Progress report on implementing data improvement strategies

Milestone Language: Demonstrate evidence of implementing at least 3 strategies from your Data Implementation Plan (DIP) including:

- Identifying and outreaching to the assigned but unseen population
- Using gaps in care reports that include practice and MCP data
- Data exchange with 2 external partners, at least 1 of which is a Qualified Health Information Organization (QHIO)

Note: Before completing this Milestone, the team needs to have submitted Milestone 6: Data Implementation Plan

Section 1: Identifying and Outreaching to the Assigned but Unseen Population

Please share updated data/information for your assigned and unseen patients in your Medi-Cal Population. Your data should reflect your *entire* Medi-Cal population, not just the patients in your selected population of focus (PoF). This is a point-in-time measure: you take the assigned Medi-Cal members as of that specific moment that you are pulling that data and look back 6 months to see who has had a visit. This includes all visit types, not just well visits.

Numeric:

Numerator: Number of assigned Medi-Cal patients who have had a visit in the past 6 months	**Denominator: Total number of assigned Medi-Cal patients**	**Assigned and Seen Rate (%) (Auto Calculated)**	**Assigned and Unseen Rate (%) (Auto Calculated) Assigned and Unseen Rate = 100% minus Assigned and Seen Rate**

Implemented Strategies:

Please complete the table below to describe how your practice has worked to improve care for **assigned and unseen patients**.

For each intervention listed in your accepted DIP (and any new interventions your team has implemented), fill in the following columns:

1. **Interventions (Assigned & Unseen):**
   List the specific intervention your practice implemented. Include those from your accepted DIP, and any new ones you have added.
2. **Activities to Implement Intervention:**
   Describe what your practice actually did to carry out the intervention. Be specific—include any workflows, staff roles, outreach efforts, or tools used.
3. **Lessons Learned:**
   For each intervention, share one key lesson your team learned. Indicate:
   - Whether the intervention seems to be working
   - If not, what your team plans to change or improve based on that experience
4. **Evidence of Implementation:**
   List the supporting documentation you are submitting as proof that the intervention was carried out. At least one piece of evidence is required for each intervention. Examples include:
   - Patient outreach lists
   - Contact or call logs
   - Scheduling reports
   - Team meeting minutes or notes
   - Scripts or outreach templates

   If a single piece of evidence supports multiple interventions, you may indicate that in this column.

Table 1. Assigned & Unseen Interventions

Interventions (Assigned & Unseen)	Activities to Implement Intervention	Lessons Learned	Evidence of Implementation the Practice is Submitting
[insert intervention from accepted DIP]			
[insert intervention from accepted DIP]			
[insert intervention from accepted DIP]			
[insert intervention from accepted DIP]			
[new intervention – not in accepted plan]			
[new intervention – not in accepted plan]			

Types of Outreach

Please complete **Table 2** to provide more information on the types of outreach your practice engaged in and the outcomes of that work.

Table 2. Outreach to Assigned & Unseen

Outreach Type	**Outreach Target** (e.g., practice goal for number of patients to reach)	**Outreach Achievement** (e.g., number of patients the practice actually reached)	**Conversion rate** (e.g., number of patients reached that converted to an appointment)
Phone			
Postal Mail			
Email			
Text			
Patient Portal Message			
Other [please describe]			

Please complete **Table 3** to demonstrate the effectiveness of the outreach to your assigned & unseen population since the start of EPT.

Table 3. Outcome Metrics

Denominator: Total number of patients with an outreach attempt (outreach of any type)	
Numerator: Number of patients who completed an appointment after outreach	

Section 2: Using Gaps in Care Reports

Population of Focus: **[Auto-populated]**

Which PoF-specific measure did you focus on? **[Drop-down menu]**

Did you change your selected PoF or measure since your DIP was approved? **[Yes/No]**

Implemented Strategies:

Use **Table 4** to describe how your practice has implemented strategies to reduce care gaps for your selected measure. Include both interventions from your accepted DIP and any additional efforts initiated during implementation.

Complete each column as follows:

1. **Interventions (Care Gap):**
   List each intervention your practice implemented to improve performance on the selected care gap measure. Include interventions from your DIP as well as any new ones added during implementation.
2. **Activities to Implement Intervention:**
   Describe the specific work your team did to carry out each intervention. This could include workflows, staff roles, EHR tools, patient outreach, etc.
3. **Lessons Learned:**
   Share at least one insight for each intervention. Note whether the intervention was successful and why. If it was not, explain what your team learned and how that learning will shape future efforts.
4. **Evidence of Implementation:**
   List the supporting documentation you're submitting for each intervention. At least one piece of evidence is required per intervention. Examples include:
   - MCP reports or dashboards
   - Internal care gap tracking or analysis
   - Follow-up logs
   - Revised policies or workflows
   - Meeting notes or team presentations

   If the same piece of evidence supports multiple interventions, please indicate that in this column.

Table 4. Care Gap Interventions

Interventions (Care Gap)	Activities to Implement Intervention	Lessons Learned	Evidence of Implementation the Practice is Submitting
[insert intervention from accepted DIP]			
[insert intervention from accepted DIP]			
[insert intervention from accepted DIP]			

[insert intervention from accepted DIP]			
[new intervention – not in accepted plan]			
[new intervention – not in accepted plan]			

Outcome Data:

Share your most recent care gap closure rate for one measure for your PoF.

- A care gap is the difference between the healthcare a patient should receive and what they actually get.
- Provide the most recent six months of data for the number and percentage of care gaps.
- You may use your own internal data if you calculate rates for these measures or you may reference Health Plan care gap reports or Pay-for-Performance (P4P) reports.
- Please complete for one PoF measure.

Updated Care Gap Closure Rates for PoF Measures

Measure [Select from drop down, only measures for your practice's PoF will be available for selection]	**Population of Focus**	**Denominator (Eligible Population)**	**Numerator (Received Care)**	**Performance Rate (%) (Auto-Calculated)**	**Care Gap Rate (%) (Auto-Calculated) Care Gap Rate = 100% minus Performance Rate**
Example: Child Immunization Status (CIS)	Child/Youth				

Section 3: Data Exchange with External Partners

Partner 1: QHIO

- QHIO Name: _____
- Date of QHIO contract signature:
- Date when practice began exchanging data with QHIO (month/year):
- Data type(s) exchanged: _____
- Barriers and mitigation strategies encountered since DIP was approved: _____

Partner 2: External Partner

- Partner Name: _____
- Data type(s) exchanged: _____
- Date when practice began exchanging data with External Partner (month/year): _____
- Barriers and mitigation strategies encountered since date of approved DIP: _____

Evidence of Implementation:

Attach fully executed data sharing agreements

List a minimum of two ways in which data exchange with an external partner is being used to improve care for your selected POF: