ALAMEDA ALLIANCE FOR HEALTH
QUALITY IMPROVEMENT – PROGRAM EVALUATION 2021

ALAMEDA Alliance FOR HEALTH

2021
Quality Improvement Program Evaluation Signature Page

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Introduction

Alameda Alliance for Health (Alliance) is a local, public, not-for-profit managed care health plan committed to making high-quality health care services accessible and affordable to County residents. The Alliance staff and provider network reflect the county's cultural and linguistic diversity. Established in January 1996, the Alliance was created by the Alameda County Board of Supervisors for county residents. The Alliance currently provides health care coverage to over 295,151 children and adults through its programs.

Under the leadership and strategic direction established by the Board of Governors (BOG), senior management and the Health Care Quality Committee (HCQC), the Health Care Services 2021 Quality Improvement (QI) Program was successfully implemented. This report serves as the annual evaluation of the effectiveness of the program activities.

The processes and data reported covers activities conducted from January 1, 2021 through December 31, 2021.

Mission, Vision, and Values

Mission

The Alliance strives to improve the quality of life of our members and people throughout our diverse community by collaborating with our provider partners in delivering high quality, accessible and affordable health care services. As participants of the safety-net system, we recognize and seek to collaboratively address social determinants of health as we proudly serve Alameda County.

Vision

The Alliance Vision is to be the most valued and respected managed care health plan in California.

Values

Teamwork – We participate actively, remove barriers to effective collaboration and interact as a winning team.

Respect – We are courteous to others, embrace diversity and strive to create a positive work environment.

Accountability – We take ownership of tasks and responsibilities and maintain a high level of work quality.

Commitment & Compassion – We collaborate with our providers and community partners to improve the wellbeing of our members, focus on quality in all we do and act as good stewards of resources.

Knowledge & Innovation – We seek to understand and find better ways to help our members, providers, and community partners.

Purpose

The purpose of the Alliance 2021 Annual QI Program Evaluation is to access and evaluate the overall quality and effectiveness of the QI Program in meeting the goals and objectives of the QI Program and Work Plan and covers Medi-Cal and Group Care lines of business. The QI Department leads the evaluation assessment in collaboration with cross function departments utilizing data and reports from committees, content experts, data analysts, work plans outcomes, Plan-Do-Study-Act studies, Performance Improvement and QI Projects to perform qualitative and quantitative analysis of initiatives and activities outcomes, identify barriers to established goals and objectives, best practices, next steps, and other improvement opportunities. The Alliance uses the annual evaluation to identify new and ongoing goals, objectives, and activities for the QI Program in the coming year.

This evaluation assesses the following elements:

Completed and ongoing QI activities that address the quality and safety of clinical care and quality of service.

Performance measure trends to assess performance in the quality and safety of clinical care and quality of service.

Analysis and evaluation of the overall effectiveness of the QI Program and of its progress toward influencing network wide safe clinical practices.

The annual QI Program Evaluation is reviewed and approved by the Health Care Quality Committee (HCQC) before being submitted for review and approval by the Alliance BOG. The HCQC and the BOG also review and approve the QI Program Description and Work Plan for the upcoming year.

Membership and Provider Network

The Alliance product lines include Medi-Cal managed care and Group Care commercial insurance. Medi-Cal managed care beneficiaries, eligible through one of several Medi-Cal programs, e.g. Temporary Assistance Needy Families (TANF), Seniors and Persons with Disabilities (SPD), Medi-Cal Expansion and Dually Eligible Medi-Cal members who do not participate in California's

Coordinated Care Initiative (CCI). For dually eligible Medi-Cal and Medicare beneficiaries,

Medicare remains the primary insurance and Medi-Cal benefits are coordinated with the Medicare provider.

Alliance Group Care is an employer-sponsored plan offered by the Alliance. The Group Care product line provides comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County.

Table 1: 2021 Trended Enrollment by Network and Aid Category

Current Membership by Network By Category of Aid							
Category of Aid	**Nov 2021**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	42,623	15%	9,085	8,900	658	16,232	7,748
Child	97,935	34%	9,163	8,746	29,410	32,796	17,820
SPD	26,427	9%	8,330	4,093	1,079	10,916	2,009
ACA OE	101, 508	35%	16,220	33,202	1,118	37,722	13,246
Duals	20,832	7%	8,168	2,230	1	7,465	2,968
Medi-Cal	289,325		50,966	57,171	32,266	105,131	43,791
Group Care	5,826		2,472	902	-	2,452	-
Total	**275,589**	**100%**	**53,438**	**58,073**	**32,266**	**107,583**	**43,791**
Medi-Cal %	98.0%		95.4%	98.4%	100.0%	97.7%	100.0%
Group Care %	2.0%		4.6%	1.6%	0.0%	2.3%	0.0%
Network Distribution			*18.1%*	*19.7%*	*10.9%*	*36.5%*	*14.8%*
			% Direct:	**38%**		**% Delegated:**	**62%**

