 Director of Member Contact Center Sr. Operations Manager 	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No No Next Steps:

Objective 4: Assess and Improve Member Experience

48. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
	CAHPS Surveys	Coordinate with DHCS and HSAG to complete the CAHPS surveys and complete analysis of survey results.	 Submit Survey Sample Frame data to HSAG. Assess CAHPS scores and complete analysis. 	1. 01/06/25 2. 07/31/25	 Sr. Director, Quality Improvement Sr. QI Manager QI Program Managers II, III 	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No No Next Steps:

49. Consumer Assessment of Healthcare Providers and Systems (CAHPS): Access to Specialty Care

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
Assess and improve member experience	CAHPS: Access to Specialty Care	Improve access to specialty care for adults and children.	 Develop interventions to improve access to specialty care. Participate in the ACAP CAHPS Collaborative. 	1. 12/31/25 2. 02/01/25 - 12/31/25	 Chief Innovation Officer Executive Director, Delivery Systems, Operations and Strategies Chief Member Experience and External Affairs Officer 	Annual Goal Met: Yes No Continue Objective: Yes No No Next Steps:

50. Consumer Assessment of Healthcare Providers and Systems (CAHPS): Improve CAHPS Scores Goals and Objectives **Planned Activities Status Update** Category **Area of Focus** Timeframe for Responsible Staff / **Completion of Department Activities** Improve CAHPS scores Annual Goal Met: Assess and CAHPS: Improve CAHPS 1. Utilize Voice of the Member to 1. 12/31/25 Chief Innovation Yes No No Officer Scores based on MY 2024 improve create interventions based on CAHPS outcomes, member areas of low performance. Executive Quarterly Updates: including Getting Care Director, experience Quickly and Getting Delivery Needed Care. Systems, Operations and Strategies Chief Member Continue Objective: Experience and Yes 🗵 No 🗖 External Affairs Officer Next Steps: **Evaluation & Barrier Analysis**

Objective 5: Ensure Organizational Oversight of Delegated Functions

51. Delegation Oversight

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff / Department	Status Update
Ensure Organizational Oversight of Delegated Functions	Completion of Delegation Oversight Audits Credentialing Quality Improvement Utilization Management Member Experience Claims Call Center Cultural and Linguistics Transportation (NEMT/NMT) Population Health Management	100% of all audits completed at least annually with corrective action plans (CAPs) closed timely.	 Complete audits per scheduled timeline Issue CAPS as applicable. Follow-up on CAPs as applicable Report to Compliance Committee and Quality Improvement Committee 	1. 01/01/25 - 12/31/25 2. 01/01/25 - 12/31/25 3. 01/01/25 - 12/31/25 4. 03/31/25, 06/30/25, 09/30/25, 12/31/25	 Sr. Director, Compliance Delegations Oversight Program Manager Privacy Officer- Internal Audit Director Delegation Oversight Audit Manager 	Annual Goal Met: Yes No Quarterly Updates: Continue Objective: Yes No Next Steps:



Quality Improvement and Health Equity Transformation Work Plan 2025