Quality Improvement Health Equity Committee Meeting

February 16, 2024

Meeting Name:	Quality Improvement Health Equity Committee		
Date of Meeting:	2/16/2024	**Time:**	9:00 AM – 11:00 AM
Meeting Coordinator:	Ashley Asejo	**Location:**	Alameda Alliance for Health HQ 1240 S. Loop Rd. Alameda
Webinar Meeting ID:	**Microsoft Teams** Click here to join the meeting	**Meeting Materials:**	Standing Committees – Alameda Alliance for Health

IMPORTANT PUBLIC HEALTH AND SAFETY MESSAGE REGARDING PARTICIPATION AT ALAMEDA ALLIANCE FOR HEALTH COMMITTEE MEETINGS

YOU MAY SUBMIT COMMENTS ON ANY AGENDA ITEM OR ON ANY ITEM NOT ON THE AGENDA, IN WRITING VIA MAIL TO "ATTN: ALLIANCE QIHEC COMMITTEE" 1240 SOUTH LOOP ROAD, ALAMEDA, CA 94502; OR THROUGH E-COMMENT AT aasejo@alamedaalliance.org YOU MAY WATCH THE MEETING LIVE BY LOGGING IN VIA COMPUTER AT THE LINK PROVIDED ABOVE. IF YOU USE THE LINK AND PARTICIPATE VIA COMPUTER, YOU MAY, THROUGH THE USE OF THE CHAT FUNCTION, REQUEST AN OPPORTUNITY TO SPEAK ON ANY AGENDIZED ITEM, INCLUDING GENERAL PUBLIC COMMENT. YOUR REQUEST TO SPEAK MUST BE RECEIVED BEFORE THE ITEM IS CALLED ON THE AGENDA.

PLEASE NOTE: ALAMEDA ALLIANCE FOR HEALTH IS MAKING EVERY EFFORT TO FOLLOW THE SPIRIT AND INTENT OF THE BROWN ACT AND OTHER APPLICABLE LAWS REGULATING THE CONDUCT OF PUBLIC MEETINGS, IN ORDER TO MAXIMIZE TRANSPARENCY AND PUBLIC ACCESS. DURING EACH AGENDA ITEM, YOU WILL BE PROVIDED A REASONABLE AMOUNT OF TIME TO PROVIDE PUBLIC COMMENT. THE COMMITTEE WOULD APPRECIATE, HOWEVER, IF COMMUNICATIONS OF PUBLIC COMMENTS RELATED TO ITEMS ON THE AGENDA, OR ITEMS NOT ON THE AGENDA, ARE PROVIDED PRIOR TO THE COMMENCEMENT OF THE MEETING.

Meeting Objective
To improve quality of care and close health equity gaps for Alliance members by facilitating clinical oversight and direction.

Members	
Name	**Title**
Steve O'Brien, MD Chair	Chief Medical Officer, Alameda Alliance for Health, Internal Medicine
Paul Lao Vang	Chief Health Equity Officer, Alameda Alliance for Health
Sanjay Bhatt, MD Vice Chair	Senior Medical Director, Quality & Behavioral Health, Alameda Alliance for Health, Emergency Medicine

Aaron Chapman, MD	Behavioral Health Medical Director and Chief Medical Officer, Alameda County Behavioral Health Care Services
Tri Do, MD	Chief Medical Officer, Community Health Center Network
Felicia Tornabene, MD	Chief Medical Officer, Alameda Health System
James Florey, MD	Chief Medical Officer, Children First Medical Group
Donna Carey, MD	Medical Director, Case Management, Alameda Alliance for Health, Pediatrics
Rosalia Mendoza, MD	Medical Director, Utilization Management, Alameda Alliance for Health, Family Practice
Peter Currie, PsyD	Senior Director, Behavioral Health, Alameda Alliance for Health
Michelle Stott	Senior Director, Quality, Alameda Alliance for Health

Meeting Agenda				
Topic	**Time**	**Document**	**Responsible Party**	**Vote to approve or Informational**
Call to Order/Roll Call:	1 min	Verbal	D. Carey	Informational
1. Alliance Updates • Introduction – Kimberly Glasby – Director, Long Term Services and Support	5 min	Verbal	D. Carey	Informational
2. Chief of Health Equity Updates	5 min	Verbal	L. Vang	Informational
3. Follow Up Item from 11/17/2023 • QIHEC Charter Update	2 min	Verbal	M. Stott	Informational
4. Committee Member Presentations	5 min	Verbal	S. Bhatt	Informational
5. Policies and Procedures • Listed below.	15 min	Document	D. Carey	Vote
6. Approval Committee Meeting Minutes • QIHEC-11/17/2023 • UMC-12/15/2023, 1/26/2024 • IQIC-1/17/2024 • CLS- 10/25/2023, 1/24/2024 • A&A-11/1/2023	2 min	Document	D. Carey	Vote
7. UM Workplan Update • UM Metrics	10 min	Document	M. Findlater R. Mendoza	Informational

Meeting Agenda				
Topic	**Time**	**Document**	**Responsible Party**	**Vote to approve or Informational**
8. Case Management updates	10 min	Document	L. Hunter	Informational
9. QI Workplan Update • DHCS Sanctions • Updates on QI Investment • 2023 HEDIS Rates	10 min	Document	M. Stott F. Zainal	Informational
10. CLS Program Description and Evaluation	15 min	Document	L. Ayala	Vote
11. PQI • Annual Training • RN Audits • Exempt Grievance • PQI Dashboard	8 min	Document	S. Bhatt C. Rattray	Informational
12. Behavioral Health Update	10 min	Document	P. Currie A. DeRochi	Informational
13. QIHEC Schedule Change • Move March 29th QIHEC to April 19th	2 min	Verbal	D. Carey	Vote
14. Public Comment	1 min	Verbal	D. Carey	Informational
15. Adjournment	1 min	Verbal	D. Carey	Next Meeting (Pending Vote)

Americans with Disabilities Act (ADA): It is the intention of the Alameda Alliance for Health to comply with the Americans with Disabilities Act (ADA) in all respects. If, as an attendee or a participant at this meeting, you will need special assistance beyond what is normally provided, the Alameda Alliance for Health will attempt to accommodate you in every reasonable manner. Please contact Ashley Asejo aasejo@alamedaalliance.org at least 48 hours prior to the meeting to inform us of your needs and to determine if accommodation is feasible. Please advise us at that time if you will need accommodation to attend or participate in meetings on a regular basis.

Policies & Procedures	
BH-003: Dyadic Services BH-004: BHT Services CBAS-002: Expedited Initial Member Assessment for CBAS Eligibility CBAS-004: Member Assignment to a CBAS Center CLS-001: Cultural and Linguistic Services (CLS) Program Description CLS-002: Member Advisory Committee CLS-003: Language Assistance Services CLS-008: Member Assessment of Cultural and Linguistic needs CLS-009: CLS Program-Contracted Providers CLS-010: CLS Program- Staff Training and Assessment CLS-011: CLS Program- Compliance Monitoring CM-001: Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment CM-004: Care Coordination of Services CM-009: Enhanced Care Management – Infrastructure CM-010: Enhanced Care Management - Member Idenfication and Grouping CM-011: Enhanced Care Management - Care Management and Transitions of Care CM-013: Enhanced Care Management - Oversight Monitoring & Controls CM-014: Enhanced Care Management - Operations Non-Duplication CM-016: Enhanced Care Management – Staffing CM-018: Enhanced Care Management - Member Notification CM-021: Community Supports - Asthma Remediation CM-022: Community Supports - Housing Deposits CM-023: Community Supports - Housing Tenancy and Sustaining Services CM-024: Community Supports - Housing Transition Navigation CM-025: Community Supports - Medically Supportive Food/Meals/Medically Tailored Meals CM-026: Community Supports - Recuperative Care (Medical Respite) CM-027: Community Supports - Oversight Monitoring and Controls	HED-001: Health Education Program HED-002: Health Education Materials HED-006: SABIRT Services HED-007: Tobacco Cessation HED-009: Diabetes Prevention Program LTC-001: Long Term Care Program LTC-002: Authorization Process and Criteria for Admission, Continued Stay, and Discharge from a Nursing Long Term Care Facility LTC-004: LTC Bed Hold and Leave of Absence PHM-001: Population Health Management Program PHM-002: Basic Population Health Management PHM-005: Population Assessment QI-124: Initial Health Appointments QI-125: Blood Lead UM-002: Coordination of Care UM-010: Coordination of Care- Long Term Care UM-012 to BH-005: Care Coordination-Behavioral Health UM-013 to BH-006: Care Coordination-Substance Abuse UM-018: Targeted Case Management and Early and Periodic Screening, Diagnosis and Treatment UM-024: Care Coordination-Dental Services UM-032: Therapeutic Enteral Formulas UM-045: Communication Services UM-050: Tracking and Monitoring of Services Prior Authorized UM-052: Discharge Planning to Lower level of Care, (including Granting Administrative Days Pending Placement for Facilities contracted for Administrative Days) UM-056: Standing Referrals UM-060: Delegation Management and Oversight UM-062 to BH-007: Behavior Health Treatment UM-063: Gender Affirmation Surgery & Services UM-068: Tertiary and Quaternary Review Process UM-069: Continuous Glucose Monitoring Equipment

Alameda Alliance Updates

Dr. Donna Carey

ALAMEDA Alliance FOR HEALTH

Chief Health Equity Officer Update

Lao P. Vang

ALAMEDA Alliance FOR HEALTH

Follow-up Item: QIHEC Charter

Michelle Stott

ALAMEDA Alliance FOR HEALTH

ALAMEDA ALLIANCE FOR HEALTH

QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE (QIHEC)

Purpose

Quality Improvement Health Equity Committee, (QIHEC) is a standing advisory committee of the Board of Governors (BOG) and is responsible for the implementation, oversight, and monitoring of the Quality Improvement Health Equity (QIHE) Program and Utilization Management (UM) Program for Alameda Alliance for Health ("Alliance"). The structure, functions, and scope of the QIHEC, as outlined in this charter, shall be in accordance with the regulatory requirements of the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and National Committee for Quality Assurance (NCQA).

Policy/Scope

The QIHEC oversees the development, implementation, and effectiveness of the QIHE Program and is accountable to the BOG. The QIHEC is chaired by the Chief Medical Officer (CMO), in collaboration with the Chief Health Equity Officer.

The QIHEC is responsible for the following activities:

1) Approves and recommends policy and procedure decisions to ensure compliance with QIHE standards
2) Analyzes, evaluates and provides feedback on the results of QIHE activities, including annual review of the results of the performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other subcommittees, such as the Member Advisory Committee
3) Institute actions and ensure appropriate follow-up to address performance deficiencies
4) Monitor whether the provision and utilization of services meets professionally recognized standards of practice.
5) Ensures practitioner participation in the QIHE Program through planning, design, implementation or review
6) Reviews the QIHE Trilogy documents, such as the annual plan, program description, and program evaluation
7) Maintains signed and dated meeting minutes

Structure

1) Membership of QIHEC

The QIHEC shall consist of voting members (including the chair and vice-chair) and standing members of the committee. The committee shall endeavor to include multiple provider network providers including at minimum, those who provide services to members affected by health disparities, limited English proficiency (LEP), children with special health care needs (CSHCN), seniors and persons with disabilities (SPDs), and persons with chronic conditions. The number of voting members may be limited if they are in the same clinical practice sub-specialty (unless the committee member has a specialty in multiple areas).

Voting committee members shall work primarily in an institution within the coverage area of Alameda Alliance (Alameda County) or work for a clinic/hospital/practice/pharmacy that often serves Alameda Alliance members if outside of Alameda County (e.g., University of San Francisco Hospital or affiliated clinic).

Committee members shall not allow affiliations with outside interests to impair the responsible exercise of his or her duties as an QIHEC member.

1) **Voting Members**:

The Committee shall be comprised of the following members:

a) Alliance Chief Medical Officer (*Chair*) or designee
b) Alliance QI Medical Director (Vice-*Chair*)
c) Practicing provider representing Internal Medicine
d) Practicing provider representing Family Practice
e) Practicing provider representing Pediatrics
f) Practicing provider representing Behavioral Health
g) Practicing physician(s) representing common medical specialties
h) Alliance Chief Health Equity Officer
i) Alliance UM Medical Director
j) Alliance Case Management Medical Director
k) Alliance Senior Director, Quality

2) **Regular Guests (non-voting)**

Regular guests shall not be counted towards a quorum or be subject to term limits, but they shall be allowed to participate fully in discussion, and shall be required to complete a Conflict of Interest (COI) Form annually. Non-voting guests may include:

a) Chief Executive Officer
b) Designated Alliance Pharmacist(s) / Pharmacy Director
c) Designated Alliance personnel representing Provider Relations
d) Designated Alliance personnel representing Case Management
e) Designated Alliance personnel representing Quality Improvement
f) Designated Alliance personnel representing Utilization Management
~~f)~~g) Designated Alliance personnel representing Grievance & Appeals
~~g)~~h) Clinician guests who practice in a medical specialty being discussed at that meeting.

3) **Officers of the QIHEC**

a) **Chairman of the QIHEC – Chief Medical Officer (CMO)**

The CMO shall be responsible for, but not limited to, the following:

i. Serve as Chair
ii. Appoint a medical director to serve as the Vice Chair of the QIHEC.

iii. Preside at all meetings of the committee and report on QIHEC matters at regular meetings of the Board of Governors.
iv. Be a voting member of the committee and count toward determining whether a quorum is present.
v. Collaborate with the CHEO on supervision of QIHE activities

b) **Vice Chair of the QIHEC – QI Medical Director**

The QI Medical Director shall serve as Vice-Chair to the committee and shall be responsible for developing the agenda and materials to be reviewed by the QIHEC.

Other Officers Other officers may be appointed by the QIHEC by a majority vote as needed.

c) The Officers shall be voting members of the committee and shall be counted toward determining whether a quorum is present at each QIHEC meeting.

d) If both the Chair and Vice Chair of the QIHEC are absent or unable to act at a meeting where a quorum is present, the Chair will select one of the attending committee members to act as Chair pro tempore, with all the authority appurtenant thereto, if the Chair has not selected a committee member to preside at the meeting.