Table 2: 2021 Trended Categories of Aid, Distribution and Growth/Loss

Category of Aid Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Nov 2019	Nov 2020	Oct 2021	Nov 2021	Nov 2019	Nov 2020	Oct 2021	Nov 2021	Nov 2019 to Nov 2020	Nov 2020 to Nov 2021	Oct 2021 to Nov 2021
Adults	32,357	37,638	42,177	42,623	12.9%	13.8%	14.4%	14.4%	16.3%	13.2%	1.1%
Child	89,711	94,620	97,636	97,935	35.8%	34.6%	33.3%	33.2%	5.5%	3.5%	0.3%
SPD	25,691	26,314	26,366	26,427	10.2%	9.6%	9.0%	9.0%	2.4%	0.4%	0.2%
ACA OE	79,104	89,752	100,844	101,508	31.6%	32.8%	34.3%	34.4%	13.5%	13.1%	0.7%
Duals	17,779	18,990	20,692	20,832	7.1%	6.9%	7.0%	7.1%	6.8%	9.7%	0.7%
Medi-Cal Total	244,642	267,314	287,715	289,325	97.6%	97.8%	98.0%	98.0%	9.3%	8.2%	0.6%
Group Care	6,056	5,982	5,880	5,826	2.4%	2.2%	2.0%	2.0%	-1.2%	-2.6%	-0.9%
Total	**250,698**	**273,296**	**293,595**	**295,151**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.0%**	**8.0%**	**0.5%**

Table 3:2021 Trend Enrollment by Age Category

	Members				% of Total (Distribution)				% Growth (Loss)		
Age Category	Nov 2019	Nov 2020	Oct 2021	Nov 2021	Nov 2019	Nov 2020	Oct 2021	Nov 2021	Nov 2019 to Nov 2020	Nov 2020 to Dec 2021	Oct 2021 to Nov 2021
Under 19	92,318	97,068	99,912	100,206	37%	36%	34%	34%	5%	3%	0%
19 - 44	79,016	91,897	103,423	104,239	32%	34%	35%	35%	16%	13%	1%
45 - 64	54,703	57,413	60,392	60,571	22%	22%	21%	21%	5%	6%	0%
65+	24,661	26,918	29,868	30,135	10%	10%	10%	10%	9%	12%	1%
Total	**250,698**	**273,296**	**293,595**	**295,151**	**100%**	**100%**	**100%**	**100%**	**9%**	**8%**	**1%**

In November of 2021, the Alliance annual membership increased by 8.0% from November 2020 . The Alliance experienced membership growth in all age categories from 2020 to 2021 with a **3.0%** membership growth for ages under 19, **13%** growth (largest growth category) in the 19-44 age category, **6.0%** growth for 45-64 age category and **12%** growth for the 65+ age category. Percent of total distribution by age category remained stable from 2020 -2021.

A driver of the increase in membership was the economic downturn related to the 2020 – 2021 pandemic and the lack of member dis-enrollments from health plans by the state.

Medical services are provided to beneficiaries through contracted provider networks. Currently, The Alliance provider network includes:

Table 4: 2021 Provider Network by Type, Enrollment and Percentage

PROVIDER NETWORK	PROVIDER TYPE	MEMBERS (ENROLLMENT)	% OF ENROLLMENT IN NETWORK
Direct-Contracted Network	Independent	52,288	17.6 %
Alameda Health System (AHS)	Managed Care Organization	58,590	19.7%
Children First Medical Group (CFMG)	Medical Group	32,573	11%
Community Health Clinic Network (CHCN)	Medical Group	109,059	36.8%
Kaiser Permanente	HMO	44,218	14.9%
	TOTAL	**275,589**	**100%**

The Alliance offers a comprehensive health care delivery system, including the following scope of services:

- Ambulatory care
- Hospital care
- Emergency services
- Behavioral health (mental health and addiction medicine)
- Home health care
- Hospice
- Palliative Care
- Rehabilitation services
- Skilled nursing services - Skilled

- Managed long-term services and support (MLTSS)
  - Community based adult services
  - Long Term SNF Care (limited)
- Transportation
- Pharmacy

Care coordination along the continuum of care including arrangements for linked and carved out services, programs, and agencies.

These services are provided through a network of contracted providers inclusive of hospitals, nursing facilities, ancillary providers and service vendors. The providers/vendors are responsible for specifically identified services through contractual arrangements and delegation agreements.

The Alliance provider network includes:

Table 5: Alliance Ancillary Network

ANCILLARY TYPE	COUNT
Behavioral Health Network	1
DME Vendor	1 Capitated, 12 Non-Capitated
Health Centers (FQHCs and non-FQHCs)	68
Hospitals	17
Pharmacies/Pharmacy Benefit Manager (PBM)	Over 200
Skilled Nursing Facilities	65
Transportation Vendor	1 individual vendor with 380 individual transportation providers

Alliance members may choose from a network of over 590 primary care practitioners (PCPs), more than 7000 specialists, 17 hospitals, 68 health centers, 6 nursing facilities and more than 200 pharmacies throughout Alameda County. The Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan members. Our members' optimal health is always our first priority.

