QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE
11/17/2023
Remote via Microsoft Teams and in person

Committee Member Names and Titles	Specialty	Present
Steve O'Brien, Chief Medical Officer		X
Aaron Chapman, MD, Medical Director, Alameda County Behavioral Health Care Services	Psychiatry	X
Wesley Lisker, MD, Kaiser Permanente	Nephrology	X
Tri Do, MD, Chief Medical Officer, Community Health Center Network	Internal Medicine	X
Felicia Tornabene, MD, Alameda Health Systems	Internal Medicine	
James Florey, MD, Chief Medical Officer, Children First Medical Group	Pediatrician	X
Sanjay Bhatt, MD, Medical Director of Quality, Alameda Alliance for Health	Emergency Medicine	X
Peter Currie, MD, Senior Director, Alameda Alliance for Health	Behavioral Health	X
Donna Carey, MD, Medical Director of Case Management, Alameda Alliance for Health	Pediatrician	X
Michelle Nepomuceno Stott, RN, MSN, Senior Quality Director, Alameda Alliance for Health		X
Rosalia Mendoza, MD, Medical Director, Utilization Management, Alameda Alliance for Health		X

Alliance Staff Member Names and Titles	Present
Angelica Glasco Olivares, Behavioral Health Case Management Navigator	X
Angela Moses, Quality Review Nurse	X
Ashley Asejo, Clinic Quality Programs Coordinator	X
Beverly Juan, MD, Medical Director, Community Health	X
Bob Hendrix, Quality Improvement Project Specialist	X
Christine Rattray, Quality Improvement Nurse Supervisor	X
Dennis Mullenix, Behavioral Health Triage Specialist	X
Diana Fajardo, Behavioral Health Triage Specialist	X
Farashta Zainal, MBA, Quality Improvement Manager	X
Fiona Quan, Quality Improvement Project Specialist	X

Gil Duran, Population Health and Equity Manager	X
Grace St. Clair, MS-HCA, Director of Compliance & Special Investigations	X
Helen Lee, PharmD, MBA, Senior Director of Pharmacy Services	X
Hellai Momen, Quality Review Nurse	X
Hermine Voskanyan, ABA Analyst	
Homaira Momen, Quality Review Nurse	X
James Burke, Lead Quality Improvement Project Specialist	X
Jaymelee Chambers-Skondin, RN, Manager Long-Term Care	X
Jennifer Karmelich, Director Quality Assurance	X
Jessica Jew, Population Health and Equity Specialist	X
Jessica Pedden, Quality Analytics Manager	X
Julie Anne Miller, Senior Director of Health Care Services	X
Kathy Ebido, Senior Quality Improvement Specialist Nurse	X
Kisha Gerena, Accreditation Manager	X
Lao Paul Vang, Chief Health Equity Officer	X
Lily Hunter, Director of Social Determinants of Health	X
Linda Ayala, MPH, Director of Population Health	X
Loc Tran, Manager Access to Care	X
Matt Woodruff, Chief Operating Officer	X
Mao Moua, Manager, Cultural and Linguistic Services	X
Megan Hils, MPH, Quality Improvement Project Specialist	X
Richard Golfin, III, Chief Compliance Officer	X
Rosa Reyes-Quintanilla, Disease Management Health Educator	X
Rosa Sanchez, Facility Site Quality Improvement Coordinator	X
Sangeeta Singh, Quality Improvement Project Specialist	X
Tanisha Shepard, Quality Improvement Project Specialist	X
Other Participants	
Melinda Hammon, Kaiser Permanente	
Community Members in Attendance	
None	

Agenda Item	Responsible Person	Discussion	Action	Follow-Up by QI Staff
Call to Order	S. O'Brien	The meeting was called to order at 9:00 a.m.		

1. Chief Medical Officer Alameda Alliance Update	S. O'Brien	• This committee is now officially the Quality Improvement and Health Equity Committee (QIHEC)
		  ○ Due to a change in CalAIM- a committee required by the DHCS Medi-Cal contract
		  ○ Emphasized the focus on equity; committee was renamed to reflect that focus and will now include updates from the Chief Health Equity Officer
		• Julie Anne Miller retired, announced the selection of new Sr. Director of Health Care services: Allison Lam
		• Introduced Chief Health Equity Officer Lao Paul Vang
		• Jan 1 new members will join the Alliance:
		  ○ 80-90,000 Anthem members
		  ○ 30,000 undocumented individuals ages 26-39
		  ○ Total of 110-120,000 new members, which is a 1/3 increase in membership
		  ○ More volume in production lines: member services, claims, UM, CM, inpatient, long-term care, BH, grievances and appeals. Have done upstaffing to prepare
		• Board has directed an increased focus on quality		

2. Chief Health Equity Officer Update	L. P. Vang	• Provided overview of health equity initiatives at the Alliance:
		  ○ Data analysis on non-utilization with emphasis on whether there are any disparities
		  ○ Create a health equity and diversity, equity, and inclusion (DEI) roadmap for the Alliance
		  ○ Create a DEI curriculum as mandated by a recent all-plan letter (APL)		

Agenda Item	Responsible Person	Discussion	Action	Follow-Up by QI Staff
		○ Create a framework of accountability for health equity and DEI with key performance indicators (KPIs) to measure progresses and challenges		
3. Policies and Procedures	S. O'Brien	**Policies and Procedures** Policies approved through e-vote. **<u>Quality</u>** QI-XX: Clinical Practice Guidelines QI-101: Quality Improvement and Health Equity Program QI-104: Potential Quality Issues (PQIs) QI-107: Appointment Access and Availability Standards QI-114: Monitoring of Access and Availability Standards QI-135: Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) **<u>UM</u>** UM-018: Targeted Case Management and Early and Periodic Screening, Diagnosis and Treatment UM-036: Continuity of Care UM-057: Authorization Service Request UM-059: CoC for MCal Beneficiaries Who Transition into MCal Managed Care **<u>HED</u>** HED-XX: Doula Services HED-001: Health Education Program **<u>PH</u>** PH-004: Community Health Workers **<u>CLS</u>** CLS-002: Community Engagement		