4) **Closed Sessions**

a) Prior to meeting in closed session, the Chair or Vice-Chair of the committee must orally announce the items to be discussed in closed session (§ 54957.7(a).).
b) At the conclusion of each closed session, the agency must reconvene into open session (§ 54957.7(b).).
c) If any final decisions have been made in the closed-session meeting, a report may be required (§ 54957.1.).
d) Closed Sessions will be based on California Government Code Title 5, §54954.5(h) – REPORT INVOLVING TRADE SECRET and the agenda shall contain a description of what the discussion will concern and the estimated date of public disclosure (month/year).
e) The results and actions taken by the committee during the closed session shall be summarized and disclosed, but not trade secrets.

5) **Meeting Agendas and Minutes**

a) At least 72 hours prior to a regular meeting, an agenda shall be posted containing a brief general description of the topics to be discussed, including items to be discussed in closed session. (§ 54954.2(a).)
b) The agenda shall be posted at the main entrance of the Alliance's principal offices and/or any other location freely accessible to members of the public.
c) Agenda and materials will be sent to the QIHEC committee members at least five (5) days before a regular meeting.

d) When minutes of the QIHEC have been approved, copies of the minutes shall be retained by the Alliance and be made available for inspection and copying according to applicable law.
e) The minutes, including any QIHEC activities of any fully delegated subcontractors and downstream fully delegated subcontractors, findings, recommendation and actions are submitted to the Alliance's Board of Governors.
f) The written summary of the QIHEC activities are publicly available on the Alliance's website at least on a quarterly basis
g) Compliance Department will submit signed QIHEC meeting minutes to the Department of Health Care Services (DHCS) for all meetings.

6) **Non-Agenda Items**

a) Prior to discussing a matter which was not previously placed on an agenda, the item must be publicly identified so that interested members of the public can monitor or participate in the consideration of the item in question.
b) The body may discuss a non-agenda item at a regular meeting if, by simple majority vote, the body determines that the matter in question constitutes an emergency pursuant to §54956.5. (§ 54954.2(b)(1).) or that it should be discussed at a future meeting.
c) Any discussion held pursuant to non-agenda items must be conducted in open session, since emergency meetings held pursuant to §54956.5 cannot be conducted in closed session.

7) **Voting**

a.) All official acts of the committee shall require the affirmative vote of the majority of the members present and voting, at a regular or special meeting with a quorum present.
b.) A simple majority (50% of voting members + 1) shall constitute approval of the proposed action.
c.) A tie vote is a lost vote, as a majority was not obtained.
d.) Absent members may not vote by proxy.
e.) Electronic voting approval may be an option in lieu of a regular or special meeting if a quorum is not present or other circumstances as directed by the CMO

8) **Quorum**

a) A quorum, defined as a simple majority (50% + 1) of voting members, must be present for the QIHEC to vote on any matter.
b) If a quorum is present but members are prohibited from voting because of conflicts of interest, then official acts shall require the majority of those present who are not so prohibited from voting.
c) If a quorum is not met at a regular scheduled meeting, the meeting shall be postponed to a future date or cancelled.

9) **Meeting Schedule and Special Meetings**

a) The QIHEC shall hold regular meetings at least quarterly, at minimum four times per year.
b) The QIHEC may hold special meetings at any time and place as may be designated by the Officers or a majority of the members of the committee. The provisions of applicable open meeting laws with respect to special meetings of the full Board shall apply to special meetings of the QIHEC.

10) **Public Comment:**

a) Every agenda for a regular meeting shall provide an opportunity for members of the public to directly address the QIHEC on any item under the subject matter.
b) Where a member of the public raises an issue which has not yet come before the committee, the item may be briefly discussed but no action may be taken at that meeting (§ 54954.3(a).).
c) The QIHEC may establish procedures for public comment as well as specifying reasonable time limitations on particular topics or individual speakers.

Membership Terms of Service

Members of the QIHEC may be dismissed from the committee (in alignment with the BOG procedures) if:
(1) in the opinion of the majority of the other committee members, a member fails to carry out his or her duties appropriately;
(2) the member fails to attend three consecutive, properly noticed regular and/or special meetings of the committee without having secured prior authority to do so from a majority of the governing committee members;
(3) the member ceases to be employed by or be a member of the group from which he or she was appointed to the committee;
(4) the member fails to attend fifty-percent (50%) or more properly noticed regular and/or special meetings.

New Voting QIHEC members are appointed by the Board of Governors, with all current active members having the right to nominate potential members. The Chair or Vice-Chair shall notify the Board of Governors of the vacancy at the next regular Board of Governors meeting and submit nominations at that time.

If a voting QIHEC member loses eligibility for serving on the committee, the member must immediately notify the Officers. To be eligible as a qualified voting member of the Alliance QIHEC, the provider must:

1. Meet ONE of the following criteria:

a. Be employed by the Alliance as the Chief Medical Officer, QI Medical Director, UM Medical Director, Case Management Medical Director, Senior Director of Quality
b. Be an active member of the Alliance Board of Governors

OR

2. Meet ALL of the following criteria
    a. Work primarily within Alameda County or for an organization that regularly serves Alameda Alliance members;
    b. Has an appropriate clinical background commensurate with the duties of the committee;
    c. Maintain an active medical or pharmacy license in good standing as appropriate;
    d. Complete a non-disclosure agreement and conflict of interests form annually; and
    e. Update their employment and licensure status annually and immediately after any changes.

Voting Member and Regular Guest Qualifications

Committee members should be highly qualified, with a proven dedication to the health and welfare of the Medi-Cal and other populations, and must have a combination of the following qualifications:

1. A thorough familiarity with the health care delivery structure in Alameda County, and the needs of the Medi-Cal population;
2. A demonstrated working knowledge of the Medi-Cal program;
3. A thorough understanding of the multitude of issues facing the implementation of a managed care system;
4. A commitment to the creation of a publicly funded health care system for the good of the public, rather than for the benefit of special interests;
5. An ability to be an active and contributing participant throughout the process; and
6. Sensitivity for patient concerns.

Duties and Rights of All Committee Members

1. Attend all meetings of the committee
2. Contribute to the discussion during committee meetings
3. Make a motion
4. Vote or abstain on any motion

Any committee member may resign, effective upon the giving of written or oral notice to the Chair or Vice Chair of the QIHEC, unless the notice specifies a later time for the effectiveness of such resignation. The acceptance of a resignation shall not be necessary to make it effective. The Chair or Vice Chair shall notify the QIHEC in writing of an oral notice of resignation.

Appendix List:

Appendix A: Annual Conflict of Interest Disclosure Form

APPENDIX A

Confidentiality and Conflict of Interest

Confidentiality

As a member of this committee, you recognize that you owe a fiduciary duty of care to Alameda Alliance for Health (AAH). This includes a duty of confidentiality. In connection with your service, you may be given or have access to confidential information of AAH or third parties. Confidential information is all information that AAH considers to be confidential or proprietary information of AAH or third party sources.

Confidential information may include, but is not limited to, information regarding the organization, operations, programs, activities, policies, procedures, practices, financial condition, trade secrets, membership lists, and standards of AAH, its members, or third parties. Confidential information also may include, but is not limited to, unpublished or pre-release versions of AAH standards, white papers, and other documents and information, or internal use only or limited circulation documents and information.

You covenant and agree that you will not disclose or permit to be disclosed any confidential information, and that you will not appropriate, photocopy, reproduce, or in any fashion replicate any confidential information without the prior written consent of AAH.

You agree that any disclosure of confidential information in violation of this agreement shall cause immediate and substantial damage to AAH and to any parties that provided the confidential information to AAH.

You agree to use reasonable efforts to maintain the confidentiality of the confidential information. You also agree not to use any confidential information for your own benefit unless authorized in advance in writing by AAH. Confidential information shall not include information that you rightfully obtain from a third party without comparable restrictions on disclosure or use.

Conflicts of Interest

All Committee members must act at all times in the best interests of AAH and not for personal or third-party gain or financial enrichment. When encountering potential conflicts of interest, committee members shall identify the potential conflict and, as required, remove themselves from all discussion and voting on the matter. If you believe you have a potential conflict please contact the Compliance department immediately. Specifically, members of the committee shall:

- Avoid placing (and avoid the appearance of placing) one's own self-interest or any third-party interest above that of AAH.
- Not make any health care or medical decisions based on financial incentives.
- Not engage in any outside business, professional or other activities that would directly or indirectly materially adversely affect AAH.

- Not engage in or facilitate any discriminatory or harassing behavior directed toward AAH staff, members, officers, directors, meeting attendees, exhibitors, advertisers, sponsors, suppliers, contractors, or others in the context of activities relating to AAH.
- Not solicit or accept gifts, gratuities, free trips, honoraria, personal property, or any other item of value from any person or entity as a direct or indirect inducement to provide special treatment.

Acknowledgement

I understand and agree that my failure to comply with the terms of this agreement will have consequences and may result in disciplinary action up to immediate termination and criminal prosecution, depending upon the infraction's severity, evidence of my intentions, and the sensitivity and scope of the information compromised.

By signing and dating this agreement in the spaces provided below, I certify that I have read this agreement, and that I agree to its terms.

Signature_____ Date_____

Name (please print) _____

Committee Member Presentations

Dr. Sanjay Bhatt

ALAMEDA Alliance FOR HEALTH

2024 Committee Member Presentation Schedule

3/29/2024 (4/19/2024): Presentation from Dr. Chapman

5/17/2024: Presentation from AHS

8/16/2024: Presentation from CHCN

11/15/2024: Presentation from Dr. Florey (CFMG)

Policies and Procedures

ALAMEDA Alliance FOR HEALTH

Department	Policy #	Policy Name	Brief Description of Policy	Description of Changes/Current Revisions	Policy Update (X)	New Policy (X)	Annual Review or Formatting Changes (X)	
Medical Services	BH 003	Dyadic Services	The policy covers Dyadic services and dyadic caregiver services	New Policy		X		
Medical Services	BH 004	BHT Services	The policy covers behavioral health treatment (BHT) services	New Policy		X		
UM	CBAS-002	Expedited Initial Member Assessment for CBAS Eligibility	Describes the process for doing an expedited assessment for CBAS eligibility	Addition of regulatory language related to the Individual Plan of Care, clarification of which members are eligible for an expedited assessment, circumstances in which the Face to Face requirement is waived, updated definitions and references.	X			
UM	CBAS-004	Member Assignment to a CBAS Center	Policy describing the process to determine which CBAS center is most appropriate for a member, taking into considerations the member's characteristics and preferences.	Annual Update, no changes required.			X	
CLS	001	Cultural and Linguistic Services (CLS) Program Description	Describes elements of the Alliance Cultural and Linguistic Services including objectives, activities, roles, work plan and organization chart.	Yearly review, minor grammar, formatting and logo updates only.				
CLS	002	Member Advisory Committee	Describes role, function and policies for the Alliance Member Advisory Committee.	Yearly review, minor grammar, formatting and logo updates. Replaced "Member" with "Community" and "MAC" with "CAC" to align with name change to Community Advisory Committee. Also updated CAC Terms of Service and attendance to align with CAC charter updates.	x			
CLS	003	Language Assistance Services	Describes how the Alliance ensures interpreter and translation services for Alliance members who require language assistance services.	Yearly review, minor grammar, formatting and logo updates. Replaced HCQC with QIHEC. Replaced words for cultural appropriateness and appropriate program name. Updated alternative format information to align with APL. Also, spelled out acronyms.	x			
CLS	008	Member Assessment of Cultural and Linguisic needs	Describes how the Alliance monitors the language needs of members and ensures these members have access to language assistance services.	Yearly review, minor grammar, formatting and logo updates. Replaced HCQC with QIHEC. Updated policy reference to updated policy name. Added additional wording in References and Definitions/Acronyms sections.	x			
CLS	009	CLS Program - Contracted Providers	Describes how the Alliance ensures its providers are informed of their responsibilities and provide language assistance services to members.	Yearly review, minor grammar, formatting and logo updates. Replaced HCQC with QIHEC. Added "provider quarterly packets" as another modality to share interpreter services access information.	x			
CLS	010	CLS Program - Staff Training and Assessment	Describes how the Alliance ensures staff receives cultural sensitivity training and are assessed for bilingual capacity.	Yearly review, minor grammar, formatting and logo updates. Replaced HCQC with QIHEC. Added new HR policy as a reference. Added new contractual requirements/enhancements related to the cultural sensitivity training.	x			
CLS	011	CLS Program - Compliance Monitoring	Describes how the Alliance ensures quality language assistance services through monitoring of staff, providers and language services vendors.	Yearly review, minor grammar, formatting and logo updates. Replaced HCQC with QIHEC. Replaced words for cultural appropriateness. Also, replaced "MAC" with "CAC" to align with name change.	x			

CMDM	CM-001	Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment	Identify, screen, enroll and assess for CCM.				X	
CMDM	CM-004	Care Coordination of Services	Structure of Plan's Care Coordination Services	Addition of language to ensures no duplication of services information sharing processes IHSS referrals Children with Special Health Care Needs (CSHCN) Direct Observed Therapy for TB Addition of language to ensure regular communication with IHSS regarding open medical issues and related social issues. BPHM reqs.	X			
CMDM	CM-009	Enhanced Care Management - Infrastructure	Infrastructure for ECM	Update policies to be in alignment with most recent approved MOC submission (February 2023).	X			
CMDM	CM-010	Enhanced Care Management - Member Idenfication and Grouping	Identifying members for ECM eligibility and assigning members to ECM providers	Update policies to be in alignment with most recent approved MOC submission (February 2023).	X			
CMDM	CM-011	Enhanced Care Management - Care Management and Transitions of Care	Responsibilities of ECM providers to provide care management and transitions of care to ECM members	Update policies to be in alignment with most recent approved MOC submission (February 2023).	X			
CMDM	CM-013	Enhanced Care Management - Oversight Monitoring & Controls	Oversight and monitoring process of ECM providers	Update policies to be in alignment with most recent approved MOC submission (February 2023).	X			
CMDM	CM-014	Enhanced Care Management - Operations Non-Duplication	Identifying members who are receiving ECM and preventing duplication of services	Update policies to be in alignment with most recent approved MOC submission (February 2023).	X			
CMDM	CM-016	Enhanced Care Management - Staffing	Expectations for staffing of ECM providers	Update policies to be in alignment with most recent approved MOC submission (February 2023).	X			
CMDM	CM-018	Enhanced Care Management - Member Notification	Informing member of ECM eligibility, and determination of authorization	Update policies to be in alignment with most recent approved MOC submission (February 2023).	X			
CMDM	CM-021	Community Supports - Asthma Remediation	identify, refer, authorize for asthma remediation				X	
CMDM	CM-022	Community Supports - Housing Deposits	identify, refer, authorize for housing deposits				X	
CMDM	CM-023	Community Supports - Housing Tenancy and Sustaining Services	identify, refer, authorize for housing tenancy and sustaining services				X	
CMDM	CM-024	Community Supports - Housing Transition Navigation	identify, refer, authorize for housing transition navigation				X	