The Alliance Quality Improvement (QI) Program strives to ensure that members have access to quality health care services.

QI Structure and Resources

A. QI Structure

The structure of the Alliance QI Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate use of the Alliance health care delivery network for medical and behavioral health care services. Additionally, the structure is designed to enhance communication and collaboration on QI program goals and objectives, activities, and initiatives, that impact member care and safety both internal and external to the organization, inclusive of delegates. The QI Program is evaluated on an on-going basis for efficacy and appropriateness of content by Alliance staff and oversight committees.

B. Governing Committee

The Alameda County Board of Supervisors appoints the Board of Governors (BOG) of the Alliance, a 15-member body representing provider and community partner stakeholders. The BOG is the final decision-making authority for all aspects of the Alliance QI Programs and is responsible for approving the annual QI Program Description, Work Plan, and Program Evaluation. The BOG delegates oversight of Quality functions to the Alliance Chief Medical Officer (CMO) and the Health Care Quality Committee (HCQC) and provides the authority, direction, guidance, and resources to enable Alliance staff to carry out responsibilities, functions, and activities of the QI Program. QI oversight is the responsibility of the HCQC.

The HCQC develops and implements the QI program and oversees the QI functions within the Alliance.

The HCQC:

- Recommends policies or revisions to policies for the operational effectiveness of the QI Program and the achievement of QI program objectives.
- Oversees the analysis and evaluation of the QI, Utilization Management (UM) and Case Management (CM) programs and Work Plan activities and assesses the results.
- Ensures practitioner participation in the QI program activities through attendance and discussion in relevant QI committee or QI subcommittee meetings.
- Identifies needed actions, and ensures follow-up to improve quality, prioritizing actions based on their significance and provides guidance on which to choose and pursue as appropriate. The HCQC also assesses the overall effectiveness of the QI, UM, CM and Pharmacy & Therapeutics (P&T) Programs.

The HCQC met a total of 6 times in 2020:

- January 21, 2021
- March 18, 2021
- May 20, 2021
- July 15, 2021
- September 16, 2021
- November 18, 2021

The 2021 QI Program Description was reviewed and approved at the March 18, 2021, HCQC meeting and unanimously approved. The 2020 QI Program Evaluation and the 2021 QI Work Plan were presented at the May 20, 2021, HCQC meeting and unanimously approved.

C. Committee Structure

The BOG appoints and oversees the HCQC which, in turn, provide the authority, direction, guidance, and resources to enable Alliance staff to carry out the QI Programs. The BOG also oversees the Peer Review and Credentialing Committee (PRCC) which provides a peer review platform and, also a platform to review provider credentialing and re-credentialing. Committee membership is made up of provider representatives from the Alliance contracted networks and the Alliance community including, those who provide health care services to Behavioral Health, Seniors and Persons with Disabilities (SPD) and chronic conditions.

The HCQC provides oversight, direction, recommendations, and final approval of the QI Program documents. Committee meeting minutes are maintained summarizing committee activities and decisions and are signed and dated.

HCQC charters a sub-committee, the Internal Quality Improvement Sub-Committee (IQIC) which serves as a forum for the Alliance to evaluate current QI activities, processes, and metrics. The IQIC also evaluates the impact of QI programs on other key stakeholders within various departments and when needed, assesses, and plans for the implementation of any needed changes. HCQC assumes responsibility for oversight of the IQIC activities and monitoring its areas of accountability as needed. The structure of the committee meetings is designed to increase engagement from all participants.

The major committees that support the quality and utilization of care and service include:

- Healthcare Quality Committee (HCQC)
- Peer Review and Credentialing Committee (PRCC)
- Member Advisory Committee (MAC)
- Pharmacy and Therapeutics (P&T) Sub-committee
- Utilization Management (UM) Sub-committee
- Access and Availability Sub-committee

- Internal Quality Improvement Sub-committee (IQIC)
- Cultural and Linguistic Services Sub-committee

Additionally, joint operations meetings (JOMs) support the quality improvement work of the Alliance. Each committee meets at least quarterly, some monthly, and all committees / sub-committees, except the PRC and MAC committees, report directly to the HCQC. The PRC and MAC report directly to the BOG. The PRCC supports the quality and utilization of safe care and service for the Alliance membership and reports directly to the BOG. Each committee continues to meet the goals outlined in their charters, as applicable. The HCQC membership includes practitioners representing a broad range of specialties, as well as Alliance leadership and staff.

D. Evaluation of Senior- Level Physician and Behavioral Health Practitioners

The BOG delegates oversight of QI and UM functions to the HCQC which is chaired by the Alliance Chief Medical Officer (CMO) and vice-chaired by the Medical Director of Quality. The CMO and Medical Director provides the authority, direction, guidance, and resources to enable Alliance staff to carry out the QI Program. The CMO delegates senior level physician involvement in appropriate committees to provide clinical expertise and guidance to program development.