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		CLS-011: CLS Program - Compliance Monitoring **<u>CMDM</u>** CM-004: Care Coordination of Services		
4. Approval Committee Meeting Minutes	S. O'Brien	**Committee Minutes – Approved by e-vote.** • HCQC – August 18, 2023 • IQIC – October 11, 2023 • A&A Meeting – August 2, 2023 • UMC – August 25, 2023; October 27, 2023		

5. QIHEC Charter	M. Stott	**M. Stott presented key points of the Charter:**
		
		• Charter officially denotes the committee as QIHEC, formerly HCQC.
		• Standing advisory committee of the board. Responsibilities include implement oversight and monitoring of program and provide feedback.
		• Includes both the quality improvement equity program and the utilization management program.
		• Changes from HCQC:
		  ○ Chaired by Chief Medical Officer (CMO) in collaboration with Chief Health Equity Officer (CHEO); CHEO is also a voting member.
		  ○ Committee analyzes, evaluates, and provides feedback on activities presented to the committee including review of HEDIS rates, utilization data, member satisfaction, findings and activities from subcommittees.
		  ▪ Member Advisory Committee (MAC) will now report to this committee.
			Request for G&A to be included in the Charter. Update will be brought back to next QIHEC Meeting.	

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		○ Institute actions to ensure follow-up to any performance deficiencies. ○ Trilogy documents including Annual Plan, Program Description, and Program Evaluation will be presented to this committee. ○ Minutes and activities of any subcontractors will be submitted to the board. ○ A written summary of QIHEC activities will be publicly available on the Alliance website on at least a quarterly basis. Comments: • S. O'Brien: Wants to emphasize the importance of this committee. Auditors always look at the minutes and the interactions. They like that we feature presentations from members of the committee. We welcome your feedback. • R. Golfin: Requested to screen share the entirety of the charter document. • R. Gebhart: Asked whether this is a Brown Act committee. S. O'Brien: it is, we are hosting the meeting in person and posting agenda and materials according to the required timeline. We don't ask our voting members to attend in person. We are working with our legal team on this. • J. Karmelich: Asked that a designated non-voting member from Grievances and Appeals be added to the list on the charter. S. O'Brien: that is a request to change an item that already went out for a vote, bring it to Michelle for amendment at the next meeting. • R. Golfin: Asked to confirm that this is the highest clinical, overseeing committee at the Alliance. S. O'Brien confirmed.		

Agenda Item	Responsible Person	Discussion	Action	Follow-Up by QI Staff
		The committee voted on the charter. Quorum was reached, motion to approve by T. Do, seconded by S. Bhatt. Motion was passed.		

6. Kaiser Permanente: Trilogy Documents	M. Hamon	**Kaiser Foundation Health Plan Quality Structure and Program Overview**
		
		• Kaiser Permanente is comprised of 3 entities: Kaiser Foundation Health Plans, Kaiser Foundation Hospitals, and Permanente Medical Groups.
		• Presented Northern California regional quality oversight structure (see slide).
		• Purpose of Regional Quality Oversight Committee:
		  ○ Evaluate quality of care and services provided to members and patients
		  ○ Support continuous improvement in these areas
		  ○ Establish the Quality Program
		  ○ Ensure quality priorities are aligned and integrated with other key organization strategic priority areas
		  ○ Ensure the organization meets standards established by regulatory agencies and accreditation organizations and meets public expectations.
		• Regional Credentialing and Privileging Committee: makes credentialing decisions, oversees credentialing policies, procedures, and processes; promotes uniformity and consistency in the application of the above, and oversee the Practitioner Performance Review and Oversight program.
		• Member Concerns Committee: providers oversight of member satisfaction processes across the continuum of care: review of regional and statewide reports, analysis of complaints and grievances data, review of member experience data, receiving reports from each medical center on the member experience work.
			Presentation slide included in packet.	

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		• Resource Management Committee: utilization management committee: identifies and promotes utilization strategies and activities, oversee Health Plan Utilization Management, monitors utilization across the health care continuum, consults with Medical Centers on Utilization Management issues.
		• Access Committee: Timeliness of access includes specialties, subspecialties, imaging. especially around diagnostic access with new modalities/tools. Oversees adherence to health plan and regulatory body requirements around timely access and times, proactively addressing areas at risk for not meeting requirements, approving policies, procedures, and processes for access oversight. This committee looks at mental health access, but there is also a Behavioral Health QOC that looks at behavioral access as well.
		• 2023 Quality Plan Documents "Trilogy": Quality program description and evaluations and workplan. Also includes UM program description. Extremely robust and comprehensive document that outlines where all work is being done and the oversight and structure.
		  ○ Workplans: Includes SMART goals to drive performance improvement; use small tests of change with PDSA cycles.
		  ○ Program description: changes focused on journey in health equity and ensuring they have provided language and access for culturally diverse populations and meeting their needs across the organization. Added a Culturally and Linguistically Appropriate Services program description and partnered with Equity, Inclusion, and Diversity (EID) department to add more on the work they have been doing. On a journey to become a Health Equity Accredited Organization with NCQA.		

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		○ Workplan: Focused on driving outcomes and meeting objectives the team has set. Began giving departments benchmarks and reporting on how they are doing throughout the year so that we can achieve our targets in a more appropriate pace. Check-ins throughout the year, updating targets that they met in 2022. ○ Utilization Management: Added a visiting member section, and footnotes to address Medi-Cal carve outs for Specialty Mental Health and Substance Use disorders. ○ 2022 Evaluation: achieved 60% of total goals. We have a lot of workplans so the denominator of these goals is large, so meeting 60% is still meeting a lot of our goals. However this is seen as not enough, will continue to meet more frequently with workplan owners and continue to identify technology opportunities to enhance workflows to meet or achieve. The use of telehealth/telephone appointments or reaching out to members where they are has been an area we have seen other organizations and some of our departments benefit from; we are still in the COVID "hangover"- there are still some processes that haven't normalized/become a new normal. Still challenged with staffing and returning to pre-pandemic workflows and procedures. Slow move but moving in the right direction, expect to see more positive outcomes and improvement on the 60% next year. The committee voted on approval of the documents. Motion to approve by J. Florey, seconded by T. Do, motion approved.		