CMDM	CM-025	Community Supports - Medically Supportive Food/Meals/Medicalyl Tailored Meals	identify, refer, authorize for medically supportive food/meals/medically tailored meals				X	
CMDM	CM-026	Community Supports - Recuperative Care (Medical Respite)	identify, refer, authorize for recuperative care (medical respite)				X	
CMDM	CM-027	Community Supports - Oversight Monitoring and Controls	identify, refer, authorize for oversight monitoring and controls				X	
HED	001	Health Education Program	Descibes Alliance Health Education Program Elements	Yearly Update and minor grammar edits.			X	
HED	002	Health Edcation Materials	Describes process for creating and approving health education and member informing materials.	Yearly update and minor grammar and edits.			X	
HED	006	SABIRT Services	Describes alcohol and drug screening, assessment, brief interventions and referral to treatment benefit.	Yearly update and minor grammar and edits.			X	
HED	007	Tobacco Cessation	Describes Alliance policy on tracking tobacco use and implementing cessation services.	Yearly update and minor grammar and edits.			X	
HED	009	Diabetes Prevention Program	Describes how the Alliance offers the Diabetes Prevention Program to eligible members.	Yearly update and minor grammar and edits.			X	
LTC	LTC-001	Long Term Care Program	Describes Long Term Care program, overarching policy	Updated for ICF/DD and Subacute APLs	x		x	
LTC	LTC-002	Authorization Process and Criteria for Admission, Continued Stay, and Discharge from a Nursing Long Term Care Facility	Describes admission/Re-auth and Discharge processes in LTC	Changed owner to LTSS Director. Updated language to align with the new LTC Carve ins for S/A and ICF/DD. Removed language referencing the 21 day list. Updated regulatory references.	x		x	
LTC	LTC-004	LTC Bed Hold and Leave of Abcense	Describes procedures for Bed Holds and Leaves of Abcense for LTC populations	Updated for ICF/DD and Subacute APLs	x		x	
PHM	001	Population Health Management Program	Descibes the elements of the Alliance's Population Health Management Program in alignment with the DHCS PHM Policy Guide. Refers to Alliance policies and procedures that detail Alliance population health management elements and programs.	Updated to align with December DHCS PHM Policy Guide updates to the Population Needs Assessment (PNA) including colllaboration with Local Health Agencies, use of Quality and Key Performance Indicators to assesss programs, and added definitions.	X			
PHM	002	Basic Population Health Management	Describes Alliance Population Health Management supports including provision of BPHM services by PCPs, role of Alliance ECM, LTC and Care Management staff, Wellness and Prevention activities and refers to related P&Ps and services.	Updated EPSDT language to "Medi-Cal for Kids and Teens," added Alliance P&P references for Population Health and Disease Management, added MOU development, and removed requirement to have toll-free telephone number for network providers to align with updated DHCS Contract.	X			
PHM	005	Population Assessment	Describes how the Alliance understands and assessess its member population and subpopulations by demographics, health, utilization, SDOH and other characteristics in compliance with DHCS PHM Policy Guide and NCQA PHM requirements.	Move P&P from HED to PH, rewrote/updated to align with DHCS PHM Policy Guide, including LHJ engagement, meaningful participation in Community Health Assessments and shared goals, objectives with LHJs, engagement with the Alliance CAC.	X			
QI	124	Initial Health Appointments	Requirements around Initial Health Appointments - a comprehensive assement tht is compled during a patient's initial encounter	Changes to meet APL 22-030, updated codes and outreach requirements	X		X	

QI	125	Blood Lead	This policy and procedure outlines the process for meeting compliance with State and Federal regulations for blood lead screening and reporting requirements for Medi-Cal managed care health plans.				X	
UM	UM-002	Coordination of Care	Coordination of Care for all AAH members following the PHM policy guide for Basic Population Health Management	Collaborated with the PHM Department to update the policy to reflect the requirements in the PHM Policy Guide. This policy was sent to the state as a deliverable in March 2023. Updated formatting, removed verbaige about disenrollment for members in LTC Settings as it is no longer applicable.	x		x	
UM	UM-002	Coordination of Care	Overarching policy that describes the regulations, practices and processes to coordinate the care of members across the organization, including primary care, case management, and Population Health Management.	Addition of regulatory language regarding population health management, assessment of need and delivery of services, role of primary care, EPSDT, CCS, adherence to information sharing requirements, closed loop referrals, along with regulatory references, definitions, and grammatical corrections	X			
UM	UM-010	Coordination of Care-Long Term Care	Care Coordination to admit and discharge members appropriately into the Long-Term Care Facilities.	Changed policy name and number to an LTC Policy- LTC-005. Will Retire this policy number. Updated formatting, removed language related to Hospice admissions and disenrollment back to FFS. Added languague about ECM, Corrected verbiage on the HCBA waiver from the NF waiver langage which is outdated. Enhanced the process for TCS referrals. Updated policy and references sections.	x		x	
UM to BH	Change: UM-012 to BH-005	Care Coordination-Behavioral Health	Policy that describes the processes for coordination of care for persons with mental health or Substance Use Disorders	Transfer of policy ownership from UM department to BH department	X			
UM to BH	Change: UM-013 to BH-006	Care Coordination-Substance Abuse	Policy that describes the processes for coordination of care for persons with Substance Use Disorders	Transfer of policy ownership from UM department to BH department	X			
UM	UM-018	Targeted Case Management and Early and Periodic Screening, Diagnosis and Treatment	TCM and EPSDT	Addition of details on LGAs and information exchange with LGAs	X			
UM	UM-024	Care Coordination-Dental Services	Describe care coordination, utilization management, and oversight processes for dental services, including coordination with Dental FFS	updates made to align with revised DHCS APL 23-028, specifying requirements for IV moderate and deep sedation/general anesthesia, and other medically necessary services, when administered in connection with dental services not performed by dental providers . Minor formatting changes. Updated phone number.	x		x	
UM	UM-032	Therapeutic Enteral Formulas	Policy related to authorization and oversight of members receiving Enteral Nutrition	Formatting updates. Removed the Emergency Request. Updated ages-21 and younger is considered Pediatric per DHCS for this benefit. Added verbiage related to the deleniation between formula and supply responsbility. Expedited changed from 3 working days to 72 hours to align with timeleness standards. Removed context about WIC as it is covered in Policy UM-030 and is not applicable to members receiving enteral nutrition. Added information re: Group Care LOB Process	x		x	

UM	UM-045	Communication Services	Describes UM processes for provision of culturally and linguistically appropriate communications (including verbal, written, and alternate format communications) to members and providers	added Alternate Format communication requirements per DHCS APL 22-002	X			
UM	UM-050	Tracking and Monitoring of Services Prior Authorized	This policy describes the methods by which AAH monitors the services that have been authorized prior to care, including those for whom AAH has not received a claim, and the follow up to prompt members to obtain the authorized care.	Annual Update, no changes required.			X	
UM	UM-052	Discharge Planning to Lower level of Care, (including Granting Administrative Days Pending Placement for Facilities contracted for Administrative Days)	Discusses process to follow and requirements by the hospital to facilitate transition to lower level of care and/ or request admin days.	Formatting updates, Enhanced explaination of members who may be facing barriers to discharge	x		x	
UM	UM-056	Standing Referrals	Policy governing the management of Standing Referrals for members who require continuing specialized care over a prolonged period of time.	Addition of regulatory language clarifying the purpose and methods to authorize standing referrals.	X			
UM	UM-060	Delegation Management and Oversight	QM/UM Delegation and Oversight	Formatting updated. Changed ICE to HICE	x		x	
UM to BH	Change: UM-062 to BH-007	Behavior Health Treatment	Policy describing the provision of Behavioral Health Treatment (BHT,) such as Applied Behavioral Analysis (ABA) and others, to persons with Autism Spectrum Disorder, including coordination with Regional Center Services and Alameda County Mental Health.	Transfer of policy ownership from UM department to BH department	X			
UM	UM-063	Gender Affirmation Surgery & Services	Gender Affirmation medically necessary criteria to receive GA services for adolescents and adults, referral letter criteria, and general GA scope of care.	Added criteria for GA surgeries and procedures for adolescents, per WPATH SOC 8 guidance; updated Consent Law and Minor Consent language.	X			
UM	UM-068	Tertiary and Quartenary Review Process	Overview of T/Q academic defintions and management of service requests to these centers, for in-network and out-of-network requests.	Annual Review - Updated Cancer Centers of Excellence titles, updated active course of treatment language and continuity consistent with APL 22-032 guidance, added behavioral health for TQ decision making of authorizations. Updated audit cadence.	X		X	
UM	UM-069	Continuous Glucose Monitoring Equipment	Medical criteria and PA processed for MediCal and Group Care members	MediCal Rx transition for MediCal members will now occur on 7/1/2023 to reflect the Special Population of new Anthem members who will be eligible for COC up to 6 months.	X			

Approval of Committee Meeting Minutes

- QIHEC- 11/17/2023
- UMC- 12/15/2023 & 1/26/2024
- IQIC- 1/17/2024
- CLS- 10/25/2023 & 1/24/2024
- A&A- 11/1/2023

ALAMEDA Alliance FOR HEALTH

UM Workplan Updates

QIHEC
Michelle Findlater, Director of Utilization Management
Rosalia Mendoza, UM Medical Director
February 16, 2024

ALAMEDA Alliance FOR HEALTH

Agenda

The purpose is to track and trend:

- YearOverYear Summary
- Inpatient Denial Rates by Network
  - Denial Reasons by Alliance
- Outpatient Denial Rates by Network
  - Denial Reasons by Alliance
- Emergency Department Volume
  - By Network
  - By Facility

YearOverYear Summary

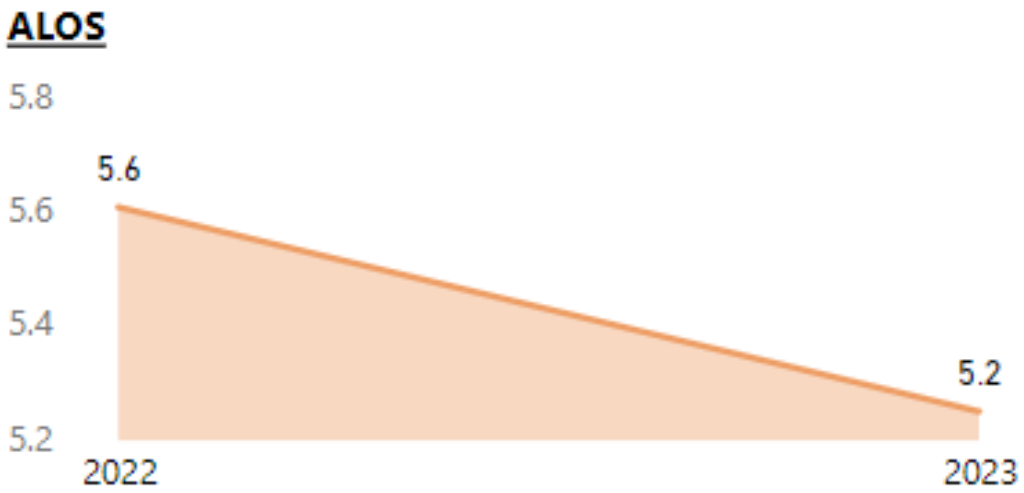
PowerBI: #12005 IP Claims Utilization

Date: October 2022 –September 2023

Excluded: LTC AID Category & LTACs

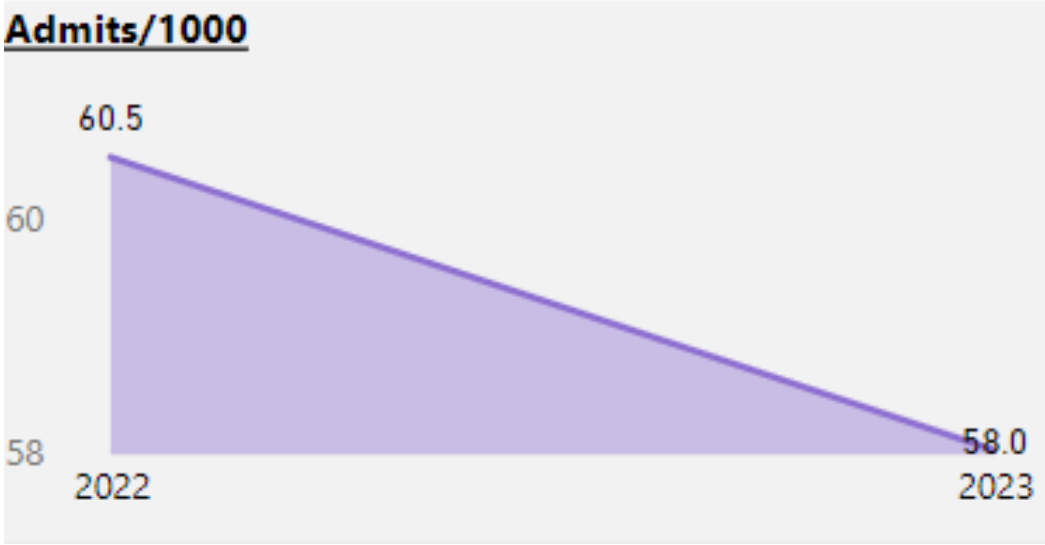
ALAMEDA Alliance FOR HEALTH

Average Length of Stay (ALOS)