During 2021, Dr. Aaron Chapman, a psychiatrist and CMO of Alameda County Behavioral Health Care (ACBH), actively participated in the HCQC meetings and provided clinical input ensuring policies and reports considered behavioral health implications.

The active involvement of senior-level physicians including the psychiatrist from Alameda County Behavioral Health (ACBH) has provided consistent input into the quality program. Their participation helped ensure that the Alliance is meeting accreditation and regulatory requirements.

E. Program Structure and Operations

The Alliance QI Program encompasses quality of care across the Alliance enterprise and across the health care continuum.

2021 QI Program activities included, but were not limited to the following:

- Evaluation of the effectiveness of the QI program structure and oversight
- Implementation and completion of ongoing QI activities that addressed quality and safety or clinical care and quality of service
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service
- Analysis of QI initiatives and barriers to improvement

- Monitoring, auditing, and evaluation of delegated entities QI activities for compliance to contractual requirements with the implementation of corrective action plans as appropriate
- Internal monitoring and auditing of QI activities for regulatory compliance, and assurance of quality and safety of clinical care and quality of service
- Development and revision of department policies, procedures, and processes as applicable
- Development and implementation of direct and delegate network corrective action plans as a result, of non-compliance and identified opportunities for improvement, as applicable.

F. QI Resources

The Alliance QI Department key staff included licensed physicians and registered nurses, qualified non-clinical management staff, as well as non-clinical specialist staff and non-clinical administrative support coordinators. The assignment and performance of work within the team, whether working on site or remotely, for both clinical and non-clinical activities, is seamless to the Alliance operations processes. Established job description expectations with assigned tasks and responsibilities remain unchanged regardless of the geographical location of staff member.

The QI program moved forward in providing quality improvement guidance enterprise-wide meeting regulatory and accreditation standards and promoting positive health outcomes for the Alliance membership. In late October 2020 the QI Department experienced a vacancy in the Access to Care Manager position due to employee resignation and this position remained vacant through 2021 despite aggressive recruitment and use of temporary to hire staff. The Senior Director of Quality provided direction and oversight of Access and Availability unit during 2021. Health Care Services continues to evaluate staff turn-over and strives to provide a positive work environment while creating a stable work force.

Throughout 2021, vendor partnerships were a part of the QI resource strategy. The QI department continued to augmented QI resources via consultants and analytic expertise for the HEDIS program.

Additionally, the Alliance maintained its strong relationship with healthcare services support and survey vendor, SPH Analytics (SPH).

In 2021 SPH supported the QI Department work with implementation, analysis, and reporting on the following surveys:

- Afterhours and Emergency Instruction Survey

- Member Satisfaction Survey (CAHPS 5.0, CG CAHPS)
- Provider Satisfaction Survey

Overall Program Effectiveness

The Alliance's quality improvement efforts strive to impact the safety and quality of care and service provided to our members and providers. Review of the Alliance's 2021 QI activities as described herein demonstrates the Alliance's QI department ability (in collaboration with internal and external entities) to successfully assess, design, implement, and evaluate an effective QI Program including but, not limited to, the following:

Improved focus on the importance of chronic condition management and accessing appropriate care through initiatives to educate and connect with members, direct and delegated providers, community-based organizations, state and county entities and enhance our improvements to our internal operations.

1. Maintained a targeted focus on the analysis of key drivers, barriers, and best practices to improve access to care.
2. Expanded staff knowledge of health disparities and equity within the Alliance membership through population data collection, analysis, and segmentation and targeted quality improvement activities as part of Population Health Management Program
3. Promoted the awareness and concepts of inter-departmental QI initiatives and activities, including Plan-Do-Study-Act (PDSA), and Inter-Rater Reliability (IRR), to:
    - identify, investigate, and resolve Potential Quality Issues (PQIs)
    - identify and address service over-and-under utilization
    - promote patient safety
    - remove barriers to access to timely care and services
4. Invested in quality measurement analysis expertise.
5. Identified Potential Quality Issues (PQIs) operations gaps and root cause analysis to identify and overcome barriers, as well as best practices resulting in internal workflow improvements and staff retraining.
6. Exhibited improvement in HEDIS measures' performance including CIS-Combo 10, IMA-Combo 2, PPC, AMR, CCS and AMM.
7. Ensured timely Facility Site Review (FSR/Medical Record Review (MRR) audits and Physical Accessibility Review Surveys (PARS) in person and virtually within a PHE environment.
8. Targeted QI initiatives to improve direct and delegate provider engagement in access to care efforts to improve rates of preventive care and services, screenings, and referrals for members

9. Targeted partnerships with community-based county agencies and delegate providers to improve referral and resources triage and management through technology collaboration and support.
10. Promoted healthcare access and safety education for members and providers through targeted pharmacy substance use programs.
11. Improved engagement with interpreter services vendors and Alliance network providers to ensure quality interpreter services at all points of healthcare service contact.
12. Enhanced engagement with Behavioral Health delegate for improved and timely access to care.
13. Collaborated with First 5 of Alameda County and delegate provider networks to improve WCV and EPSDT service utilization for pediatric and adolescent members.