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7. CFMG: HEDIS Performance Improvement Program	J. Florey	J. Florey acknowledged Brendan Kelly IT Governance and Data Analyst Project Manager for IT aspects of performance improvement program, along with Sharon Wright Director of Provider Relations are key people in their program.
		
		Program has succeeded in first 9 months of implementation; increased all HEDIS measures except chlamydia screening due to external factors: Alameda school districts rescheduled summer vacation which created a mismatch in access of primary care practices and when teenagers were available for appointments. Group has a lot of structural challenges without enterprise electronic health record.
		
		• Structural challenges: no direct IPA management control of data, no aligned incentives, no aligned money flow along value chain, under capitalized infrastructure.
		  ○ Workaround: Cozeva data management tool; feed encounter data from CFMG providers, supplemental data from AAH including pharmacy, lab, and any additional data, and CAIR. Eventually expect to feed HIE into this.
		  ○ Repackage data into reports and a user interface: monthly performance reports, weekly gap in care action reports that are member specific and measure specific, P4P pro forma which expresses the performance and gap in care reports in dollars for providers as they are more responsive, QI outreach program that reinforces electronic material that is shared, and EHR corroborating from provider practices.
		  ○ Luma: text messaging platform. Message members on a monthly basis, gaps in care that are immediately actionable. Also messaging for well child visits		

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		segmented by quarters, carry forward those who do not complete visits in previous quarter. • Barriers implementing the program: strongly held value by physicians that completeness and accuracy is a primary concern; tug of war between health plan reports that are more complete and accurate but not timely, and Cozeva reports that are timely but may not be as complete. Cultural evolution at CFMG: imperfect information delivered timely is actionable, perfect information delivered too late is not helpful. • Converted population into a marketing campaign. Traditional push to primary care, but concern that PCPs are overwhelmed with mandates, expectations have at least doubled. Previously described reports are the "push" to primary care for outreach. Also "pull" to patients, felt that they were expecting too much of providers to make an outbound call to everyone who has a gap. Text messaging campaign, a call to action to receive identified health care. Concern they were replicating the trauma of covid messaging about receiving immunizations. Each text has embedded links to website that provide additional information to patients about the benefits of the care: i.e. if I get this care how will it affect me, what good is to me, what's in it for me, rather than recommending care from an expert. Second lesson: messaging identified the source of gaps as coming from the health plan, received heated feedback that their relationship was with their doctor, the Alliance doesn't have any right to their data. Changed the voice of the messaging to PCP which was preference of doctors to start with, conveys authority and authenticity. • Segmented messaging accord to value chain to situate providers within a larger context rather than being isolated offices, unable to appreciate role they play in providing best possible care for patients (see slide for more details)		

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		• Slide that shows volume of messages sent. Message delivery rate is >90% and remains that way throughout the year, do not call rate 3-5%, well below published standards. Believe that is because they message at a cadence that doesn't overburden members and is in the voice of their PCP
		• HEDIS rates presented as of Sept 30 2023.
		  ○ Add 30% to numerator, as an estimate to where we could be at 9 months into the year.
		  ○ Lead screening machines at point of service
		  ○ Chlamydia screening declined, likely due to summer scheduling of visits
		  ○ Increased combo 2 and combo 10 to 45% and 25% respectively, 25% reflects continuing difficulty in getting patients to have second flu vaccine
		  ○ W30a is flat for structural reasons- not being able to account for first visit under the mother. Circumventing that by trying to accommodate CHDP recommended periodicity, and recommending to doctors to do 6 visits in the first 15 months regardless of the first visit. We won't know how that's working out until the end of the year.
		  ○ Making impact on W30b, project rate to be 85%
		  ○ WCV were flat which was a disappointment but is likely related to difficulties with access- summer vacation period in the school district
		
		Comments:
		S. O'Brien: great to have a delegate so interested in quality and thinking through the processes of what it takes and what their role can be in trying to promote it. The texting campaign is a great one. We have limitations as a plan on who we can text message, the provider		

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		has more ability and representing the provider has been a great way of outreaching, kudos to the program, it's great to see positive results. J. Florey: Would like to point out this is an example of the collegiality between the delegate and the plan. We can't provide the incentive (gift certificates), the health plan can; you can't do the text messaging, we can. When we melded those programs, that's how we have made this progress- because of the partnership between our organization and the health plan.		
8. Provider Pay for Performance Program	S. Bhatt T. Cheang F. Zainal	F. Zainal: Alliance has made a quality investment into P4P for 2024, more details to come; want to make the program worthwhile and continue toward quality performance. • Timeline: measures have been finalized, senior leadership has approved the program. Working an e-version of the program guide instead of print; print versions are available if requested. Today presenting P4P, distribution and meetings with delegates will happen in December and the early part of next year. • 2024 P4P measures correlate with MCAS measures. Promotion of quality care and preventive care. Four areas of focus are preventive care, access, readmission, and member satisfaction. • Total of 16 measures broken up and align with the types of practice: family, internal medicine, and pediatrics. 70 points for clinical quality measures, 30 points for other measures, total of 100 points. • Under children, most of the measures are the same. Measures in red text we were below MPL last year and the measures also look low this year, therefore will be part of the 2024 P4P. new in P4P is colorectal cancer screening. (see slide for details on measures below MPL).		

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		• Non HEDIS measures: under access, have continued with urgent and non-urgent appointments. Under preventive care, at least one PCP visit within the measurement year, which is a new measure. Under chronic disease, readmission rate is brought up again. • Additional monitoring measures: avoidable ED visits per 1000, percentage of acute hospital stay discharges which has follow-up ambulatory visit within 7 days, CPTII code utilization for BP readings (aimed at direct providers where we are not receiving CBP codes through administrative rates), developmental screening in the first 3 years of life, depression screening and follow-up for adolescents and adults, topical fluoride for children. • T. C.: Additional measure: encourage providers to participate in Manifest Medex Health Information Exchange, reward and incentive providers based on the number of members they have. Different pay rates for new participants vs ongoing, must continually submit data. This is a new measure to improve our data capture, especially with EHRs, everyone has different EHRs, very difficult to individually pull all that data together. Participation in Manifest HIE will help us do that, they have various providers already and are throughout the state; there are a lot of other benefits too, some of that will be coming through with the packet. Comments: S. O'Brien: important point: trying to accurately reflect the care that's been given by gathering the data, to accurately reflect the quality of care that's been given by our providers so that we as a community are not penalized with rate reductions or withholds or penalties for quality.		