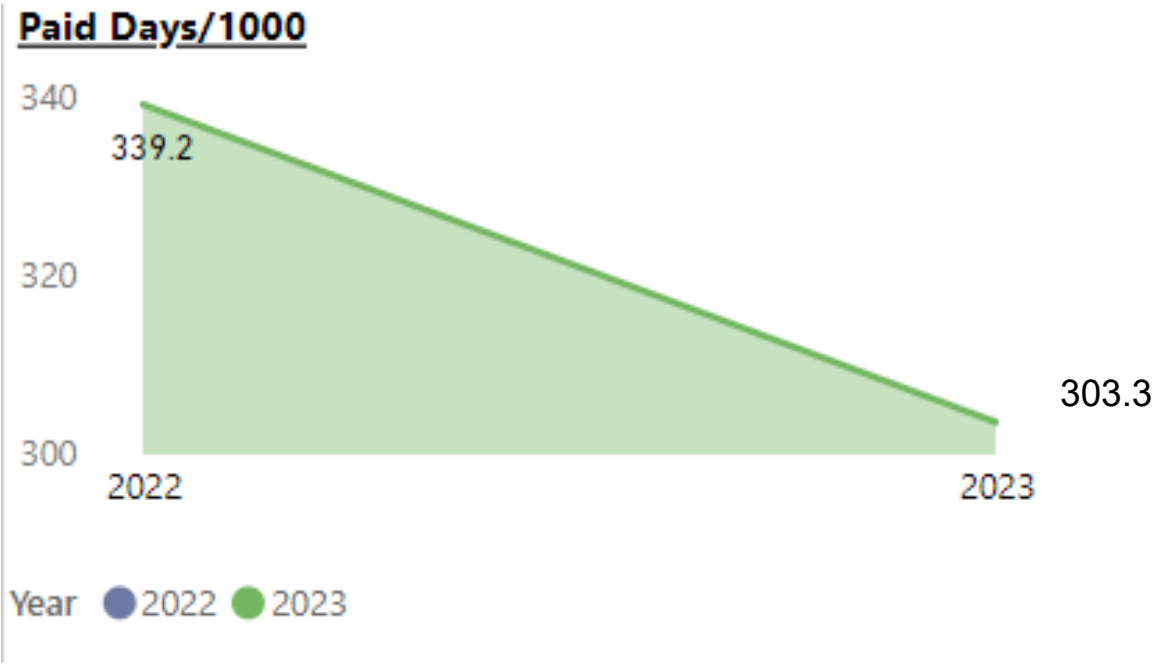
- ALOS trending downward to 5.6 (-0.4)
- Highest contribution to ALOS among **Alliance Network 5.6** (-0.2) > **AHS 5.0** (-0.9) > **CHCN 5.0** (-0.6)
- Longest LOS by aid category: SPD (5.7) > Duals (5.5) > ACA OE (5.0)

Admits/1000



- 2023 Admits/1000 decreasing downward 58.0 (-2.5)
- Highest contribution to Admits/1000 by network: **Alliance Network** 98.5 (-8.2) > **AHS** 59.1 (-12.7) > **CHCN** 48.5 (-6.6)
- Highest admits by aid category: **Duals** (160.2) > **SPD** (65.1) > **ACA OE** (46.2)

Paid Days/1000

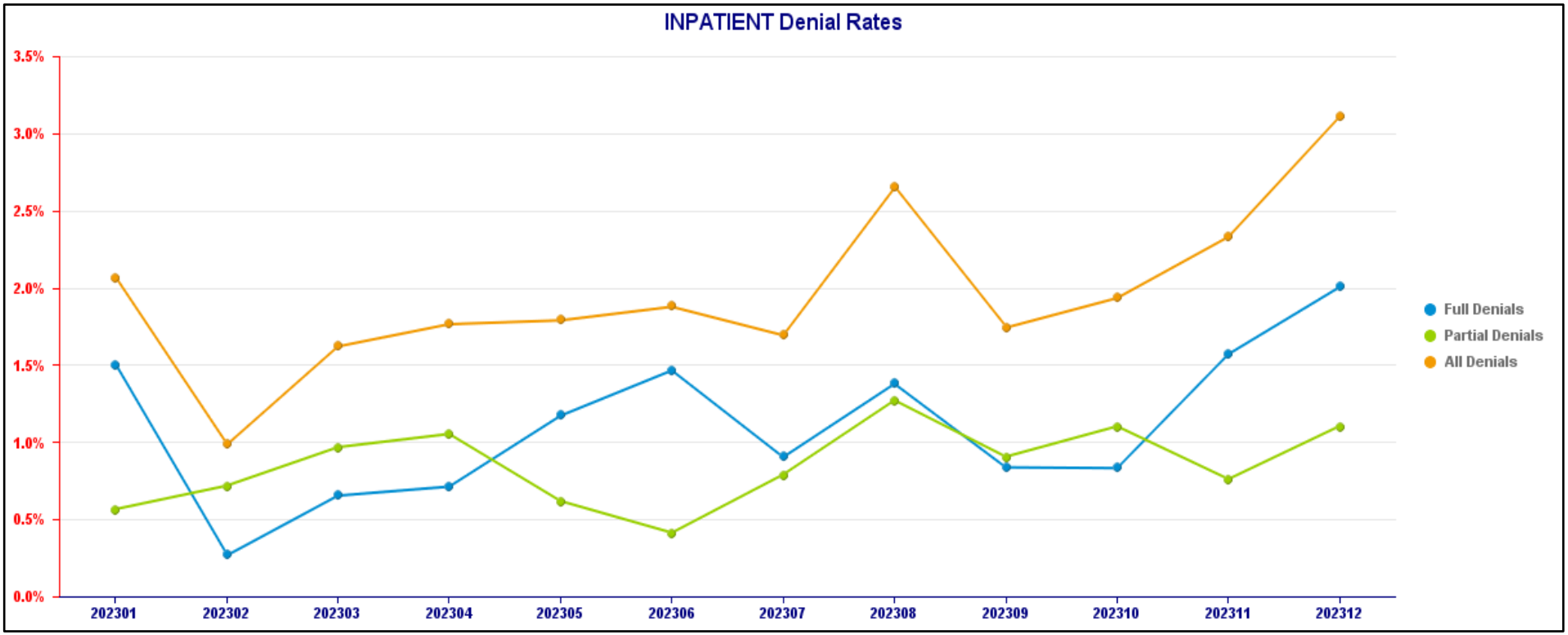


- 2023 Paid Days/1000 decreasing downward 303.3 (-35.1)
- Highest contribution to Paid Days/1000 were: **Alliance** (555.6) > **AHS** (294.6) > **CHCN** (244.6)
- Highest Paid Days/1000 by aid category: **SPD** (941.5) > **Duals** (881.2) > **ACA OE** (231.6)

Inpatient Denial Rates by Network

Excel: #01292 All Auth Denial Rates
Date: January 2023 –December 2023

ALAMEDA Alliance FOR HEALTH



- All IP Denial rates were steady until late Q4, with rises seen in Partial and Full Denials
- AAH is the only Network where Denial Reason are currently recorded
- 2023 Nov/ Dec Denial rise due to “Not Eligible” and “Not Medically Necessary”

Med Nec not met due to:
1) Denial Modification for Administrative Days when Acute stays Not Met (Partial Denials)
2) Elective PA Med Nec Not Met

Outpatient Denial Rates

Excel: #01292 All Auth Denial Rates

Date: January 2023 – December 2023

IP Denial Reasons data is only recorded by AAH network at this time.

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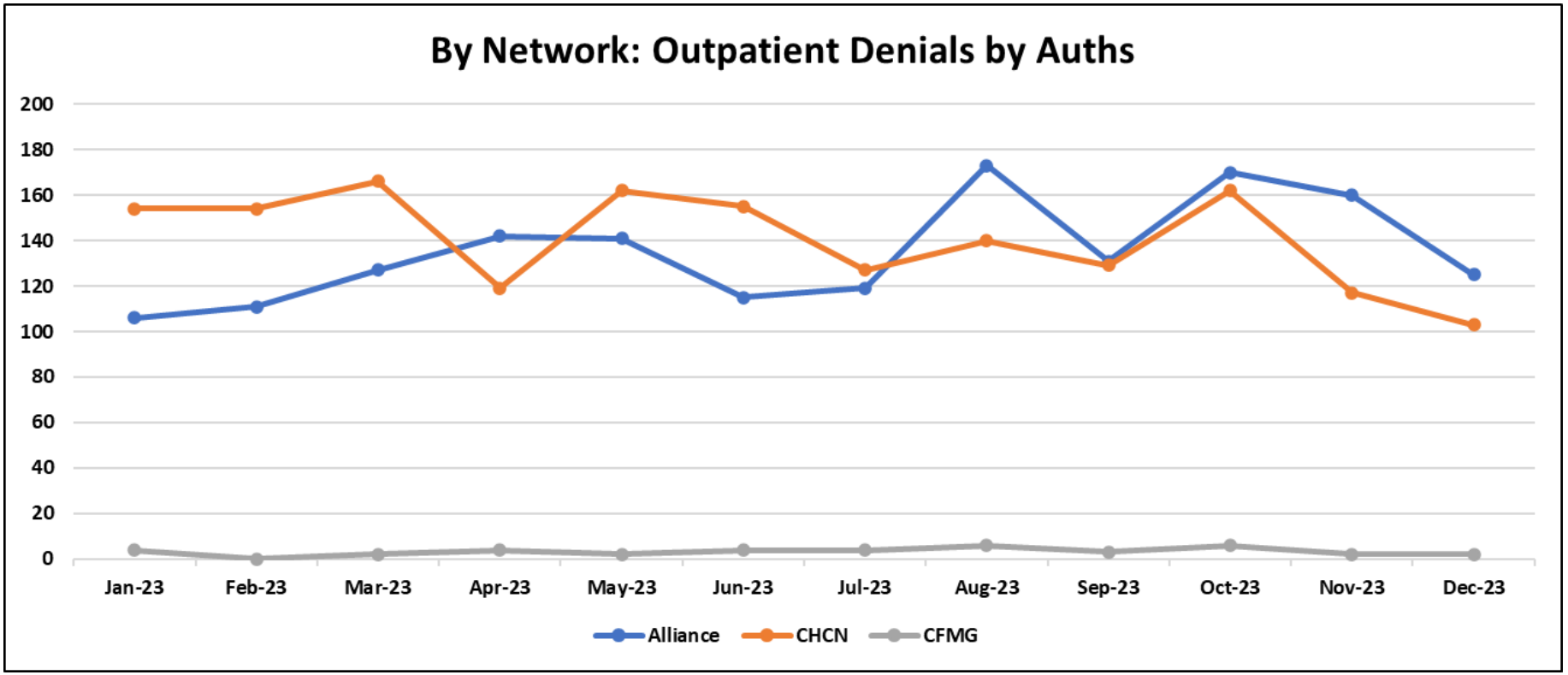

- Among the Alliance network, OP denials fluctuated between 100-160 denials monthly

Alliance - Highest denials based on LOC: Consultation, Diagnostic X-Ray/Radiology, & TQ Specialty Care
CHCN – Highest denials based on LOC: Hospital –OP, Professional Services, and Consultation
CFMG – Highest denials based on LOC: Orthotics & Prosthetics, DME/Supplies, & ECM

By Alliance: OP Denial Reasons

Excel: #01292 All Auth Denial Rates
Date: January 2023 –December 2023

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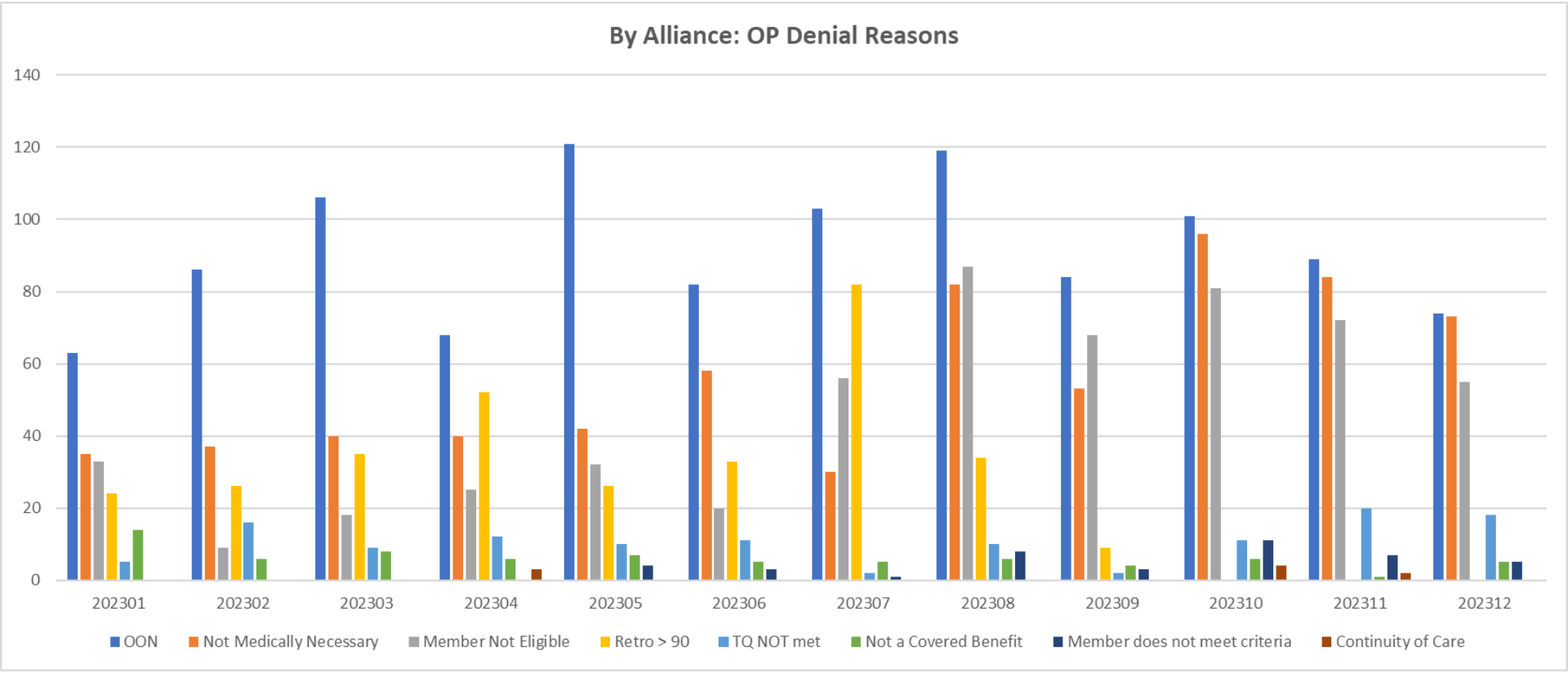