The Alliance is invested in a multi-year strategy to ensure that the organization adapts to health plan industry changes now and within 3 - 5 years. An effective QI program with adequate resources is essential to the Alliance's successful adaptation to expected changes and challenges.

Serving Members with Complex Conditions

The Alliance continues to identify members with complex health conditions in need of supportive services based on data collection and analysis. The Alliance links members to Asthma and Diabetes Disease Management, Complex Case Management (CCM), Transition of Care (TOC), and Enhanced Care Management Programs and services based on healthcare needs.

Members identified as potential candidates for Asthma Disease Management are mailed outreach materials explaining their condition and the process to enroll in Disease Management. Disease Management is optional. Members who do not pursue Disease Management programs are also provided information related to community resources available to support their health concerns.

Additionally, some of the Alliance members were identified as “high risk” for complex health conditions through claims, encounter, and referral data. Identified members are forwarded to case management and health homes management for follow up. Complex Case Management (CCM) and Enhanced Care Management staff outreach to “high risk” members by telephone and communicate with Community-Based Organization (CBO). When outreach attempts are successful, initial assessments are performed and care plans are developed. Members who agree to care are assisted with provision of services and recommendations to support managing their conditions. When outreach is attempted but unsuccessful, the case is closed.

Members were also identified for TOC” assistance. TOC assistance is designed to ensure that the coordination and continuity of health care occurs for members who are discharged from Medical or Surgical inpatient care settings to a different level of care. Tracking and trending of outcomes through CM and DM processes is a key component of the Case Management and Disease

Management program activities. Serving all members inclusive of those with complex needs and conditions for tracking and trending of more targeted improvement in health outcomes through population health and needs assessments data collection will continue to be a part of the Health Care Services fabric in 2021.

Provider Outreach and Engagement

During 2021, the Provider Services department provided continued outreach to all PCP, Specialists and Ancillary provider offices via the use of fax blasts. In-person visits continue to be suspended due to the Shelter-in-Place orders went into effect in March 2020 and since Alameda Alliance employees are currently working from home. Subsequently, outreach and engagement with providers resumed through alternative modalities of virtual meetings, email, telephone, and mail.

Topics covered in the outreach, engagement, and fax blasts included but, were not limited to: Member Satisfaction update and reminders, Provider Satisfaction updates, Provider Appointment Availability Survey (PAAS) updates, Rx Safety Guidelines and updates, Blood Lead Screening information, DHCS Medi-Cal Rx updates, Immunizations, provider network updates, outpatient authorization updates and reminders, Secondary Claim notice, Annual Healthcare Effectiveness Data and Information Set® (HEDIS) medical record data retrieval notice, Fraud, Waste and Abuse information, Cultural Sensitivity Training, Telehealth Survey information, Timely Access Standards Reminders, Pay-for-Performance program, provider contracting updates, and COVID-19 Vaccine information.

In addition to ongoing quarterly visits, every newly credentialed provider received a new provider orientation within 10 days of becoming effective with the Alliance. This orientation includes a very detailed summary which includes but not limited to:

- Plan review and summary of Alliance programs
- Review of network and contract information
- How to verify eligibility
- Referrals and how to submit prior authorizations
- Timely Access Standards
- Member benefits and services that require PCP referral
- How to submit claims
- Filing of complaints and the appeal process
- Interpreter Services process
- Initial Health and Staying Healthy Assessment
- Coordination of Care, CCS, Regional Center, WIC program

- Child Health and Disability Program
- Members Rights and Responsibilities
- Member Grievances
- Potential Quality Issues (PQIs)
- Health Education
- HEDIS Education

Overall, there were over 500 quarterly packets mailed to providers with updates as mentioned above. Additionally, 2,870 outreach occurrences conducted during the 2021 calendar year. The Provider Services department plans to continue our robust provider outreach and engagement strategies in 2022.

Member Outreach and Member Services

The Alliance Member Services (MS) Department continues to have a strong focus on providing high-quality service. The Alliance mission is to help our members live a healthy life provider access to high-quality care and services that they need. Providing excellent customer service is just one of the many ways that we serve our members, providers, and community.

The Alliance monitors access to its Member Services Department on a quarterly basis. The following internal standards and goals are used to evaluate access to Member Services Department by telephone.

Member Services Department Telephone Access Standards	
Standards	Goal
% of calls answered by a live agent within 30 seconds	80%
Calls Abandoned before a live voice is reached	≤ 5 %

Quarterly call center metrics are presented below in the Member Services dashboard. The dashboard represents blended (Medi-Cal and Group Care) customer service results.

Table 6: 2021 Quarterly Call Center Metrics

ALLIANCE MEMBER SERVICES STAFF	Q1	Q2	Q3	Q4
Incoming Calls	35400	37357	38568	33282
Answered Calls	33287	33412	30002	27725
Abandoned Rate	6%	10%	22%	17%
Average Speed to Answer (ASA)	01:13	01:42	04:46	03:40
Calls Answered in 30 Seconds (All)	65%	54%	26%	38%
Average Talk Time	07:56	07:22	08:01	08:10
Calls Answered in 10 Minutes (goal: 100%)	100.0%	100.0%	87%	90%
Recordings/Voicemails	Q1	Q2	Q3	Q4
Incoming Calls (R/V)	5413	5422	5854	5084
Answered Calls (R/V)	5413	5422	5854	5084
Abandoned Rate (R/V)	0%	0%	0%	0%
Calls Answered in 30 Seconds (R/V)	100%	100%	100%	100%
Blended Results	Q1	Q2	Q3	Q4
Incoming Calls (R/V)	40813	42779	44422	38366
Answered Calls (R/V)	38700	38834	35856	32809
Abandoned Rate (R/V)	5%	9%	19%	14%
Average Speed to Answer (ASA)	01:03	01:27	03:59	03:05
Calls Answered in 30 Seconds (R/V)	72%	61%	38%	48%

The pandemic presented many challenges that impacted our call volumes, abandonment rate; talk times and service levels. Increased level of member emotion and anxiety in service calls contributed to increase in talk time averages. Staffing challenges due to the pandemic had a tremendous impact on the call center. Member Services implemented various changes to help meet the needs of our members, including the re-design of its call tree menus to offer additional self-service options to improve member experience and satisfaction. The Department continues to monitor and track call center operations to ensure compliance and quality standards are met.

Member Advisory Committee (MAC)

In 2021, the Member Advisory Committee (MAC) functioned to provide information, advice, and recommendations to the Alliance on member educational and operational issues in respect to the administration of the Alliance's cultural and linguistic services. These advisory functions include but are not limited to, providing input on the following:

- Culturally appropriate service or program design
- Priorities for the health education and outreach programs
- Member satisfaction survey results
- Findings of the population needs assessment
- The Alliance's outreach materials and campaigns
- Communication of needs for provider network development and assessment
- Community resources and information

The Member Advisory Committee received information from the Alliance on public policy issues, including financial information, and data on the nature and volume of member grievances and the grievance disposition.

The MAC met four times in 2021:

- March 18, 2021
- June 17, 2021
- September 16, 20201
- December 2, 2021

Some of the key topics discussed in 2021 included:

- Alameda Alliance for Health Strategic Plan
- COVID-19
- Cultural and Linguistics Work Plan and Report
- Grievances & Appeals
- Communications & Outreach collateral, events, and activities
- Member Health Programs such as Transition of Care, Stanford Cancer Program, Enhanced Care Management, Major Organ Transplant and Community Supports

- Pharmacy Updates
- Pediatric Care Pilot – EPSDT Services
- Population Needs Assessment
- Questions & Answers for member concerns
- Timely Access Report

Member Newsletter

The Alliance 2020 Spring/Summer and Fall/Winter *Member Connect* newsletters were published and shared with more than 150,000 member households and provider offices. The newsletter contained a variety of disease self-management and preventive care topics and education on:

- COVID-19
- Childhood injury prevention
- Heart health
- Autoimmune diseases
- Alliance response to racism
- Cancer care
- Smoking Cessation
- Asthma care
- Well-child and well-care visits
- Preventive care for children
- COVID-19 safety at doctor visits
- Tips for successful telehealth visits
- Immunizations
- Language Services
- Cancer care program

Safety of Clinical Care

In 2021, the Alliance continued its organizational focus on maintaining safety of clinical care for its membership.

A. Substance Use Disorder

In 2020 the Alliance partnered with our network providers and other local leaders to develop a Substance Use Disorder Program and have continued the work through 2021.

Alameda Alliance has continued to use multiple strategies involving Member *and Provider Educational Outreach and Pharmacy Safeguards*. The Alliance has worked together with our internal analytics team to create an accurate and comprehensive monthly report opioid overutilization, grandfathered members, hospice/palliative, cancer, and sickle cell members on opioids, and monitoring the changes in MME (morphine milli equivalence)

The Alliance has identified a list of members in Q4 2020 who were considered chronic users and potential chronic opioid users. Chronic users are defined as members with prescriptions of greater than 300 MME consecutively for the last three months, and potential chronic opioid users are defined as members with prescriptions between 50 to 89 MME consecutively for the last three months. The Alliance will continue to address members with another MME tier after successful member and provider educational outreach are completed through mailings and potential phone outreach in coordination with case management. The Alliance also has compiled a list of members who presented to the ED with opioid and benzodiazepine overdose and a separate list of members on concurrent use of opioids and benzodiazepines.

In 2021, the Alliance sent out quarterly educational mailings that is pertinent to members and providers. The mailings included:

1. Lists of identified members who are chronic users, high risk members on becoming chronic users, concurrent chronic opioid/benzodiazepine usage and members presenting to ED for opioid/benzodiazepine overdose
2. Provider Opioid and Benzodiazepine Tapering Tools
3. Opioid Safety guide for members and caregivers
4. Non-opioid formulary alternatives
5. Treatment for opioid dependence

Table 7: Escalation Process based on opioid use

Day	Member	Provider
1	Original mailing gets sent out	Original mailing gets sent out.
45	Repeat mailing. Refer to case management if member is on greater than 300 MME.	Repeat mailing.
90	Check if member transition to buprenorphine or received appropriate pain treatment.	Receive letters from medical director. Submit a PQI.
120	N/A	Include operations and peer review committee to decide whether to keep in-network.

B. Opioids Stewardship Report

Progress in 2021

August 2021: Mailings to 13 high-risk members with prescriptions of greater than 300 MME consecutively for the last three months. These members received:

- High risk cover letter
- Health education: Safety guide for patients and caregivers
- Health education: Treating pain without opioids
- Health education: Medicines for opioid dependence
- Map of providers in member's area

November 2021: Mailings to 63 rising risk members with prescriptions between 50 to 89 MME consecutively for the last three months. These members received:

- Rising risk cover letter
- Health education: Safety guide for patients and caregivers
- Health education: Treating pain without opioids

December 2021: Mailings to providers with members who were on any of the following lists:

- Opioid and Benzodiazepine Co-use list (68 members)
- Rising risk list: 50-89 MME for 3 consecutive months (64 members)
- High risk list: 300+ MME for 3 consecutive months (11 members)
- Opioid and Benzodiazepine ER list (137 members)

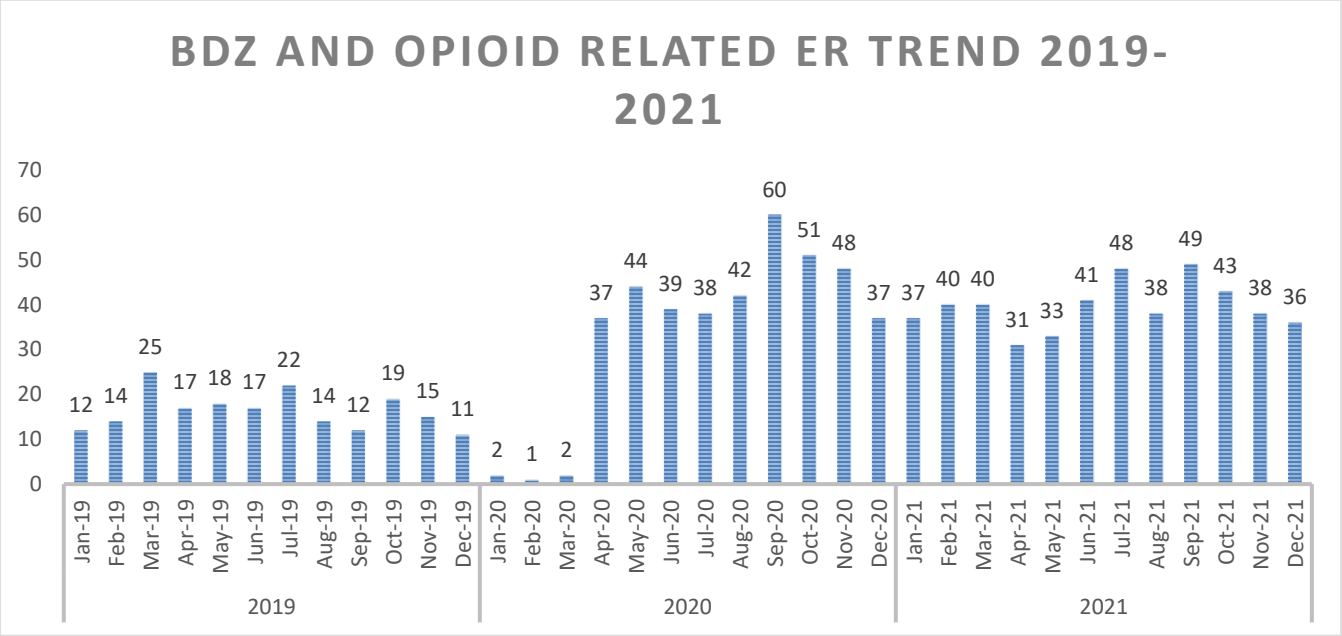
The Alliance developed a Provider packet featuring Tapering Tool, shared data for providers/delegates/committees and had the health education materials, maps, and member facing materials approved

Opioid and Benzodiazepine ER Reporting

- Reports based on claims data and reflects each unique claim with opioids/benzodiazepine related ICD code.
- Reports are shared with assigned PCPs of members on these reports on a quarterly basis.
- There was almost a 2-fold increase on average on opioid/benzodiazepine related ER visits between 2019 and 2020.

- The Alliance will continue to improve our opioid stewardship program. Below are results of our interventions.