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		T. Cheang: NCQA is slowly moving more toward electronic measures, meaning hybrid measures where we pull records manually to get medical charts, that's going to lessen over time. So getting credit and making sure patients are getting the care, getting it through the EHR systems electronically will be a huge benefit to all of us and more accurately reflect what's being done. J. Florey: Steve, please consider providing the HIE enrollment incentive to other QHIO than MedEx. In our case, MedEx represents another data silo. Cozeva has just attained QHIO so we are investigating the utility of their HIE that would be integral to our existing platform but completely interoperable with MedEx. Our CZ HIE data would be incorporated in our regular weekly CZ feeds to AAH. F. Zainal: HEDIS rates YTD (as of October 5). We received the MPLs for 2023. DHCS doesn't release until toward the end of the year because they have to go through their process to determine the MPLs, until they are released we base our benchmarks on the previous year's MPL. Some of the measures the MPL went up, in other down. On the slide those that are bolded in dark font went up, the ones marked in blue the rates went down. • Under behavioral health we are under MPL for both ED visit after mental illness and alcohol abuse. The rate for FUA went up so unfortunately we are now below MPL. Those are both admin measures, doesn't look good for us. • Under well-child, we're below MPL on a few measure: W15 still have about 200 more kids to go, numbers are looking better, hopeful we will reach it by the end of the year. Other measure we are below MPL on is adolescents 3-21, over 9,000 more children to screen to get to MPL. Lead screening in children although rates have substantially increased over		

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		last year we are still below MPL. This is a hybrid measure so final rates will depend on chart review, but we're getting closer and we're hopeful we'll meet MPL. They finally released MPL for topical fluoride 19.3% and right now our rates look really low but part of that is that we receive most of the data from the state toward the end of the year, hopeful our rates will go up but not sure if we'll make 19%. • Disease management: below MPL on controlling high blood pressure, currently at 39.23%, MPL increased to 61.31%. Also below on A1c poor control for diabetes. Both of those are hybrid measures so our rates will depend on chart review. • Under women's health, cervical cancer screening rates are still low at 49.6%, MPL is 57.11% so we still have a lot of women to screen to get to the MPL. This is a hybrid measure so we'll see what our rates look like. Timeliness for prenatal care- our rates look lower, this is one measure we have seen a decrease over the last 2 years; final rates will depend on chart reviews. • We want to give you a summary of pay for performance payouts over the last 3 years. This slide covers 2020, 2021, and 2022. In 2022 the dollars pool was $5 million, 39.95% of pool were earned, which means that over $3 million were left on the table. We really want [providers] to earn the full amount they are eligible for. We hope that with our partnership and working together we can get toward earning those dollars back and not leaving so much money behind. Comments: S. O'Brien: Important to remember the data is not end of year data, it's just data where we are now. We have wide gaps in certain areas. Also calling out lead screening: very important because of the measure generally, but also because of pending end of the CHDP		

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		program, in which case we'll be taking on primary responsibility for lead screening for kids in the community, we take that role very seriously.		
9. Quality Improvement Financial Investment	M. Stott S. Bhatt F. Zainal	S. Bhatt • We talk a lot about quality, and we talk about all of the different factors that influence quality, why we have this committee, the amount that we value everyone here. We wanted to put into a slide deck: what are the kinds of things that are influencing quality, and here are our current rates, and most importantly what is the Alliance going to do given all the additional focus on quality. • As a focus on quality, our goals are: 1) get high quality care in a timely manner, 2) improve [member and provider] satisfaction, 3) get all HEDIS rates above MPL, 4) close our health disparity gaps, 5) promote quality to our internal and external providers. Going back to P4P piece: health disparity gaps. While the program is being built out, here is our direction of movement: along with our CHEO, Alliance is making an investment into health equity- identifying those members in particular groups who have lower quality scores, and putting somewhere between $1-1.5 million towards that population in an effort to promote brining those specific members, those particular groups into care in an effort to close those equity gaps. We'll talk more about the details of the program as we finalize them. • Different focuses on quality: financial impact. Number 1, DHCS is creating quality withholds: they are looking at our quality scores and saying you are performing at a particular rates, we are going to withhold a percentage of our per member per month dollars and see how you perform in the subsequent year. 2: quality factor sanctions. For example last year, the first year [of sanctions], they sanctioned us $25,000.		

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		This year we performed with a larger number of factors below MPL, and it's their second year, so we anticipate similar or an increase in the sanction amount. 3: we've been talking about a value-based payment program, again driven by DHCS. 4: DMHC has identified equity and quality measures; we are waiting for additional input there, but most of the metrics overlaps with the metrics of DHCS. 5: in Jan 2025, we'll be a D-SNP plan, so there are multiple focuses on quality there. 6: reinvestment: a certain percentage of money we have will be reinvested in our community in an effort to improve equality. • Next piece affecting quality: performance impact. On Jan 1 2024, the Kaiser population will be directly contracted with the state, those members will no longer be the responsibility of Alameda Alliance. Kaiser has historically performed the highest of our direct and delegated providers. So we anticipate a decrease in our quality scores. Secondarily, we will gain the Anthem blue cross population, this population performs slightly the Alliance Medicaid population, when we inherit that population we believe we will see a slight decrease in our quality scores. And then there is the ongoing redetermination impact, we have yet to see what impact that has on quality. • Other pieces, the state is comparing us to our sister plans with the AQFS [aggregated quality factor score] and against regional plans throughout the state, affecting our quality withhold. • Slide presenting where Alliance stands in comparison to all other Medi-Cal plans on AQFS. Blue arrow: Alameda Alliance. Orange: our neighboring counties, Contra Costa, San Francisco Health Plan. Additionally Monterey/Santa Cruz and Central Coast are above the Alliance. Below Alliance and toward the middle is Anthem Alameda. We performed in the upper quartile, but we perform slightly below what our		

