Policy and Procedure No: QM 19.7	**Revision No: 7**
Division: Care Management	
Department: Quality Management	
Title: PHC-CA Quality Improvement and Health Equity Transformation Program	
Effective Date: 1/1/2024	
Supersedes Policy No: QM 19.0, QM 19.1, QM 19.2, QM 19.3, QM 19.4, QM 19.5, QM 19.6	
Reviewed/Revised by: Sandy Johansson	**Review/Revision Date: 12/10/2025**
Approving Committee: Quality Management Committee	**Date: 12/11/2025**
Executive Oversight Committee Date: 12/16/2025	

Purpose:

To describe how PHC California (the Health Plan) develops and implements its Quality Improvement and Health Equity Transformation Program (QIHETP) that complies with the Department of Health Care Services (DHCS) requirements and replaces the Health Plan's legacy Quality Improvement Program.

Policy:

1. The Health Plan must deliver quality care that enables all its Members to maintain health and improve or manage a chronic illness or disability. The Health Plan must ensure quality care in each of the following areas:
    a. Clinical quality of physical health care;
    b. Clinical quality of Behavioral Health care focusing on prevention, recovery, resiliency, and rehabilitation;
    c. Access to primary and specialty health care Providers and services;
    d. Availability and regular engagement with Primary Care Providers (PCP);
    e. Continuity of care and Care Coordination across settings and at all levels of care, including transitions in care, with the goal of establishing consistent Provider-patient relationships; and
    f. Member experience with respect to clinical quality, access and availability, culturally and linguistically competent health care and services, continuity of care, and Care Coordination.
2. The Health Plan must apply the principles of continuous quality improvement (CQI) to all aspects of the Health Plan's service delivery system through analysis, evaluation, and systematic enhancements of the following:
    a. Quantitative and qualitative data collection and data-driven decision-making;
    b. Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

c. Feedback provided by Members, community partners, and Network
d. Providers in the design, planning, and implementation of its CQI
e. activities; and
f. Other issues identified by Contractor or DHCS.

3. The Health Plan's QIHETP is built upon the California Department of Health Care Services (DHCS) Population Health Management (PHM) framework. The Health Plan employs data-driven methodologies to identify clinical and social drivers of health, monitor performance of clinical and service initiatives, identify opportunities for improvement and implement corrective action plans with the goal of improving the health of Medi-Cal enrollees and health equity for all populations.

4. The Health Plan aligns its internal quality and health equity efforts with DHCS' Health Equity Framework within the Comprehensive Quality Strategy Report.

5. The Health Plan monitors and reports Medi-Cal Accountability Set (MCAS) measures, and stratifies these measures by various demographics including, but not limited to, age, gender, race/ethnicity, and primary language.

6. The Health Plan reviews and acts on items identified through DHCS' reports including but not limited to the Technical Report, Health Disparities Report, Preventive Services Report, focus studies, and Encounter Data Validation Report.

7. The Health Plan is required to incorporate its county-specific Population Needs Assessment, as detailed in the Population Heath Management Policy Guide, build community partnerships and improve enrollee participation to fully understand the barriers preventing all populations from receiving care and preventive services as well as social drivers of health.

8. The Health Plan employs a Health Equity Officer who is responsible for developing and implementing the QIHETP.

9. The Health Plan develops and provides an annual QIHETP submission to DHCS.

10. The Health Plan's QIHETP:

    a. Includes a comprehensive assessment of Quality Improvement (QI) and health equity (HE) activities with evaluation of effectiveness of interventions.

    b. Incorporates quality performance measure results with a plan to address any deficiencies. (In the event the Plan retains subcontractors or downstream subcontractors, these entities shall be included).

    c. Incorporates methods to address External Quality Review technical support and evaluation report recommendations.

    d. Utilizes data from various sources (performance results, encounter data, grievances and appeals, utilization review, and consumer satisfaction surveys) to analyze delivery of services and quality of care provided by contracted providers as well as to identify, evaluate and reduce health disparities. (In the event the Plan retains subcontractors or downstream subcontractors, these entities shall be included).

e. Involves the participation of the Health Plan's network providers in the QIHETP and Population Needs Assessment (PNA). (In the event the Health Plan retains fully delegated subcontractors and downstream fully delegated subcontractors, these entities shall be included).