- AAH UM Reviews contributing to OP Auth Denials:
  Most Common: “OON”
  Second most common AAH denial reason “Not Medically Necessary”

- Tertiary/ Quaternary (TQ) denial has started to increase in Q4 2023.
- Retro > 90” has decreased from September– December following the Provider centric Retro policy change in March

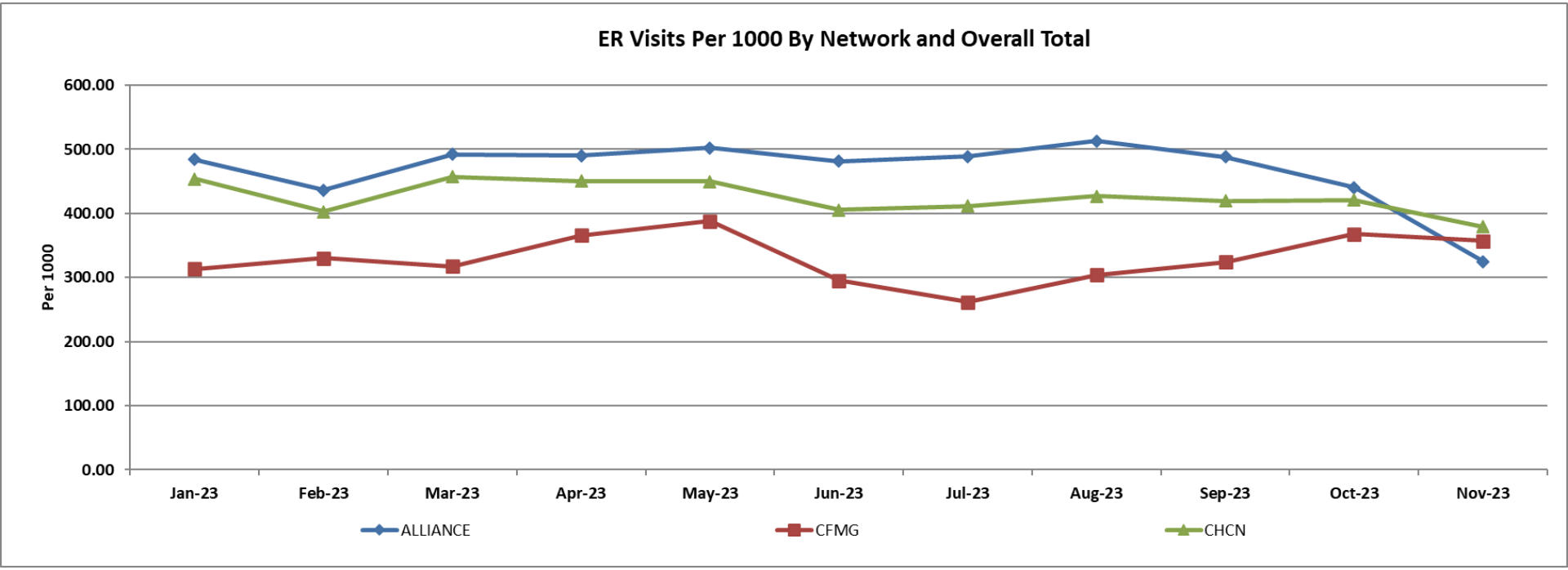
OP Denial Reasons data is only recorded by AAH network at this time.

Emergency Department Volume

Excel: #03046 ER Visits by Network

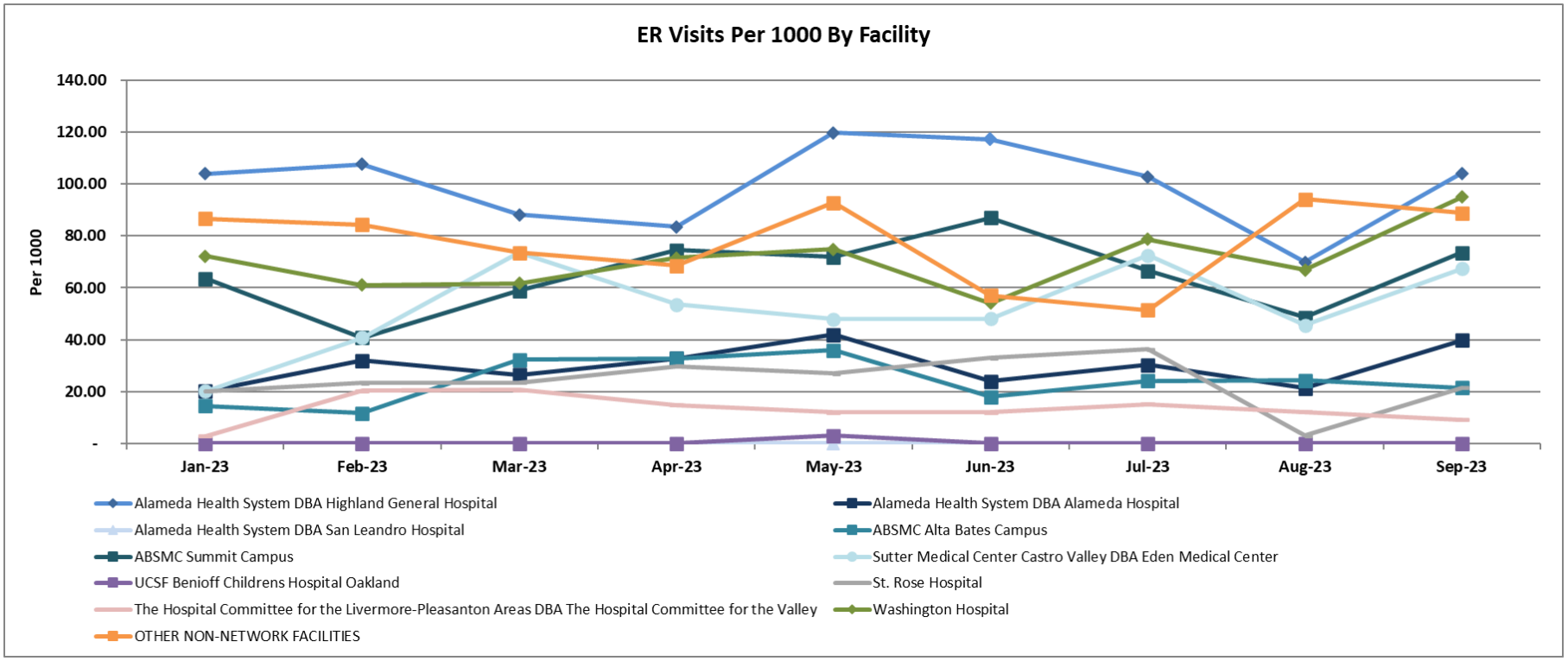
Date: January 2023 – November 2023

ALAMEDA Alliance FOR HEALTH



Alliance Highest ER Visits by AID Category:

ACA OE – Chest Pain, Headache, Epigastric Pain
SPD - Chest Pain, Headache, Primary Hypertension
Adult – Chest Pain, Headache, Acute Upper Respiratory Infection



Top ER Admissions by Facility

Washington Hospital – *Acute Upper Resp Infection, Chest Pain, Urinary Tract Infection, Abdominal Pain, Headache*

Highland Hospital – *Chest Pain, Acute Upper Resp Infection, Other Spec Disorders, Dizziness, Headache, Acute Pharyngitis, Essential Primary Hypertension*

Eden Medical Center- *Chest Pain, Abdominal Pain, Dizziness, Epigastric Pain, Headache, Nausea w/ Vomiting*

Thanks!

Questions?

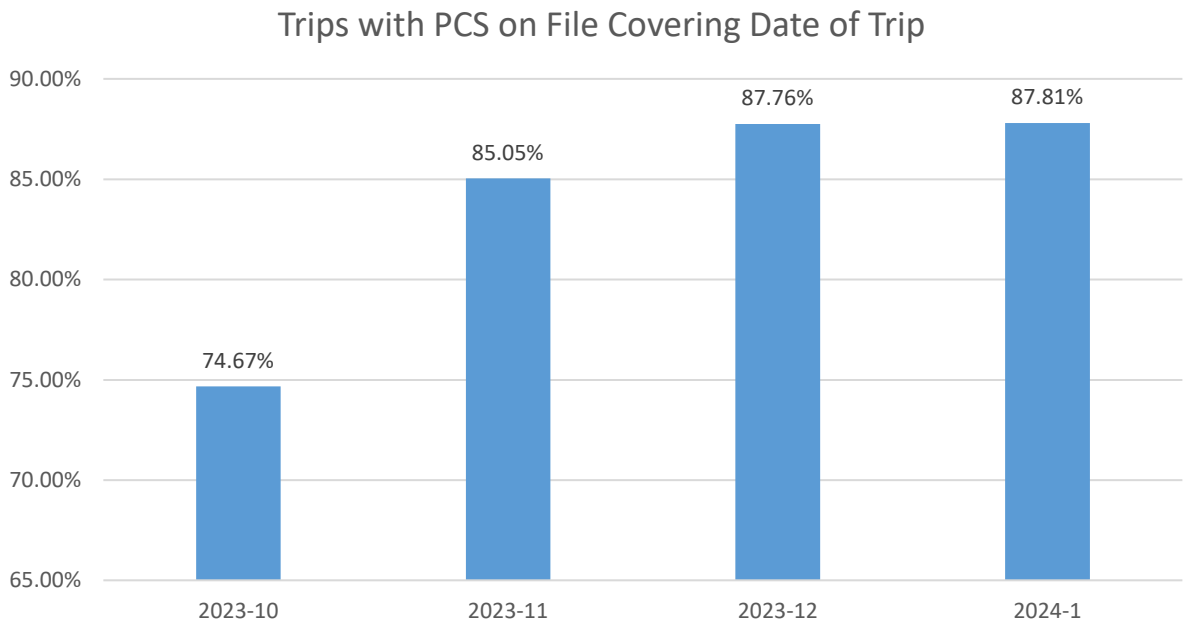
Case and Disease Management Update

by Lily Hunter, RN, BSN, MBA

ALAMEDA Alliance FOR HEALTH

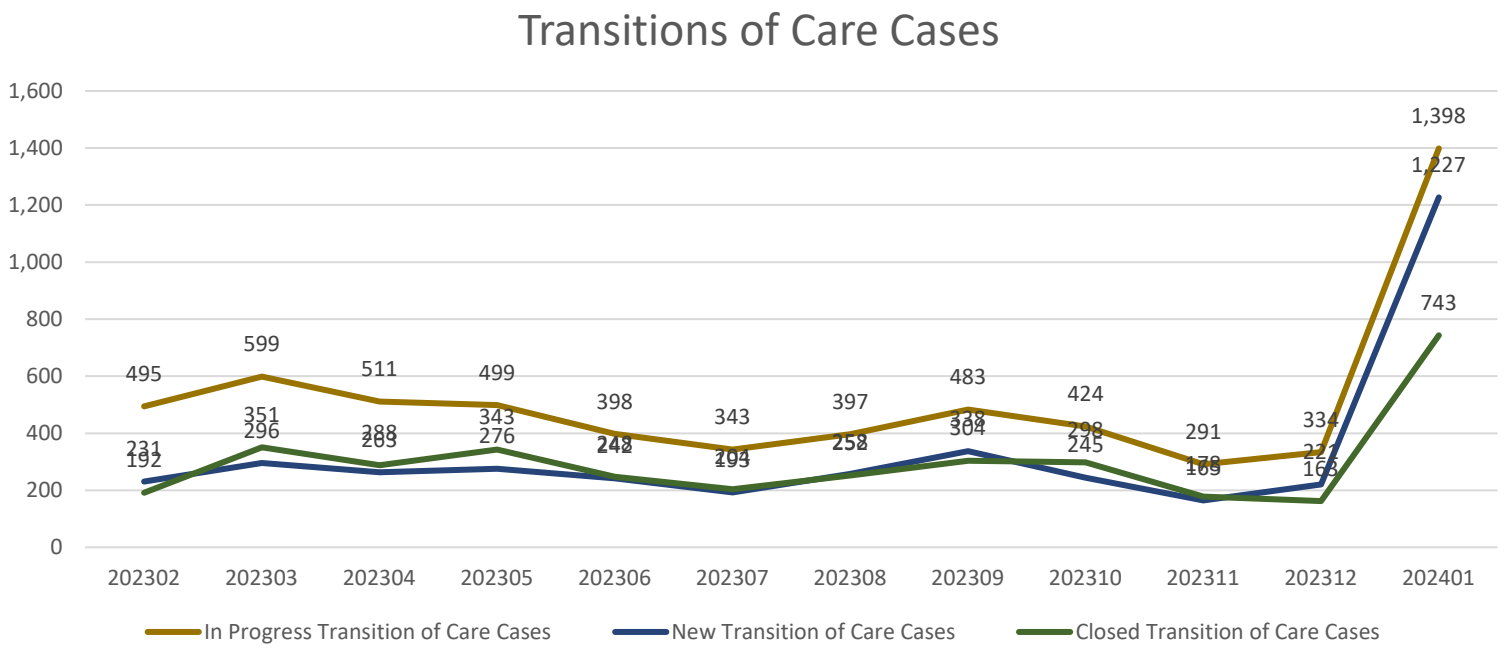
CM - Transportation

- CM preparing for DHCS Audit on Transportation, specifically Physician Certification Statement (PCS)
- Insourced function from subcontractor Modivcare, previous estimated compliance rate of 30-50%
- Analytics tracking PCS compliance on date of trip