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		neighboring county providers' rates are. Kaiser/KP North is number 2. • DHCS released an APL 2312 which puts plans into 3 tiers: green, orange, red. We fell below MPL for controlling blood pressure metric, so they put us into the green tier. As a result the number of projects we have to do are slightly lower, the financial sanctions are slightly lower than the orange and red tiers. M. Stott • Shown here are the HEDIS rates for MY2023 for some of the shared or common measures that we're held to for the sanctions and withholds by DHCS and other regulatory bodies like DMHC. We're focused on these measures in particular and prioritizing these. As of October the projected number of [measures below] MPL are 4, so if it stands we would be sanctioned for those 4 measures. We still have supplemental data to get, some of these are hybrid so they are captured in the medical record. In pretty good shape overall but of course we want to continue to not have any sanctions at all and to have all of these measures above the MPL. You can see in the number to treat to MPL there's quite a few in the areas that are noted as pink or red. • With the focus on quality, the organization is putting investment toward quality improvement efforts. The board has yet to approve the investment, but these are the strategies we have put forward to our senior leadership team; the funds would be probably in the range of $3-5 million if it was all approved by the board. Five strategies we are going to be working on: ○ Provider engagement: Pay for performance; we increased the funding to make sure that is worthwhile		

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		to all the providers given the amount of work in workflows and the changes that we see needed for practice management. If we see improvements made, we may be able to get sustainable funding over time. Activities with providers include providing technical assistance, doing more education on our P4P program, giving you the tools to be successful, and eventually setting us up towards a value-based payment program. This would be more of a population health approach. We know that workforce shortages are an issue, so ongoing network development to ensure timely access is an area that we want to continue to work on. ○ Member Engagement: For member outreach, we know that as we have a more member-centric approach, if you look at all of the different gaps in care for a particular member and continue to work with them and call them and make sure that all of those gaps are closed, we want to have dedicated staff who will be able to do that. It has more of a basic population health management approach, but again just making sure that members get all the care that they need, that they engage with their providers, and that they know the importance of all of these measures. Eventually we would like to have an integrated care management platform but that's a future state; there are programs that are seamless, where it does provide alerts for the care team internally to be able to help support the efforts that all of you are working on. ○ Data collection and sharing: Tiffany mentioned Manifest Medex, an area that we want to continue to		

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		promote, as well as supplemental data, EHR, data that we can get from like quest, we want any type of data and that's going to require resources from us to make sure that we capture all the services that are provided. ○ Funding and resources: there is a community investment that the state is putting forward. We don't have the information yet but it is tied to quality, or we would like it to be tied to quality. We know there are going to be lots of different projects that we're going to be working on. In particular we want to work on our BH measures, such as the follow-up for mental health illness, and pediatrics because the state is very focused on pediatrics and BH as Bold Goals. The other goal talks about maternal mental health and maternal care in general. That is an area we will focus on as well. Eventually these projects are going to be able to support all the different initiatives that are underway such as the Equity Practice Transformation Project, health disparity projects that we have to put forward to close the gaps with our members. With the health equity incentive, we are looking at closing gaps based on race and ethnicity and more targeted geographical areas. We want to have practice coaching consultants using a vendor; this may help with coding, different ways to continue to sustain the efforts that are put forward in the clinics. ○ Organizational alignment: We are going to have coordinated campaigns, so if there is a back to school night, that all have the same messaging, the same slogan, letters, text messages, flyers, and then also be able to work with all of you on those messages as well so the members can hear the same thing from all		

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		of us. We do have Alliance incentives, so we want to be able to encourage that that's rewarded based on HEDIS activities and performance. • Those are the things that are being put forward and this is the work that we're going to do for the next couple of years. Comments: S. O'Brien: I'm excited to see the increased focus and investment on quality, both by the state and by the board, and the leadership here at the Alliance. It's for the betterment of patients and really appreciate that investment and that kind of thinking, and the opportunity for more partnerships with our providers because we obviously can't do this alone. The program that Dr. Florey was representing earlier is the direction that we're looking to continue to move and try to be creative in ways to close the gaps. And also to continue our focus on equity.		
10. Population Health Management	L. Ayala G. Duran	L. Ayala • Share the our approach to population health management at the Alliance. This is part of our implementation of DHCS's CalAim vision, how to improve health overall taking into consideration social determinants of health, addressing health disparities, and understanding our members at all levels of need. PHM is a core component to our being able to do that. PHM work aligns well with the mission of the Alliance, it's all about making sure that our members have optimal health and wellbeing. Yet we do know in our membership that not all members need the same care, different populations and groups need different types of care. Not all are currently receiving the care they need; we need to find who those folks are and find ways through our HEDIS work and our analysis of the population to make sure we understand who they are and make sure they get the care they need.		

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		• Population starts off with data, understanding our members, our assessments, identifying those groups at risk, making sure our members have equitable access across the continuum of care from wellness and preventive services all the way up to intensive case management services that we offer. This is underscored with the support and collaboration of our provider and community partners with the goal of ultimate outcomes of health and equity. G. Duran • We know that the Alliance members, we have many populations from diverse backgrounds, communities, different health status, and needs. Our approach will be to look at the different characteristics for these diverse populations of members in order to drive population-based prevention approaches and risk-targeted strategies. This might mean that a generally healthy member may receive a reminder if they miss their flu shot or are due for a colon cancer screening, or a solution around nutrition and health literacy. An older member managing multiple chronic conditions with a recent hospitalization may be connected to a care manager to help monitor symptoms at home, connect them to their providers, and some durable medical equipment. • Our framework outlines the concepts of how we address health needs at all points along this continuum of health and wellbeing. That's through the participation of and engagement with targeted interventions with our diverse populations. We'll use data from various sources, analytics and member assessments, the health risk of each of these members and place them into risk tiers: low, medium-rising, and high risk tiers. That's another plug for our providers to join Manifest Medex- this will enable our population health capabilities, and programs like P4P. That's because having a deeper		

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		understanding of member populations will allow us to focus our resources and programs where they can have the greatest impact. So higher-risk patients are supported with more intensive and higher-touch programs like enhanced care management and complex care management and community supports to address SDOH. And reach even more low-risk members with broad-based wellness and prevention programs like community health workers, doulas, and the diabetes prevention program. Our framework anchors on our provider and community partnerships. As we've seen by today's discussion, we've talked our gap in care reports for providers, collaborations with street medicine to ensure care reaches our unhoused members. We know that an effective population management approach requires an assessment of member needs, program improvements, monitoring and evaluation, all operating together in a cycle [with] the overall aim to improve member health outcomes, the member and provider experience address inequities so that we can strive together towards equity.
		