f. Employs methods for equity-focused interventions to identify patterns for over-or under-utilization of physical and behavioral health care services.

g. Uses information from Public Policy and Community Advisory Committee (PPCAC) findings, enrollee listening sessions, and focus groups/surveys to inform policies and ensure community engagement and a commitment to enrollee and family focused care.

h. Incorporates population health management (PHM) findings.

i. Uses performance improvement project (PIP) findings and outcomes, consumer satisfaction surveys, and collaborative initiatives.

j. Addresses clinical quality of physical and behavioral health, access and engagement of providers, continuity and coordination across settings and all levels of care, and enrollee experience.

k. The Health Plan provides member experience and clinical performance data to its delegates at the QIHEC and upon request.

11. The Health Plan provides the following accreditation reports to DHCS on an annual basis. (In the event the Plan retains subcontractors or downstream subcontractors, these entities will be included).

    a. Contracted provider accreditation status, survey type, and level

    b. Accreditation agency results and recommended actions/improvements, corrective action plans and summaries

    c. Accreditation expiration date

12. The Health Plan, at least annually or more frequently as directed by DHCS, cooperates with and assists the External Quality Review Organization (EQRO) designated by DHCS in conducting its EQR reviews. The Health Plan implements the EQRO's technical guidance in conducting mandatory and optional activities described in 42 CFR section 438.358 and the Health Plan's contract with DHCS. The plan is required to submit patient-level data as specified by the EQRO as part of the annual performance measurement validation audit process.

13. The Health Plan makes the Quality Improvement, health equity and population needs assessment (PNA) reports and findings available to its network providers, subcontractors, downstream contractors (if any), and members of the public on the Health Plan's website.

14. Quality Improvement and Health Equity Committee (QIHEC)

    a. Membership

        i. The Health Plan ensures that its Quality Improvement and Health Equity

Committee (QIHEC) is comprised of members with diverse backgrounds to provide a full range of expertise in clinical practice, behavioral health, health administration, and public health, including community providers and the Health Plan's liaison to the Public Policy and Community Advisory Committee (PPCAC).

ii. The QIHEC's membership includes the Health Plan's Medical Director or designee, the Health Equity Officer, and a broad range of network providers that actively participate in the QIHEC. The network provider members of the QIHEC must include, at minimum, those providing health care services to:

1. Enrollees affected by health disparities
2. Limited English Proficiency (LEP) enrollees
3. Seniors and persons with disabilities
4. Persons with chronic conditions

15. The Health Plan ensures enrollee confidentiality is maintained in QI discussions and ensures avoidance of conflict of interest among the QIHEC members.

16. The Health Plan integrates Utilization Management into the QIHETP by making Utilization Management data available to the QIHEC for analysis and maintaining a Utilization Management Committee that reports up to the QIHEC.

17. The Health Plan incorporates diversity, equity, and inclusion (DEI) training within the QIHETP goals for Quality Improvement (QI) and health equity projects pertaining to cultural needs of the Health Plan's enrollees. The PPCAC assesses whether the Health Plan meets enrollee's culturally and linguistically diverse needs and provides feedback to assist the Health Equity Officer and the National Director of Quality in developing and implementing strategies to further refine the Health Plan's operations and quality of care. In addition, the Health Plan must institute, at a minimum, the following:

a. DEI training program evaluation within ongoing Quality Improvement programs (see APL 23-025 Appendix B);

b. Evaluation of staff and enrollees' grievances and complaints regarding discrimination, cultural biases, or insensitive practices;

c. Evaluation of enrollees' language access services to include written and oral interpretation services and ability to request auxiliary aids for both in-person office visits and telehealth visits;

d. Evaluation of enrollees' satisfaction regarding culturally competent care;

e. Monitoring of any actions taken by the United States Equal Employment Opportunity Commission regarding discriminatory practices by medical groups and other subcontractors;

f. Methods to identify health care needs of diverse enrollees, and the conduct of assessments to monitor the effectiveness of health care services; and

g. Provision of information on the Health Plan's quality performance upon request to enrollees in a format that is easily understood.

18. The Health Plan conducts a minimum of two performance improvement projects (PIPs) per year as required by the Centers for Medicare and Medicaid Services (CMS).

19. The Health Plan participates in DHCS mandated statewide collaborations or additional initiatives that may improve quality and equity of care for enrollees as directed by DHCS.

20. The Health Plan must have a Performance Improvement Lead and a Regional Quality and Health Equity Team to lead quality and health equity efforts across the organization.

21. The Health Plan is required to exceed the Minimum Performance Levels (MPL) as determined by DHCS. In the event the Health Plan performs below the MPL, the plan will conduct additional quality improvement and health equity improvement projects as determined in the MCAS: Quality Improvement and Health Equity Framework Policy Guide.

22. The Heath Plan is not currently required to participate in the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) enrollee satisfaction survey conducted for DHCS by Health Services Advisory Group (HSAG). The Health Plan annually conducts its own CAHPS® survey following NCQA CAHPS requirements and will provide DHCS with results upon request.

Procedure:

1. Governance

    a. The AHF Board of Directors and the Executive Oversight Committee (EOC) of the Board of Directors serve as Governing Body of the QIHETP. The Board and the EOC:

        i. Review and approve the overall QIHETP;

        ii. Review and approvals QIHETP Annual Plan;

        iii. Appoints and delegates QIHETP oversight to accountable entities;

        iv. Receives QIHE progress reports prepared by the Health Plan's Medical Director Health Equity Officer;

    b. The National Director of Quality is responsible for preparing quarterly and annual reports summarizing Quality Improvement and Health Equity activities for submission to the EOC and/or Board (as necessary). The National Director ensures that all required program documents—including the QIHETP Plan, Quality Improvement Program Description, Work Plans, and Annual Assessments—are reviewed and approved by the required committees.

2. Membership

    a. Co-Chairs:

i. The Medical Director and the Health Plan's Health Equity Officer are cochairs of the QIHEC and ensure that QHIHEC meetings occur at least four times per year.

ii. The Co-Chairs and the National Director of Quality Management are responsible for the following:

1. Ensure that the Quality Improvement Program, including Health Equity, is adequate to monitor the full scope of clinical, social and behavioral services rendered, that identified problems are resolved and corrective actions are initiated when necessary and appropriate.

2. They also ensure that fiscal management considerations must never influence clinical decision-making; all medical decisions shall be based solely on evidence-based guidelines and the best interests of the member.

3. Provides leadership in QIHE and builds collaboration with the interdisciplinary committees/teams, members, community, and other stakeholders.

4. Is responsible for the QIHE portion of the QIHEC meetings, including the annual QIHETP Plan, QIHE Work Plan, QIHE Assessment and Evaluation, QIHE agenda items, and QIHE data.

3. The QIHEC meets at least four (4) times per year to oversee the effectiveness of QIHE programs. Activities include:

a. Identifying opportunities for improvement as evidenced by the data or data trends and various feedback mechanisms.

i. Data sources include, but are not limited to, QIHE initiatives and programs, patient experience surveys, patient satisfaction surveys, providers satisfaction surveys, improvements in health equity data, member and/or stakeholder feedback.

ii. Utilization Management data, including number and types of services, denials, deferrals, modifications, appeals and grievances.

b. Analyzing data to identify differences in quality of care and utilization, as well as underlying reasons for any variations in the provision of care to its members; developing equity-focused interventions to address the underlying factors of identified health disparities, including social drivers of health (SDOH); and setting disparity reduction targets for specific populations and/or measures as identified by DHCS.

c. Designing strategies for improvement, determining how to measure success, and overseeing implementation.

d. Reviewing and updating the following documents and reports annually:

    i. Annual Quality Improvement (QI) Program Description

    ii. QIHETP and Utilization Management (UM) Program Description

    iii. Annual QI Work Plan, which includes at a minimum:

        1. Assessment of progress in implementation of Quality Improvement strategies and the effectiveness of the program;

        2. Assessment of timely completion of projects;

        3. Determine effectiveness of project and identify potential areas of improvement;

        4. Recommendations for needed changes in program strategy or administration

    iv. Quality Improvement Health Equity (HE) Work Plan

    v. UM Work Plan

    vi. Annual QI Program Assessment and Evaluation

e. The Health Plan solicits Providers to participate in the development and implementation of quality improvement initiatives.

f. Receiving feedback and suggestions from the PPCAC liaison and developing subsequent initiatives.

g. Overseeing the fulfillment of federal and state regulations for Quality Improvement, Quality Improvement contract deliverables and accreditation standards.

h. Communicating QIHEC activities and outcomes to enrollees, providers, and staff via newsletters, blast fax, telephone calls, meeting presentations, special events and other methods.

i. Overseeing the following committees reporting up to QIHEC:

    i. Utilization Management Committee

    ii. Member Provider Committee

    iii. Public Policy Community Advisory Committee

    iv. Credentialing and Peer Review Committee

v. Risk Management Committee

j. Submission of HEDIS® and CAHPS® results and other performance measures per federal and state regulations and contracts.