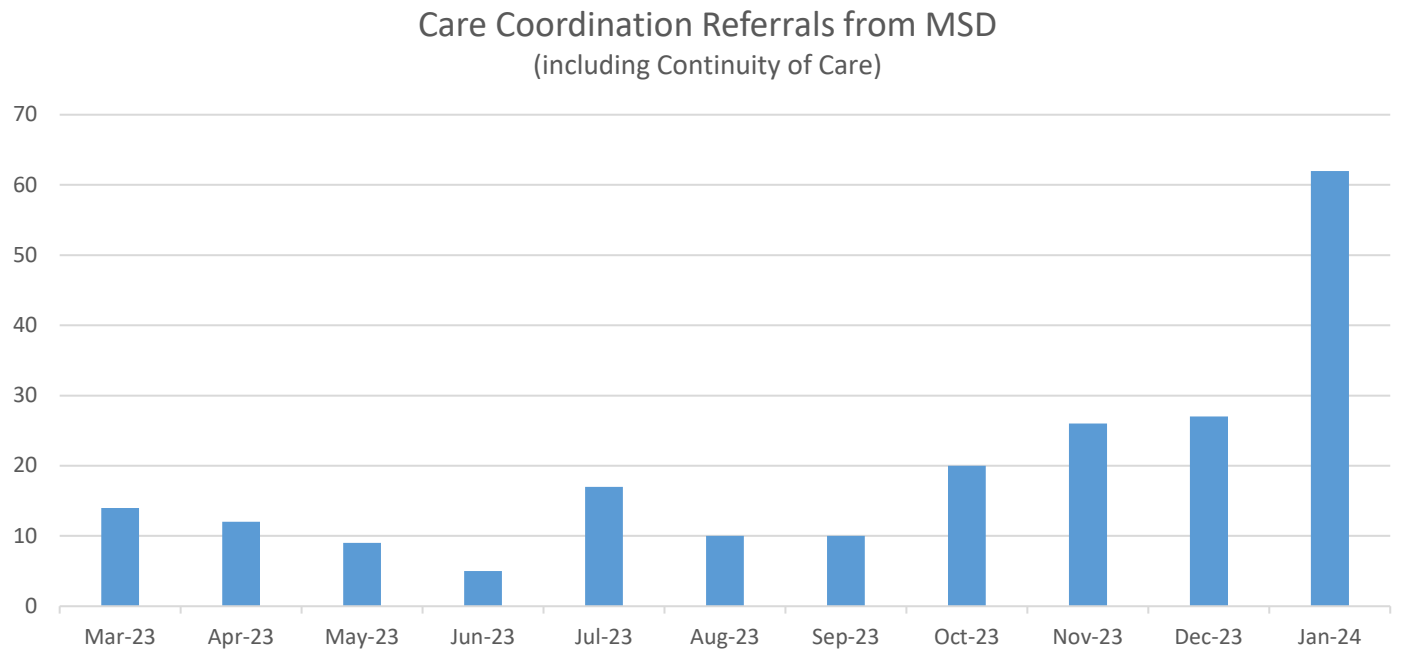
CM – Transitional Care Services

- In 2023 – MCP's tasked by DHCS to provider Transitional Care Services (TCS), formerly Transitions of Care, to high risk members.
- In 2024 – AAH CM Department providing TCS for all members of any risk level.



CM – Continuity of Care

- In 2023 – Anthem Blue Cross members transitioned to Alameda Alliance
- CM updating members on Continuity of Care Cases include authorization status and troubleshooting as needed.



Community Supports

at Alameda Alliance for Health

ALAMEDA Alliance FOR HEALTH

Community Supports offered by AAH

Community Supports	Provider	Active
Housing Transition Navigation Services	HCSA **East Bay Innovations (EBI)**	X
Housing Deposits	HCSA **East Bay Innovations (EBI)**	X
Housing Tenancy and Sustaining Services	HCSA **East Bay Innovations (EBI)**	X
Recuperative Care (Medical Respite)	Cardea Health BACS Lifelong Adeline	X
(Caregiver) Respite Services	24 Hour Home Care **Omatochi**	X
Nursing Facility Transition/Diversion to Assisted Living Facility (ALF)	East Bay Innovations (EBI) **Omatochi**	X
Community Transition Services/Nursing Facility Transition to a Home	East Bay Innovations (EBI) **Omatochi**	X

Community Supports offered by AAH

Community Supports	Provider	Active
Personal Care and Homemaker Services	24 Hour Home Care **Omatochi**	X
Environmental Accessibility Adaptations (Home Modifications)	East Bay Innovations (EBI) **Omatochi**	X
Medically Tailored Meals/Medically Supportive Food	Project Open Hand Recipe 4 Health **Alameda County Community Food Bank**	X
Sobering Centers	**Cherry Hill/Horizon**	**July 1, 2024**
Asthma Remediation	Asthma Start – HCSA **Roots Community Health Clinic**	X
Short-Term Post-Hospitalization Housing	TBD	TBD
Day Habilitation Programs	TBD	TBD

Enhanced Care Management (ECM)

at Alameda Alliance for Health

ALAMEDA Alliance FOR HEALTH

ECM Populations of Focus

	ECM Populations of Focus	Adults	Children & Youth
1	Individuals Experiencing Homelessness	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization *(Formerly "High Utilizers")*	✓	✓
3	Individuals with Serious Mental Health and/or SUD Needs	✓	✓
4	**Individuals Transitioning from Incarceration**	✓	✓
5	Adults Living in the Community and At Risk for LTC Institutionalization	✓	
6	Adult Nursing Facility Residents Transitioning to the Community	✓	
7	Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	**Birth Equity Population of Focus**	✓	✓

https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf

QI Workplan Update

Farashta Zainal

Michelle Stott

ALAMEDA Alliance FOR HEALTH

HEDIS/MCAS Performance

ALAMEDA Alliance FOR HEALTH

DHCS Sanction (MY 2022)

- **$80,000** for 5 measures below the MPL
  - Follow up for Mental Illness (30 day)
  - Lead screening
  - Well-child visit (W-30 6+)
  - Controlling blood pressure
  - Cervical Cancer Screening
- Sanctions determined by several factors:
  - Severity/beneficiary impact (no preventive care service)
  - Trending factor
  - Healthy Places Index (sanction reduction)
- Revised comprehensive quality strategy

Revised Comprehensive Quality Strategy

Quality Investment: Summary

ALAMEDA Alliance FOR HEALTH

1. Provider Engagement

- **P4P**: Increased funding
- Health Equity Incentive Pilot
- Provider Training

2. Member Engagement

- **2 FTEs** telephonic outreach on care gap lists (QI Engagement Coordinators
- Outreach: Non-utilizer, IHA outreach
- Community: Collaboration with First 5

3. Data collection & sharing

- **HIE:** Manifest MedEx (P4P)

4. Funding/Resources

- Community investment funds
- QI/Performance Improvement Projects: **2 FTEs**
- Practice coaching consultant/vendor:
  - Documentation & Coding
  - Practice coaching

5. Organizational Alignment

- Coordinated campaigns**: multi-modal communication methods (i.e. letters, text, flyers, etc.)**
- Utilize **Alliance staff incentives**

Quality Improvement Supporting Mechanisms

- Multiple Quality Improvement/Performance Improvement Projects
- Established multidisciplinary domain workgroups
- Access & Availability
  - Collaboration with Provider Services to expand provider network
  - Coordination with Local Education Authority
  - Extended Office Hours incentive
- Behavioral Health (in-sourced)
  - Coordination with Alameda County Behavioral Health (ACBH), Special Needs Committee (SNC), and high-volume providers
- Population Health & Equity
  - Alignment with DHCS Bold goals, Population Health Strategy, and HEDIS/MCAS
- Health Equity Department
  - Integration of Chief Health Equity Officer into the Quality Improvement Health Equity program to address health disparities

2023 HEDIS Rates as of Feb 2024

	2022 Rates		2023 Rates						
Measure Description	Admin Rate	Hybrid Rate	EP	Numerator	Rate	Above MPL	Number to Treat to MPL	MPL	90th Pctl
Behavioral Health									
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30 Day	29.82%		1,775	547	30.82%	N	99	36.34%	53.44%
Follow-Up After Emergency Department Visit for Mental Illness - 30 Day	49.03%		1,668	518	31.06%	N	398	54.87%	73.26%
Disease Management									
Asthma Medication Ratio	74.71%		2,140	1,495	69.86%	Y	0	65.61%	75.92%
Controlling High Blood Pressure	41.77%	54.74%	16,999	8,016	47.16%	N	2,407	61.31%	72.22%
HbA1c Poor Control (>9.0%)	37.06%	29.20%	14,385	4,907	34.11%	Y	0	37.96%	29.44%

2023 HEDIS Rates as of Feb 2024

	2022 Rates		2023 Rates						
Measure Description	Admin Rate	Hybrid Rate	EP	Numerator	Rate	Above MPL	Number to Treat to MPL	MPL	90th Pctl
Well Child									
Childhood Immunization Status - Combo 10	45.20%	52.80%	3,584	1,477	41.21%	Y	0	30.90%	45.26%
Immunizations for Adolescents - Combo 2	49.36%	50.61%	4,603	2,267	49.25%	Y	0	34.31%	48.80%
Developmental Screening in the First Three Years of Life Total	44.24%		8,538	4,639	54.33%	Y	0	34.70%	
Lead Screening in Children	57.52%	60.58%	3,593	2,180	60.67%	N	77	62.79%	79.26%
Topical Fluoride for Children Rate1 - dental or oral health services	12.18%		85,108	8,492	9.98%	N	7,934	19.30%	
Well-Child Visits in the First 15 Months of Life - 6 or More Visits	46.56%		1,418	821	57.90%	N	7	58.38%	68.09%
Well-Child Visits for Age 15 Months to 30 Months - Two or More Visits	69.01%		3,404	2,518	73.97%	Y	0	66.76%	77.78%
Child and Adolescent Well-Care Visits	49.69%		81,659	45,721	55.99%	Y	0	48.07%	61.15%
Women's Health									
Breast Cancer Screening - ECDS	56.08%		16,316	9,721	59.58%	Y	0	52.60%	62.67%
Cervical Cancer Screening	52.44%	53.83%	55,507	32,181	57.98%	Y	0	57.11%	66.48%
Chlamydia Screening in Women	64.14%		7,380	4,938	66.91%	Y	0	56.04%	67.39%
Timeliness of Prenatal Care	85.36%	87.50%	2,480	2,123	85.60%	Y	0	84.23%	91.07%
Timeliness of Postpartum Care	81.72%	85.42%	2,480	2,131	85.93%	Y	0	78.10%	84.59%

Questions?

2024 CLS Program Description

Linda Ayala

ALAMEDA Alliance FOR HEALTH

CLS PROGRAM DESCRIPTION UPDATES

Brief Description of Change(s)

• Yearly review, minor grammar and formatting.
• Changed "Member Advisory Committee" to "Community Advisory Committee" and HCQC to QIHEC.
• Updated DEI training description based on 2024 Medi-Cal Contract.
  • Content updates including health disparities, systemic racism, and bias.
• Added additional duties/responsibilities of CAC based on 2024 Medi-Cal Contract.
  • Expanded input into Alliance policies and programs.
  • Ensure CAC membership reflects the Alliance Membership.
  • Establish a CAC Selection Subcommittee to select CAC members for BOG approval.

2023 CLS Workplan Evaluation

Linda Ayala

ALAMEDA Alliance FOR HEALTH

CLS WORKPLAN 2023 EVALUATION

Activity/ Initiative	Goal	Outcome(s)	Goal Met
Member Cultural and Linguistic Assessment	Assess the cultural and linguistic needs of plan enrollees.	• Completed assessments at CLS meetings on 1/23/2023, 5/2/2023, 7/26/2023, and 10/25/2023. No significant changes to report.	Yes
Language Assistance Services	Reach or exceed an average fulfillment rate of ninety-five percent (95%) or more for in-person, video, and telephonic interpreter services.	• Q1 2023: 97% • Q2 2023: 96% • Q3 2023: 95% • Q4 2023: 95%	Yes

CLS WORKPLAN 2023 EVALUATION

Activity/ Initiative	Goal	Outcome(s)	Goal Met
Provider Language Capacity (Member Satisfaction)	Based on the Member CG-CAHPS Survey 81% of adult members and 92% of child members who need interpreter services will report receiving a non-family qualified interpreter through their doctor's office or health plan.	• Q4 2022-Adult: 83.7%; Child: 91.5% • Q1 2023-Adult: 84.4%; Child: 95.9% • Q2 2022-Adult: 87.1%; Child: 94.3% • Q3 2023-Adult: 81.8%; Child: 96.1%	Yes
Provider Language Capacity (Provider Network)	Complete NCQA NET 1 A Analysis of Capacity of Alliance Provider Network to meet Cultural and Linguistic needs of members.	• NCQA Net 1 A Report was completed and presented at the CLS Committee on 05/02/2023	Yes

CLS WORKPLAN 2023 EVALUATION

Activity/ Initiative	Goal	Outcome(s)	Goal Met
Cultural Sensitivity Training (CST): Participation	96% of Alliance staff will participate in the annual Cultural Sensitivity training.	• 96% completion rate for all Alliance staff	Yes
Cultural Sensitivity Training (CST): Enhancements	Facilitate collaborative process to update Cultural Sensitivity Training (s) to meet DHCS 2024 requirements.	• CST enhancements completed in Q3 2023	Yes

CLS WORKPLAN
2023 EVALUATION

Activity/ Initiative	Goal	Outcome(s)	Goal Met
Community Advisory Community (CAC) *Formerly known as Member Advisory Committee (MAC)*	Ensure implementation of DHCS 2024 Contract updates to Member Advisory Committee and community engagement.	• CAC members approved an updated name, charter and a resolution to establish a CAC Selection Subcommittee, 12/28/2023.	Ongoing

2024 CLS WORKPLAN

- Focus Areas
  - Assessing the cultural and linguistic needs of members
  - Language services for members (i.e., member satisfaction through CG-CAHPS and timely access through the Timely Access Survey)
  - Provider network by language capacity and race and/or ethnicity
  - Expand CAC input into Alliance programs and policies
  - Behavioral Health CLS Tracking and Monitoring

Thank you!

Questions?

PQI

Dr. Sanjay Bhatt

Christine Rattray

ALAMEDA Alliance FOR HEALTH

Annual PQI Training

January 18, 2024

ALAMEDA Alliance FOR HEALTH

What is a PQI?

Potential Quality Issue:

Suspected deviation from accepted standards of care that may indicate a significant risk to the health and/or well being of the member.