		L. Ayala
		• For 2023 we have identified in our PHM strategy three strategic pillars:
		  ○ Addressing primary care gaps and in equities. We have focused campaigns on non-utilizer outreach, breast cancer screening which is an equity initiative we have, and the under 30 months well-visits, also an equity initiative.
		  ○ Support members managing health conditions- which is the medium rising area. Focus on disease management, as well as mental health supports.		

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		○ Connecting members in need to whole person care. This year focusing on expansion of transitional care services, to support members who are moving from one level to another. Ensuring that members who experience a catastrophic incident are plugged in as needed to our different care management supports. And also making sure we're properly identifying and supporting children who can receive those California Children's Services supports. • Next slide: gives a nod to the underpinning that we are following NCQA accreditation view of how we do this work. We are looking this year and in the future years will be focusing on similar focuses that DHCS has for their clinical areas of focus, including children's preventive care, behavioral health integration, and maternity outcomes and birth equity. We are letting folks know that those are really important areas that the state together with the health plans and providers are going to be focusing on to try to move as a state – how do we improve outcomes for members. Comments: S. O'Brien: Population health is so important. Our billion and a half dollars that flow through out to the community for the care that's provided, it's a way of making sure it's structured, it's purposeful, it's not just to pay the providers, as we of course need and want to do, it's using that funding as a stream to really help goals of improving quality and health equity in the community.		
11. Non-Utilizer Pilot	F. Zainal	• Board was very invested in non-utilizer program, trying to reach members who have not utilized our services. Last year and continuing into this year, it was part of our strategic goal to outreach to 20% of non-utilizers over the age of 50 and		

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		connect 2% to primary care services, outreach to 20% of non-utilizers ages 6 and under and connect 2% to primary care services. • First pilot: identified non-utilizers as continuously enrolled members who have not utilized primary care services in at least 15 months. Some did have claims for prescriptions, ER visits, and inpatient admissions but no visits with their PCPs. Outreach campaign had two goals: update member's assigned PCP, ensuring that members were assigned to their correct provider. Then transfer the member directly to their provider to schedule an appointment. Secondary goal: identify members with HEDIS measure completion gaps. If they were missing a cervical cancer or breast cancer screening, we informed them of those services and tried to connect them to care. • Campaign details: We conducted these calls in partnership with a vendor, Xaqt, in May through June of this year. Two subgroups: adults ages 50 and older with an ER visit but no PCP visit, children ages 6 and younger. We made 3 outreach attempts. The results of dispositions were tracked (next slide). The member count- we took a sample from all of our delegates and our directs. We made outreach calls to over 7,000 members for this pilot. • Results: We had a 50% overall success rate. Success was defined as changed PCP, left a voicemail, shared general information about the health plan with the member, spoke to the member or their parent/guardian, or transferred to PCP. [This broke down to] 47% of adults and 55% of children. • 44% of calls resulted in a voicemail. 41% of members could not be reached due to incorrect, disconnected phone numbers, no option to leave a voicemail or no phone number on file. 102 (2.25%) of adults and 97 (1.26%) of children resulted in a		

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		PCP visit after our outreach program. Some feedback that we received from agents who made the calls: Members reported coverage under Kaiser, even though in our sample we took out anyone who we saw in our system as having other primary insurance, there were still members who reported they had Kaiser as another insurance. Members reporting they already had or will have an appointment. Xaqt agents experienced challenges connecting with interpreter services, or the member disconnected before the interpreter services came on the line. Members stating that they do not have time to talk at the time the calls took place. • As part of the DHCS disenrollment, we wanted to see how many of the members we reached out to disenrolled. Due to delay from the time the call list was generated and the campaign began, 71 adults and 34 children were ineligible. 103 adults and 88 children became ineligible during the campaign. 251 adults and 255 children became ineligible in the 3 months following the campaign (Jul-Sep). The majority of members were still enrolled through October of this year. • Barriers and lessons learned: we had high number of incorrect or missing numbers on file. When members were unable to stay on the call to transfer we don't know what happens after they disconnect with us, if they tell us they're going to connect with their PCP; we did follow the claims 3 months after the pilot was conducted. Voicemail is a successful contact however we don't know if it will align with the member actually connecting with their PCP. Disposition tracking was not very consistent, we had some changes with the Xaqt staff; hopefully in our next pilot that will be dispositioned correctly. • Some of the changes we are going to make in the next cycle: we're going to track when members request a callback and try		

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		to make that callback happen. The Xaqt agents use a project-dedicated phone line with a CA phone number; that's not how it started but the vendor has since connected with a CA area code so that members are more likely to pick up the call. We've also encouraged our agents to add evening call hours because not everyone is available 8-5 so they've stayed a little longer to make phone calls. We are updating the definition of non-utilizers to no encounters within the last 12 months; continue to exclude duals or other healthcare coverage and continue to identify gaps in care. Questions: Read by S. O'Brien from chat: R. Gebhart: when a number was found to be disconnected was the file updated to remove the number? Was any action taken to locate a good number? • F. Zainal: In our system we did make notations; the agents make notations of disconnected numbers or if we are able to successfully connect with them. Unfortunately, currently unless their PCP has an accurate number for them we don't have another way to obtain correct number unless the member calls us and makes those changes or they call the county to make the changes and then those changes come through to us. • R. Gebhart: When you do a notation, you don't remove the number, you just do a notation? I wonder about that, does that mean future callers will see the notation and will not call that number? Are you unable to just remove disconnected and incorrect numbers? • F. Zainal: That is correct. We cannot remove the phone numbers. Monthly when we receive the file from county department of healthcare services, it will override and pull that number back into our system. So we just make a notation so when someone else is trying to connect with that member		