4. The Health Equity Officer or designee:

a. Co-Chairs the QIHEC with the Health Plan's Medical Director. The Co-Chairs ensures the committee is held on a quarterly basis.

b. Provides leadership in QIHE and builds collaboration with the interdisciplinary committees/teams, members, community, and other stakeholders.

c. Is responsible for the QIHE portion of the QIHEC meetings, including the annual QIHETP Plan, QIHE Work Plan, QIHE Assessment and Evaluation, QIHE agenda items, and QIHE data.

d. Provides a written summary of the QIHEC activities, findings, recommendations, and actions after each meeting for submission to the EOC, DHCS upon request, and made publicly available on the Health Plan's website at least quarterly.

e. Ensures that the QIHE Program Description and Work Plan:

i. Delineates a systematic process for quality improvement and health equity that monitors and evaluates the quality, social drivers, utilization and appropriateness of care and services rendered;

ii. Identifies quality improvement methodology and quality improvement indicators;

iii. Incorporates information from following departments: Member Services, Appeals and Grievances, Care Coordination, Utilization Management; Disease Management, Health Equity, Credentialing, Provider Relations, Claims, Sales, and Marketing.

f. Attends, at a minimum, quarterly regional collaborative meetings that may be in-person.

5. The National Director of Quality or designee:

a. Briefs the QIHEC on the contents of DHCS reports, including the Comprehensive Quality Strategy, Technical, Health Disparities, Preventive Services, and Encounter Data Validation reports, and recommends updates to the QIHE Work Plan;

b. Oversees the conduct of Performance Improvement Projects;

c. Serves as Performance Improvement Lead;

d. Calculates the Health Plan's rates for MCAS measures and reports to the External

Quality Review Organization (EQRO) the results of each of required MCAS measure while adhering to the requirements set forth by HEDIS®, CMS, or other applicable technical specifications for the measurement year;

e. Monitors plan adherence to DHCS Minimum Performance Levels;

f. Oversees vendor Press Ganey's conduct of the Health Plan's annual CAHPS® survey.

6. Upon request, the National Director of Quality or designee will provide DHCS with the Health Plan's CAHPS survey results, a copy of the plan's CAHPS survey instrument and the survey's calculation/administration methodology so that DHCS can evaluate the results for compliance with state and federal requirements.

7. Staff of the Health Plan's Quality Improvement, Provider Relations, Member Services, and Administrative departments, along with the Health Equity Officer and the QIHEC, serve as the Regional Quality and Health Equity Team. This team supports QIHE work by developing and leveraging existing partnerships that include network providers, other health plans, the Los Angeles County Department of Mental Health, local health departments and government agencies, community-based organizations, regional centers, community-based service programs, continuum of care programs, Area Agencies of Aging, caregiver resource centers, Individual Family Service Plans, and enrollees.

8. The Quality Improvement Department Staff supports the QIHEC by activities that include but are not limited to:

   a. Typing agendas, collecting reports, emailing information in advance of meetings, taking minutes, and acquiring the signature of chair for approval of minutes.

   b. Administrative support for the collection of input and feedback from the interdisciplinary committees, members, providers, and stakeholders that may include help with solicitation of said input/feedback.

   c. Writing, reviewing, editing information for the Quality Improvement Program Description.

   d. Collaborating with the Chief Health Equity Officer for the submission of the QIHETP Plan, QIHE Work Plan, and the Quality Improvement Program Annual Assessment and Evaluation.

   e. Providing technical assistance to groups working on improvement initiatives.

   f. Attending technical assistance calls from the QIO and requests them, as necessary. Information is shared with other staff.

9. The Information Technology Data Management Department maintains a health information system that collects, integrates, analyzes, and reports data necessary to implement the Quality Improvement program.

10. The SFTP Upload Team uses DHCS' EQRO File Transfer Protocol (FTP) website when sending communications containing patient-level data.

Definitions:

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS®): A standardized survey of patients' experiences with ambulatory and facility-level care
2. External Quality Review Organization (EQRO): means an organization that meets the competence and independence requirements set forth in 42 CFR section 438.354, and performs EQR and other EQR-related activities as set forth in 42 CFR section 438.358 pursuant to its contract with DHCS.
3. Health Effectiveness and Data Information Set (HEDIS®): A health plan tool that measures important dimensions of care and service.
4. Health Equity: means the reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.
5. National Committee for Quality Assurance (NCQA®): is an organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive.
6. Public Policy and Community Advisory Committee (PPCAC): A committee comprised of stakeholders, community advocates, traditional and Safety-Net Providers, and members.
7. Quality Improvement (QI): means systematic and continuous actions that lead to measurable improvements in the way health care is delivered and outcomes for Members.
8. Quality Improvement and Health Equity Committee (QIHEC): means a committee facilitated by Contractor's medical director, or the medical director's designee, in collaboration with the Health Equity officer that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.
9. Quality Improvement and Health Equity Transformation Program (QIHETP): means the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in applicable laws, regulations, and this Contract.

Monitoring:

1. The Quality Improvement Department submits its current year's Program Description and Work Plan as well as the Executive Summary of previous year's Quality Improvement Activities to the Quality Improvement and Health Equity Committee for Review and Approval by the first quarter.
2. Once approved by the QIHEC, the Quality Improvement Department submits these same documents to EOC and the Board for Review and Approval.
3. Quality Improvement updates its documents according to feedback and recommendations provided by the EOC and the Board.
4. This policy is reviewed, updated if necessary and approved by the QIHEC at least annually.

References:

1. DHCS Comprehensive Quality Strategy 2022

2. DHCS Contract #23-30211, Exhibit A, Attachment III, Section 2.2.3 Quality Improvement and Health Equity Committee, and Section 2.2.7, Quality Improvement and Health Equity Annual Plan

3. DHCS All Plan Letter (APL) 23-025, Diversity, Equity, and Inclusion Training Program Requirements (Supersedes APL 99-005), published September 14, 2023.

4. DHCS APL 24-004, Quality Improvement and Health Equity Transformation Requirements (Supersedes APL 19-017), published April 8, 2024.

5. PHC California Policy and Procedure 25, Diversity, Equity, and Inclusion Training Program

6. 42 USC section 1396u-2(c)(2)

7. 42 CFR sections 438.310 et seq.

8. 22 CCR section 53860(d)

9. DHCS 2022-23 External Quality Review Technical Report

10. DHCS 2021 Health Disparities Data Report

11. DHCS 2023 Preventive Services Report

12. DHCS 2022-23 Encounter Data Validation Study Report

13. DHCS MY 2024 RY 2025 Medi-Cal Accountability Set (MCAS) for Health Care Delivery Systems, Updated November 28, 2023

14. MCAS: Quality Improvement and Health Equity Framework Policy Guide

Regulatory Agency Approval(s):

Date	Version	Regulatory Agency	Purpose	Response
7/13/2023	19.0	Department of Health Care Services (DHCS)	Operational Readiness (O/R) R.0042	Approved
10/2/2023	19.0	DHCS	O/R R.0043	AIR1
10/26/2023	19.1	DHCS	O/R R.0043 AIR1	Approved
11/1/2023	19.2	DHCS	O/R R.0037	Approved
11/2/2023	19.2	DHCS	O/R R.0040	AIR1
11/2/2023	19.2	DHCS	O/R R.0048	Approved
11/3/2023	19.2	DHCS	O/R R.0050	Approved
11/14/2023	19.2	DHCS	O/R R.0038	AIR1
11/27/2023	19.2 (rev.)	DHCS	O/R R.0040 AIR1	Approved
12/7/2023	19.3	DHCS	O/R R.0038 AIR1	Approved
8/9/2024	19.5	DHCS	APL 24-004	AIR1
9/6/2024	19.5 (rev.)	DHCS	APL 24-004	Approved
9/16/2025	19.6	DHCS	D.0330.50	Approved