Anyone can submit a PQI:

- Alliance Staff
- Member
- Delegates and Providers

PQI Types

PQIs are separated into:

- QOA (Quality of Access)
  - Appt or phone access
  - Cleanliness
  - Geo access
- QOS (Quality of Service)
  - Provider/staff attitude
  - Delay in PA
  - Safety of service provided
  - Perceived lack of follow up
- QOL (Quality of Language)
  - Provider did not schedule an interpreter for an appointment
  - Not enough providers in member's preferred spoken language in a location close to member's home
  - Interpreter or bilingual staff quality concerns
- QOC (Quality of Care)
  - Delayed / Missed Diagnosis
  - Delay in obtaining medications
  - Transportation Delays resulting in missed / delayed appointments
  - PPCs – Provider Preventable Conditions
  - Premature discharge from a hospital or skilled nursing facility

How to Submit a PQI

- **Where to submit a PQI referral:**
  - Internal to AAH: Service Request: PQI
  - External to AAH: Email: distgrppqi@alamedaalliance.org

- **Requested Information:**
  - Member First and Last Name
  - DOB
  - Identification Number
  - Full name of the person/company the complaint is against
  - Facility/Provider NPI if available
  - Reason for the Referral
    - Include as much detail as possible

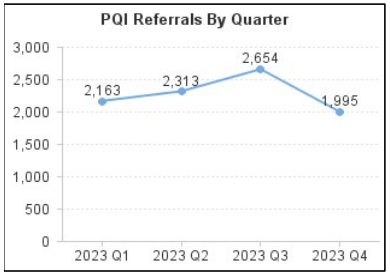
Name of Report: Clinical Reviewer PQI Case File Audit Report for Quality-of-Service Issues				
Reported by: Christine Clark Rattray, BSN RN QI Clinical Supervisor			**Date:** 1/17/2024	
Reporting period: Q4 2022 – Q3 2023				
Purpose: To ensure accurate and appropriate clinical documentation, monitoring, and oversight of Quality-of-Service (QOS) PQI case files. Quality of Access (QOA) cases are referred to the Access & Availability team while Quality of Language (QOL) cases are referred to the Cultural and Linguistics team for evaluation and appropriate intervention. All Quality-of-Care cases are audited by the Senior Medical Director of Quality or designated Medical Director at weekly case review meetings.				
Results	**Q4 2022** **Case Files Reviewed Volume** QOS = 60 **Compliance Rate:** **100%** Goal: ≥90% Goal exceeded **4/4 RN Reviewers**	**Q1 2023** **Case Files Reviewed Volume** QOS = 60 **Compliance Rate:** **98%** Goal: ≥90% Goal exceeded **4/4 RN Reviewers**	**Q2 2023** **Case Files Reviewed Volume** QOS = 55 **Compliance Rate:** **100%** Goal: ≥90% Goal exceeded **4/4 RN Reviewers** **Final count reflects LOA for 1 RN during lookback**	**Q3 2023** **Case Files Reviewed Volume** QOS = 45 **Compliance Rate:** **100%** Goal: ≥90% Goal exceeded **4/4 RN Reviewers** **Final count reflects LOA for 1 RN during lookback**
Oversight Methodology	QI Clinical Supervisor or designated clinical staff audits 5 QOS PQI case files/month for each Quality Review RN. Case files are audited for accurate and appropriate documentation that includes: i. Timely review and resolution within 120 days ii. PQI type - appropriately classified iii. Assessment of problem/grievance iv. Planned investigation v. Intervention carried out according to plan vi. Evaluation/Resolution -Pass rate of ≥90% must be met. -Retraining of QI Review Nurse will be conducted for a score of less than 90%. -A decrease in audited cases was realized for Q2 and Q3 due to LOA of one RN			
Data source:	PQI Application Database			
Improvement Opportunities	With the anticipated increase in AAH members as of Jan 1, 2024, there will be close supervision of TATs to ensure timely intervention where appropriate			
Interventions for Improvement Opportunities:	Continuous auditing of Quality of Service (QOS) cases to determine compliance with established TATs and provision of refresher training where appropriate.			

Next Steps:	Ongoing Auditing of PQI case files with identification for training opportunities

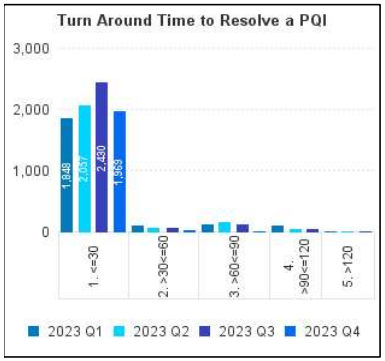
PQI Dashboard

2023 Q4

Run Date:	01/08/2024

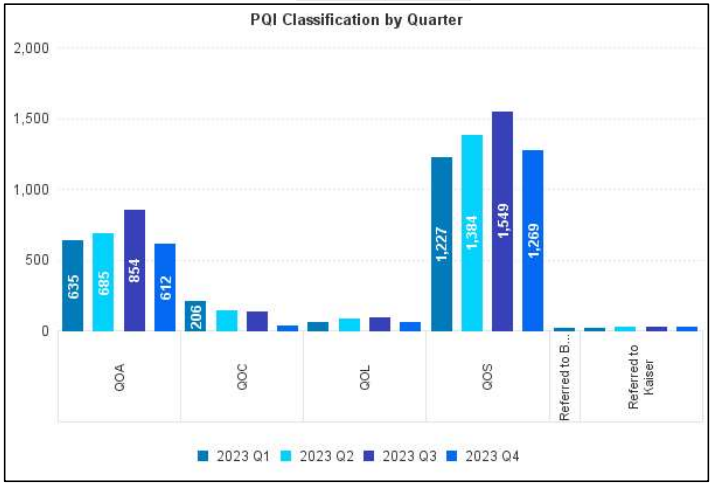


Quarter	# PQIs
2023 Q1	2163
2023 Q2	2313
2023 Q3	2654
2023 Q4	1995
Total:	**9125**

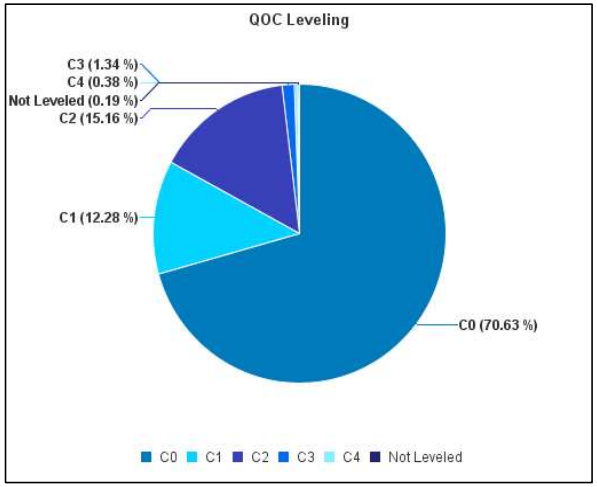


PQIs Still Open by Quarter Received

Quarter	# PQIs
2023 Q3	17
2023 Q4	133
Total:	**150**



	2023 Q1	2023 Q2	2023 Q3	2023 Q4	Total
QOA	635	685	854	612	**2786**
QOC	206	144	136	35	**521**
QOL	58	79	88	58	**283**
QOS	1227	1384	1549	1269	**5429**
Referred to Beacon	18				**18**
Referred to Kaiser	19	21	27	21	**88**
Total:	**2163**	**2313**	**2654**	**1995**	**9125**



	2023 Q1	2023 Q2	2023 Q3	2023 Q4	Total
C0	147	99	93	29	**368**
C1	23	12	24	5	**64**
C2	34	31	13	1	**79**
C3	2	1	4		**7**
C4		1	1		**2**
Not Leveled			1		**1**
Total:	**206**	**144**	**136**	**35**	**521**

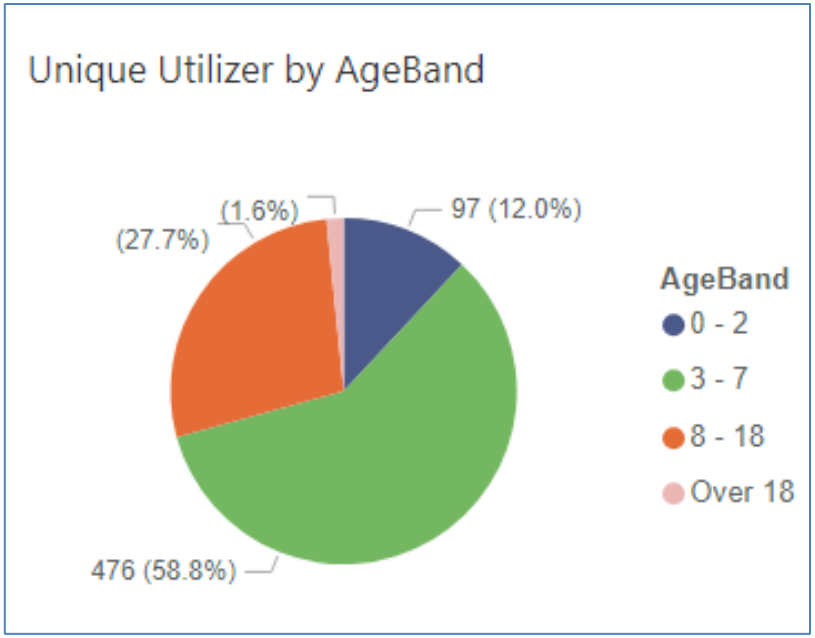
QIHEC Behavioral Health Report

02/16/2024

ALAMEDA Alliance FOR HEALTH

BHT Member Demographics

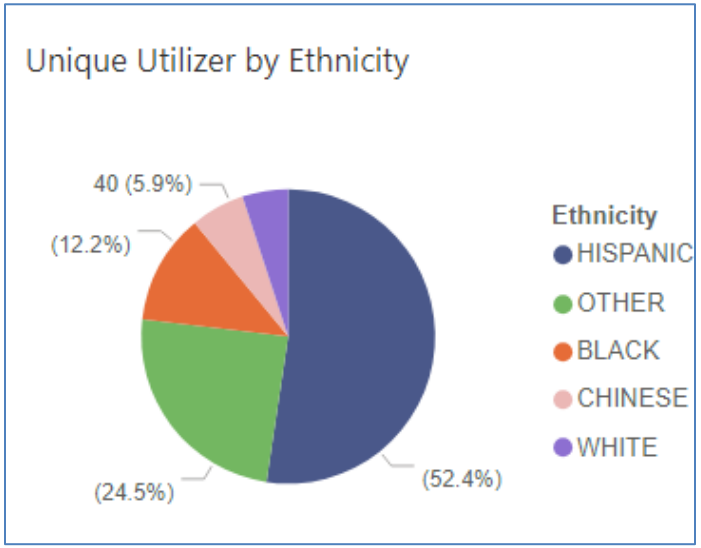
- 550 unique utilizers prior to insourcing
- 673 unique utilizers (Oct)
- 806 unique utilizers (Dec)
  - Age 3-7
    - 519 UU, $5,691,381 in paid claims
    - In this age group, 66% more males than females use the services.

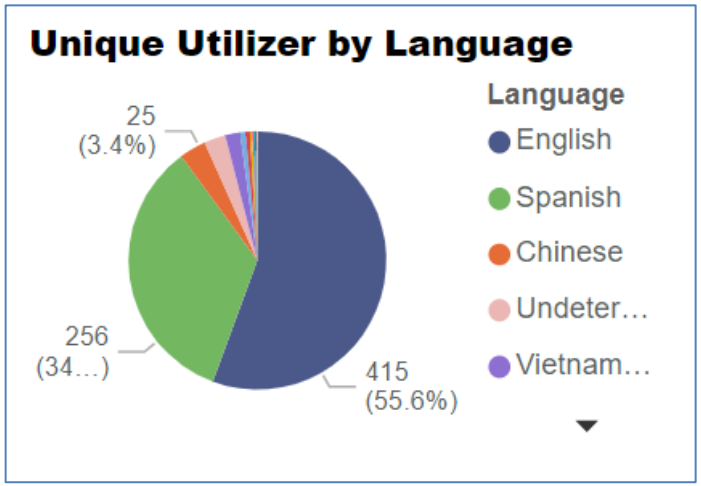


BHT Member Demographics

April 2023 and September 2023

- Limited Spanish-speaking providers
  - Resulting in delays in accessing services

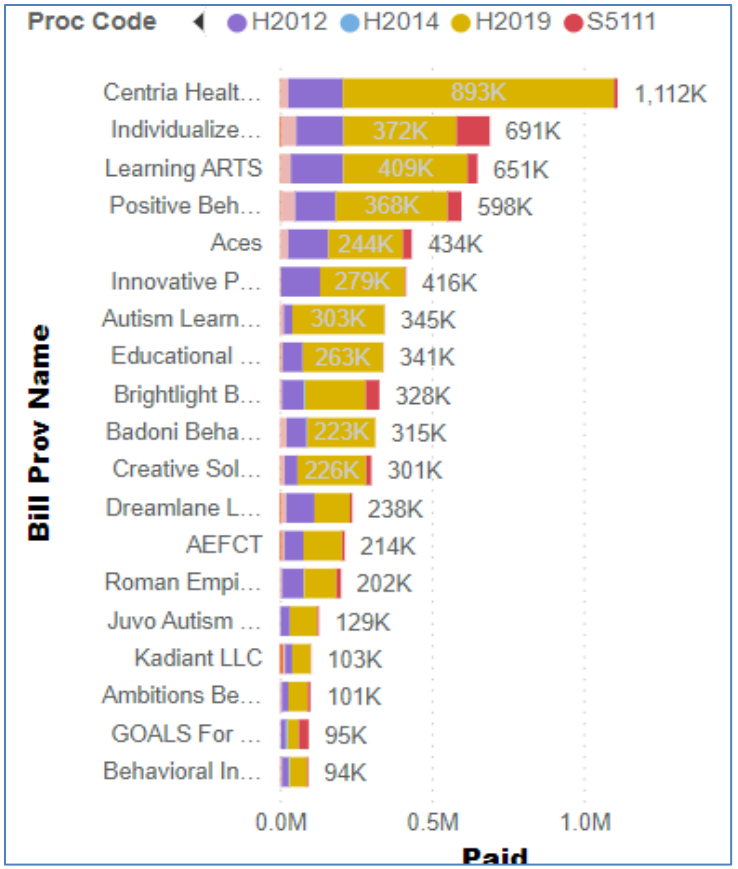




Member Utilization

Codes / Providers

- H2019 (Therapeutic Behavioral Services, per 15 minutes)
  - Most frequently utilized code
  - 554 Utilization Units
  - $4,714,714 in paid claims
- Leading service providers
  - Centria Healthcare
  - Individualized ABA Services for Families
  - Learning ARTS