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		they'll see that that number is disconnected. Unless the member makes that correction with their PCP or with the county we don't receive correct phone numbers. • R. Gebhart: Does the number come from healthcare services or from county social services agencies? • S. O'Brien: I believe it is county social services agencies; F. Zainal concur. Comments: J. Florey: I consider the issue that Linda [sic] is raising right now as one of those systemic issues that is comparable to not being able to identify a baby with the mother, having been associated with the mother's Medi-Cal number in the first 30-60 days. Our PCPs have much more reliable contact information than you have or the county has, and yet the only way we can update that information is if the member themselves are willing to make that call. Our experience is they have little motivation to do that because from their perspective their primary relationship is with their primary care doctor and that person has the right number. We try very hard to get the numbers updated for you, but if there could be some way that primary care doctors could provide you data that you could operate on I think that would be a substantial improvement for the system. I recognize that this is not an easy fix, but it is a fundamental flaw. Finally, I'm amused to see the number of people who didn't want to talk to you because that's the feedback we got when we first started messaging with the information that we were contacting them with information we had gotten from the health plan. Once again, primary care doctor is the voice. • S. O'Brien: excellent point. Dr. Bhatt: to Dr. Florey: I love the idea. You are correct the PCP will have the most accurate information. We do have a data issue where our current data gets overwritten… we do the same. We attempt to		

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		again find the appropriate phone number, it gets overwritten by files, but there must a way around that. We'll connect with our Analytics partners and our vendor to see if we can better obtain those phone numbers so that our incorrect phone number rate is not so high. Thank you for that suggestion. S. O'Brien: Definitely an important topic. We are bound somewhat by regulations. M. Stott: the state is very well aware of the fact that contact information is a problem. I don't know the details but I know they are trying to put some things in place to make sure that there is a way to have accurate contact information. Through the redetermination process, there were efforts to validate correct member information.We are hoping through the member outreach effort that we are going to put in place that we can incorporate that. So if we do call out to members, we validate the information but it does unfortunately rely on the members to go back to the county to correct the data which I agree is flawed. We'll continue to chip away at that. For mom/baby, DHCS is looking into the baby having their own Medi-Cal number. H. Lee: For those members you have a hard time catching, have you ever considered looking into pharmacy data, because they usually tend to have better phone numbers. Our analytics do have access to state Medi-Cal Rx data including member information. So just food for thought. S. O'Brien: I think it's an accurate statement to say both you and Dr. Florey, that number that the doc has, and pharmacy has, is much more likely to be a pertinent real number than the one the government has-that's the number we have through social services agencies.		
12. Compliance Update	R. Golfin	Comment to Dr. O'Brien: I agree with what you just said. We look and encourage our members to use the benefits, to seek out help, and to come to us so that we know they get the right service at the right time and it goes to the right person. I also want to recognize tis committee, a lot of great information being shared, and to share the		

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		importance of health equity at our plan and bringing it center stage, beginning now and through our long future here in Alameda County. Presentation: • I will be giving a small, brief informational update on some of the plan audit-related activities that are currently underway. At any time we have 3-5 audit engagements that are state-directed. That's about normal for a plan of this size. We have a multitude of external-facing audit engagements that we as a plan execute over our plan partners and delegates. • For state engagements, what I point out is that we are currently in the corrective action phase of 2023 our DHCS Routine Medical Survey. There were 15 findings in that survey; we had 5 repeat findings- that's something we try to avoid. In our previous audit last year we had 9 repeat findings, so we had an almost 50% reduction in repeat findings and we're hyper-focused on getting at least another 50% reduction in our 2024 audit. Our audits happen every April, so right around the time kids are on spring break, that's when we are usually gearing up for our virtual or on-site engagement with this agency DHCS. Happy to report we had a 50% reduction, hoping to get another 50% reduction. All the folks on this call and a multitude of other professionals are working steadfast, year-round, to ensure that we lessen the amount of repeat findings. • The 2021 DMHC Follow-Up: With the Department of managed Healthcare Services, this is the licensing agency. They hold an audit over with finance every 3 years, and then reviewing medical services every 3 years, and		

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		they're on different cadences. So we would see DMHC about every one and a half years, one for finance and one for medical services. The last time they did their medical services audit was in 2021, we have about an 18-month follow-up, so they're a bit late on that follow-up since it's 2023. It's time for the follow-up. That follow-up was scheduled for last month, mid-month, and the department was very flexible in scheduling that, there were some external activities that were happening at the plan and the department was very accommodating. We then received a surprise notice from the department that we did not need to have a follow-up. So hopefully they found what they were looking for and we are now waiting to hear the results of that. I can't say I've seen that happen before, but I've heard from other plans that the agency has not been very accommodating to schedules, to their needs, some plans have 2 or 3 audits going at the same time; that's very difficult to manage. We usually have 1 or 2 audits going at the same time, 3 or more that's a very difficult thing to manage. We are looking forward to hearing what the department has to say in regards to this follow-up that they did on their own, they didn't need plan input. All the folks on this call were certainly ready to provide input. • 2023 Audit activities: these are all the audit activities that happened with our downstream partner entities, 1st tier and related entities. What I'll point out is that over the past 3 years we have worked extremely hard to carry out all downstream, external-facing audit-related activity within a calendar year. Giving a high-level overview of these dates, we are completely done with our audit year from a full-scope delegated activity. We have one audit		

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		remaining with Teladoc and that will be for credentialing only, that's a very limited audit. But for our big audits, Beacon, PerformRx, Kaiser, those have all been completed in a calendar year. This is a major collaborative effort across the plan to get these audits done on time, at the right time, and to get these findings out and get moving to the next thing. Kudos to all the folks on this call, the compliance team as well. It's been about 3 years of planning to get that done. • There's one more report that has to do with behavioral health insourcing. Many on this call know we've transitioned or carve-in behavioral health services to our plan. That took place on April 1, 2023. We had a number of undertakings which are basically contractual agreements or promises that we will do certain things as a result of this transition. We had 8 undertakings total, we have 2 left; those are listed in the report.		
13. Behavioral Health GA Report	J. Karmelich	• We are presenting the BH Grievances and Appeals Report. We are going to be starting with Q1, so Jan 1 all the way up to the end of August. We are still looking at the data for Sep and Oct and that will be added to the report for the next meeting. As Richard did state, we did insource behavioral health April 1, 2023. And with any change that we have, we're going to have grievances. Any kind of change that includes coordination of care for our members, contracting of providers, any kind of change with implementation of our new BH department, there's going to be some hiccups in the process and that's what we're going to review today. • On the first graph you'll see the total number of cases that we did have for this time period. We did have a total number of 772 cases since Jan 1. There were 474 standard grievances		