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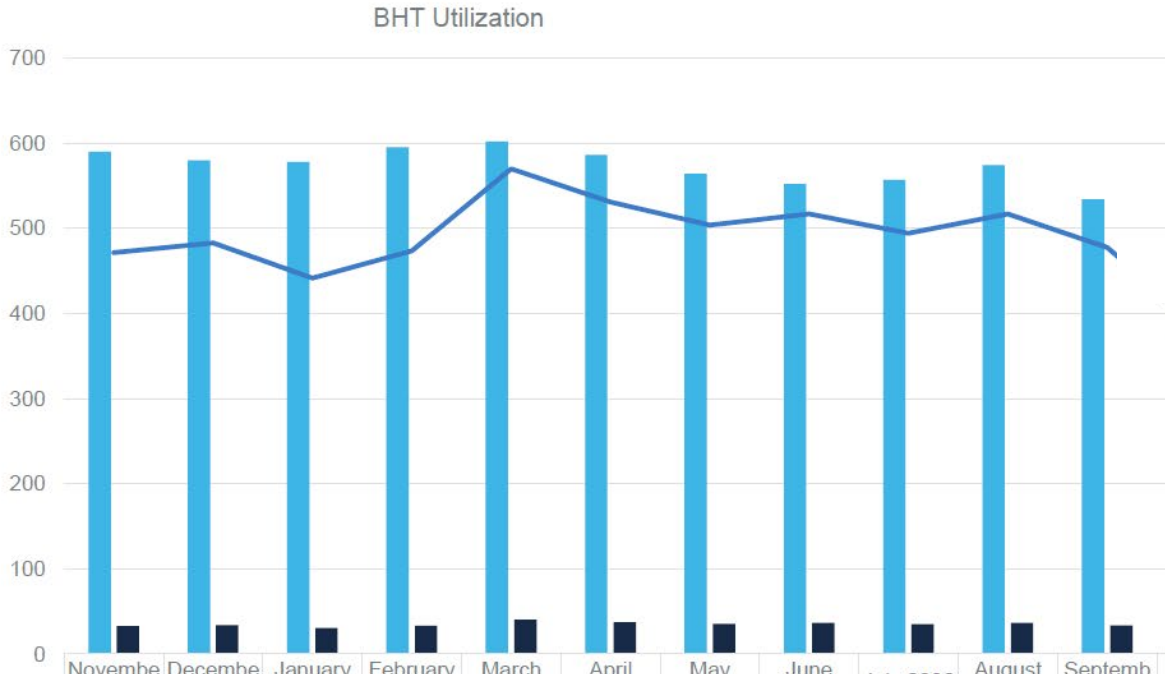
Utilization: Pre-Insourcing

Approximately 550 Unique Utilizers in 2022

BHT/ABA Utilization

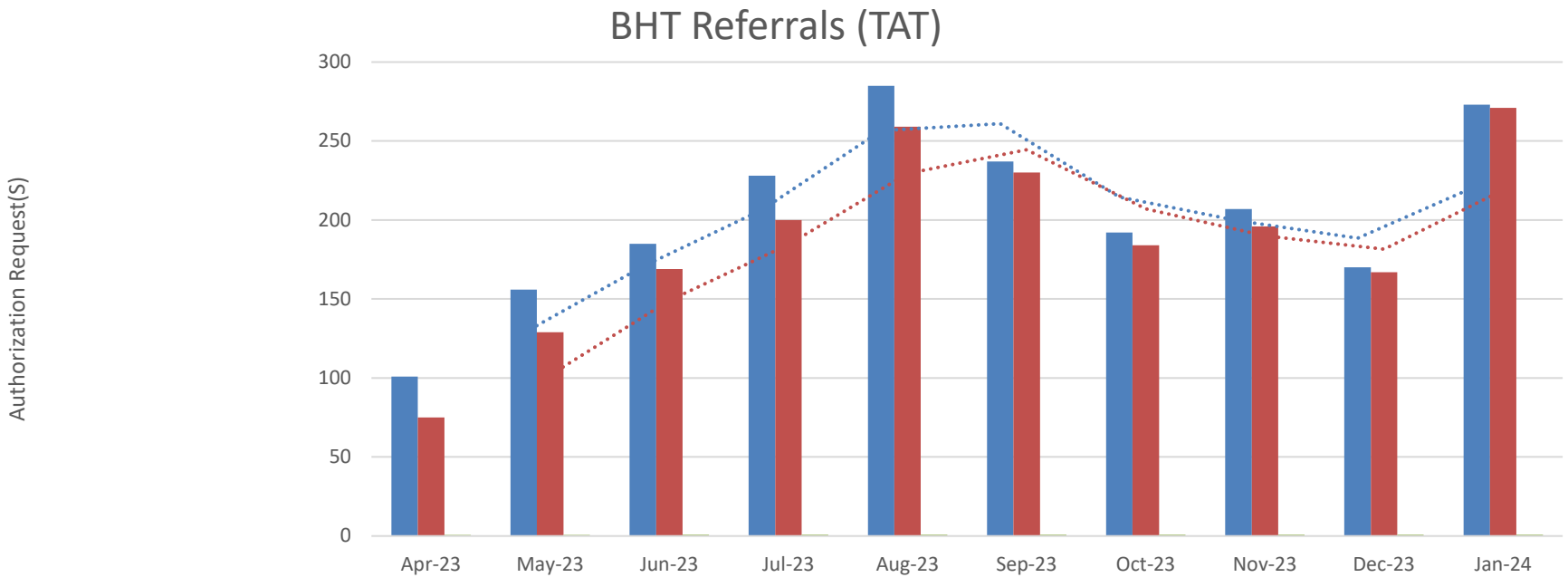


	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022
Unique Utilizers	590	580	578	595	602	586	564	552	557	574	534
Average Hours of Utilization per Unique Utilizer	33.03	33.92	30.53	33.22	40.13	37.21	35.65	36.46	34.96	36.57	33.56
Average Cost per Unique Utilizer	$2,020.78	$2,068.83	$1,892.26	$2,029.07	$2,442.94	$2,275.40	$2,159.56	$2,215.60	$2,117.77	$2,215.32	$2,047.26

beacon

BHT Authorizations & TAT

- Pent Up Demand Upon Launch (Beacon Backlog)
- Surge in January (Anthem Transition)



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Total # of Authorization Request	101	156	185	228	285	237	192	207	170	273
Met Determination TAT	75	129	169	200	259	230	184	196	167	271
% of met for determinations	74%	83%	91%	88%	91%	97%	96%	95%	98%	99%

Member Utilization

- Increased BHT auths
  - 806 unique utilizers
  - 1,761 total new auths 4/01/2023 through 12/2023
  - 600 auths pre-loaded from Beacon in March 2023)

Utilization Takeaways

- Increase in Unique Utilizers
  - 550 prior to insourcing
  - 806 post insourcing
- Positive trend and increased demand
- Network limitations

Strengths

- Member Experience
  - Up-trending utilization
  - Down-trending grievances
  - Individualized case management
- Network
  - 39 credentialed provider groups with over >600 BCBAs
- Community relationships
  - Special Needs Committee
  - High volume providers
- Alliance
  - Dedicated teams focused on member care and experience

Opportunities

- Network
  - At capacity provider network
  - Lack of additional regional provider groups with whom to contract
  - Instability (High Turn Over) of the ABA paraprofessional providers who provide direct services.
- Member Experience
  - Network Limitations resulting in increased wait times
  - Increased wait times for afternoon / evening hours and for non-English speaking families
- Alliance
  - Ongoing evaluation and revision of go-live workflows
  - Ongoing staff hiring and training

Where do we want to go?

- Expand Network
  - "Out-of-the-box" network development strategies to increase access - especially for the Limited CDE Provider Psychologists and related specialists (e.g., Speech, OT)
- Help establish additional CDE centers of excellence
- Reduce barriers to access and the # of members awaiting BHT/ABA services.
- Improved care coordination between BHT/ABA providers and referring pediatricians/psychologists.

Increase in Mental Health Utilization

- We are seeing a steady increase in the unique utilizers of mental health services from the baseline
- Ave # of members receiving mental health services in the four months prior to April 1, 2023 was 6,157.
- The # of unique utilizers of mental health services increased to 7,424 as of August 2023.
- The increase in the # of members accessing mental health services increased to 10,462 as of October 2023.

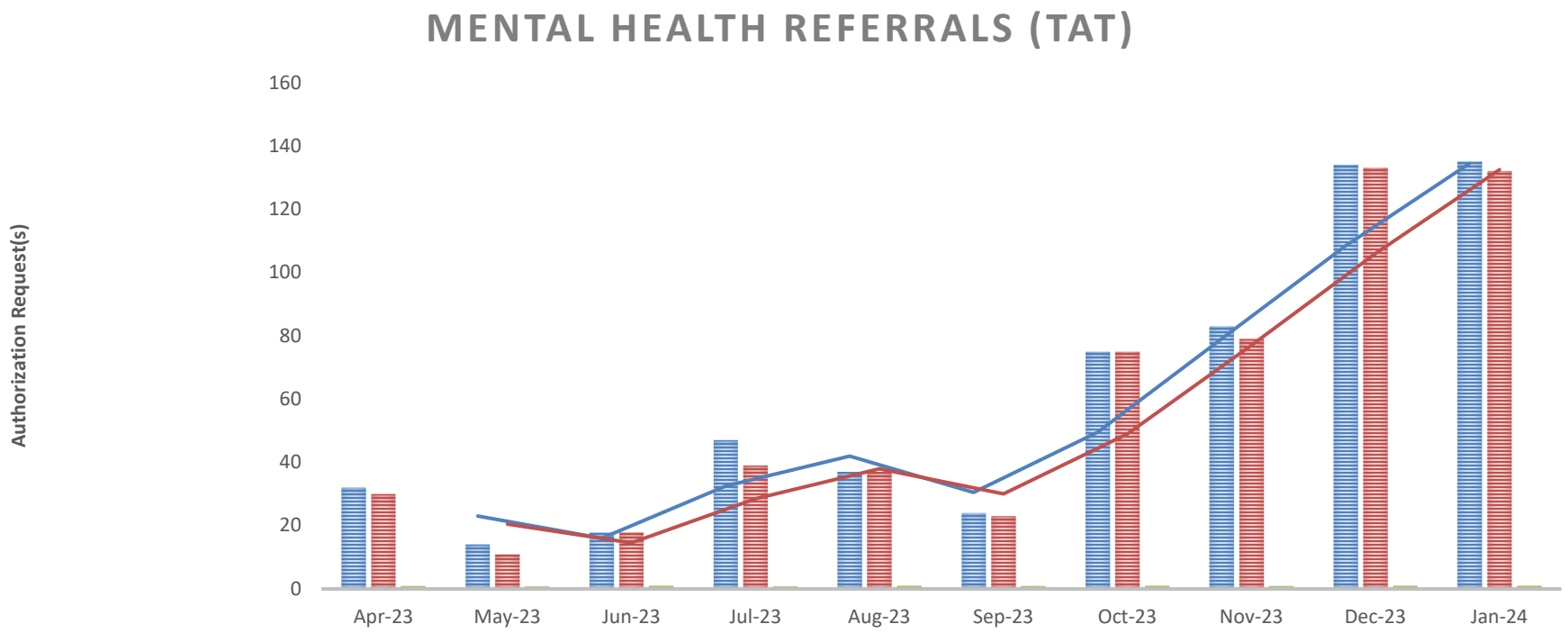
Behavioral Health Denial Rates and TAT

- Denial Rates Low: Open Access Benefit for Mental Health

Behavioral Health Outpatient Overall Denial Rates			
Oct-23	Nov-23	Dec-23	Jan-24
0.01%	0.01%	0.01%	0.01%
MH Determination Turnaround Time			
Oct-23	Nov-23	Dec-23	Jan-24
100.00%	95.00%	99.00%	98.00%
BHT Determination Turnaround Time			
Oct-23	Nov-23	Dec-23	Jan-24
96.00%	95.00%	98.00%	99.00%

Mental Health TAT

- Surge in Access December and January



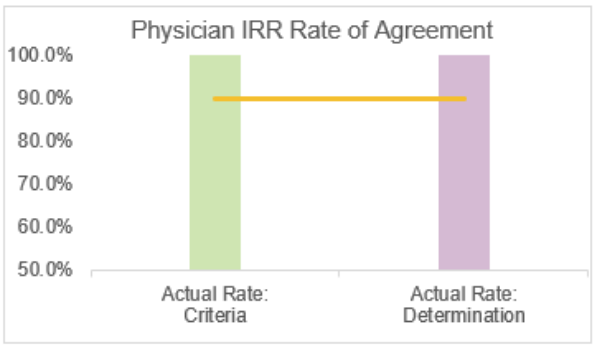
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Total # of Authorization Request	32	14	18	47	37	24	75	83	134	135
Met Determination TAT	30	11	18	39	37	23	75	79	133	132
% of met for determinations	93%	79%	100%	83%	100%	96%	100%	95%	99%	98%

2023 Inter-Rated Reliability (IRR)

- The 2023 IRR results have been outstanding with 100% consistency of determination rating from both clinical and physician reviewers, which surpasses the baseline goal of 90%.

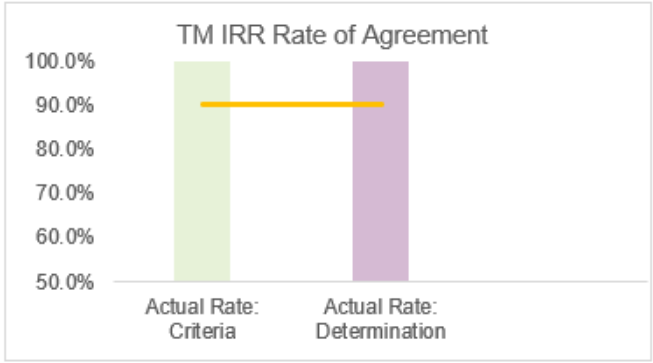
Total Number Agreement on Criteria: 8/8 = 100%

Total Number Agreement on Determination: 8/8 = 100%



Total Number Agreement on Criteria: 8/8 = 100%

Total Number Agreement on Determination: 8/8 = 100%



QIHEC Schedule Change

Dr. Donna Carey

ALAMEDA Alliance FOR HEALTH

Public Comment

Dr. Donna Carey

ALAMEDA Alliance FOR HEALTH

Thank You for Joining Us

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