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		which were handled by the grievances and appeals department. And then we did have 298 exempt grievances handled by our member services department. Exempt grievances are exempt from a written response to the member. • The second table shows grievance type and who it's filed against. This is going to go throughout the quarters. Starting with Q1 to Q3. We still have Beacon on there because Beacon was providing the benefit in Q1, so we have those grievances by quarter. And then we have against the mental health facility, then mental health professional, and then the plan. And we have the plan starting at Q2 because that's when we took over the benefit. I do want to point out that we didn't have any mental health facility grievances or professional grievances in Q1. It did bring up the question of, were we actually receiving those grievances and that's why we didn't have many to report on for those quarters from Beacon, because we were delegated- Beacon was not delegated grievances. So it brought up that question, of course we can't confirm whether or not we weren't receiving those grievances but it is interesting that we didn't have any when they had the benefit and that we do now that we have the benefit. The highest number that we did have was against the plan, we had 294 for Q2 and Q3, followed by Beacon- they had 87. We still are trickling in some grievances against Beacon for Q2 and Q3 and we are closing those out. • Next table: These are all of our grievances by grievance type. The highest number of grievances that we did identify were on quality of service at 254 for that time period. The highest number [within that] was on plan customer service. Again, with the transitions that are coming in to the Alliance there are going to be some hiccups when we trying to figure out the best way to ensure coordination of services for these members		

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		and build a department that we have not had in the past. Followed by access to care [the next highest category] we had provider availability issues, telephone/technology issues, and there were some timely access issues. • Below is a summary of the kinds of cases that we did identify. We had 254 quality of service issues, 156 for plan customer service: members not receiving return phone calls from the ABA/BH team, members not being given correct contact information for our BH/MH providers, members stated they have been trying to find a grief counseling provider but kept getting transferred around to different departments. Again with implementation we're trying to find our footing on how to best assist our members in the best way we can. We did have 67 referral issues, members having difficulty securing BH/ABA services. Members contacted several BH/ABA providers but they were not accepting Alameda Alliance insurance and needing assistance finding BH/ABA providers. Members were offered assistance but never received any follow-up. • We had 159 access to care issues, the majority were 48 provider availability; members were unhappy with the BH/MH providers that they contacted, many of those providers were not accepting new patients at the time. 41 timely access issues: members had difficulty securing timely appointments with BH providers, members waited 6-8 months to get an evaluation for autism, members had been on waiting list for ABA services. We did have some telephone access issues, there were 33 of those: members had difficulty reaching the BH department as well as other BH providers by phone. The online provider directory listed incorrect information stating that the provers were accepting new patients.		

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		• We have the table of grievances [by provider/clinic] below. For the Q1, there were 45 grievances, the majority were against Beacon Health. There were a couple of facilities that we had concerns against. Q2 and then Q3 when the plan insourced BH, the highest number were against the plan, and we're still having some Beacon Health grievances trickle in, at a total of 33. This is a list of facilities and professionals that we have identified grievances against. We are working with provider relations and Laura on the Ops team to review and discuss these grievances. • Next page: you can see a table, this shows the total number of grievances that we've had starting in Jan. You can see that the number for Beacon has dwindled down to very low as they don't have the benefit anymore. The plan, the purple line has gone up; one good thing we saw in August is that is getting lower. We are now implementing new operational improvements for our BH benefit. • We'll continue to track grievances. We do meet bi-weekly interdepartmentally to discuss network gaps for contracting opportunities and customer service issues related to implementation to improve operational workflows. Lots of departments in that meeting: grievances and appeals, BH team, provider relations, and Laura from our Ops team to discuss all of the grievances that we have for the month. Discussion of quality improvement opportunities for the BH department unable to take place due to time. They will be presented at the December Board of Governors meeting.		
14. Clinical Practice Guidelines	S. Bhatt	• We have approved as a committee QI 136 which is our clinical practice guidelines. Those are the guidelines that help providers determine or look at guidelines on types of practice. An example is Bright Futures or USPSTF. Linda wants to just		

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		walk through a couple of slides that are high-level on what those guidelines are. It is a voting item so we will vote [on] it at the end. L. Ayala began presenting the guidelines, S. O'Brien stated that it was not listed as a voting item. L. Ayala clarified that the policy was voted on and approved which has the content on the slides, but it's a new requirement for our new contract that we be more explicit about how this works. We have a new policy, we say that we will adopt, disseminate, and monitor clinical practice guidelines, in support of both providers as well as Alliance staff as we're doing our work. The criteria for the guidelines is described in the policy and stated [on the slide]. Dr. Bhatt also reviews these at the QI Medical Director, as well as we send them out for other review as needed. It does go through committee, which is why we have them here today. Once approved we will be distributing them on our website, provide relations can provide them on request. [Next slide] These are the guidelines that we currently have in the policy. Most of them focus on preventative services, perinatal care, obstetrics guidelines, mental and behavioral health guidelines.		
15. Quality Improvement Workplan	M. Stott	Quality Improvement and Health Equity Workplan (in packet): some of the highlights were included here today such as population health, non-utilizer outreach. If you could please review it; it's a dynamic document that we're going to include in your packet on a quarterly basis. It has more details about all the activitiesthat we're involved in. In general we're on track and we're going to continue to report out on our final results as we close out our year-end. Comments: S. O'Brien: the workplan is how we get the work done that we talk about here.		
1. Public Comment	S. O'Brien	No final comment from any board members or the public.		

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		S. O'Brien: Thank you to Dr. Florey and CFMG for your presentation, really great partnership. It's a real representation of [how] we wouldn't be able to do that particular thing without a partnership with people like you. So we greatly appreciate that and your focus on quality.		
2. Adjournment	S. O'Brien	S. O'Brien adjourned the committee meeting at 11:01 a.m.		

<click to insert a date>
Dr. Stephen O'Brien
Chief Medical Officer
Chair

Minutes prepared by: Megan Hils, Quality Improvement Project Specialist