Table 8: 2019-2021 Opioid/Benzodiazepine related ER Visits



The Alliance has been tracking members' ER visits related to benzodiazepines and opioids since 2019. This data is shared with clinic partners.

Table 9: Members on SAO, LAO, and both SAO and LAO for 2021

2021	SAO	LAO	BOTH
Q1	300	91	39
Q2	345	94	42
Q3	340	116	80
Q4	280	98	62

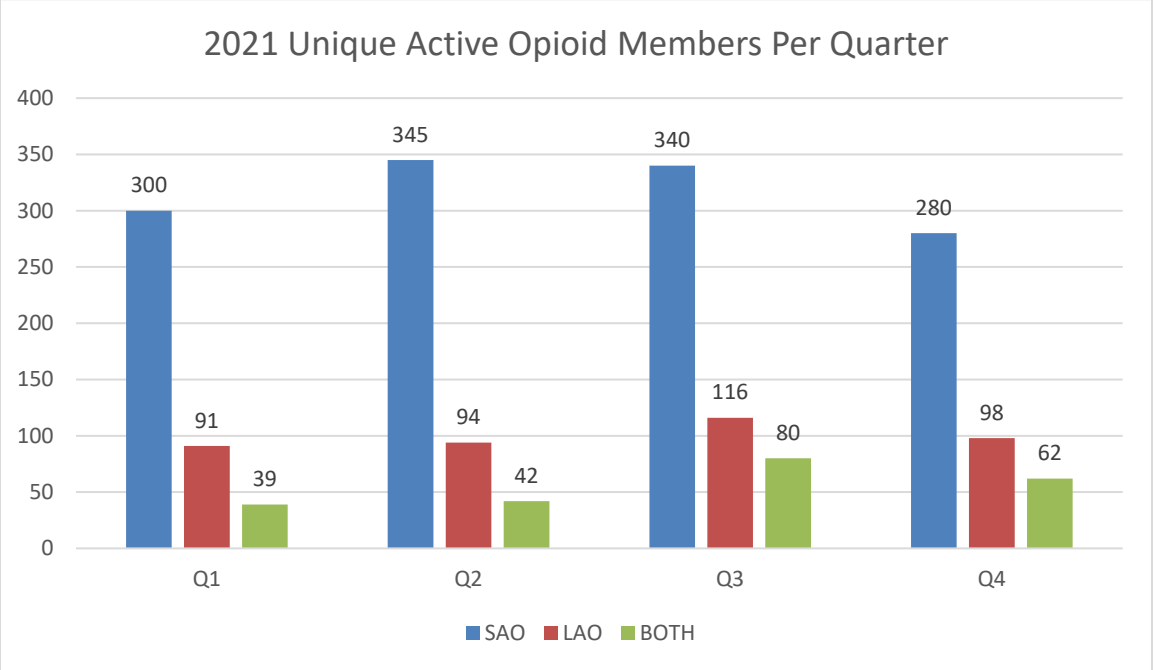
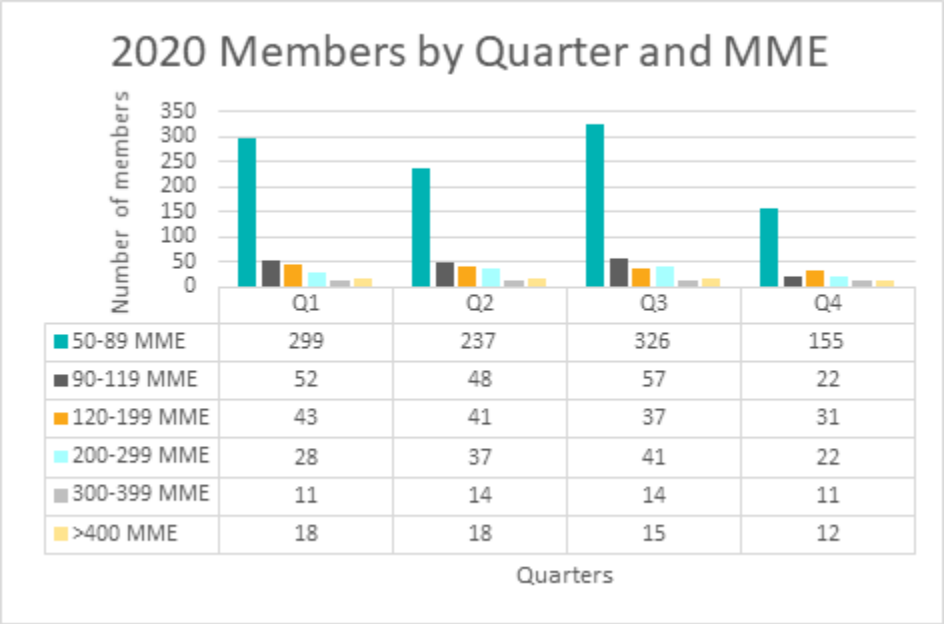
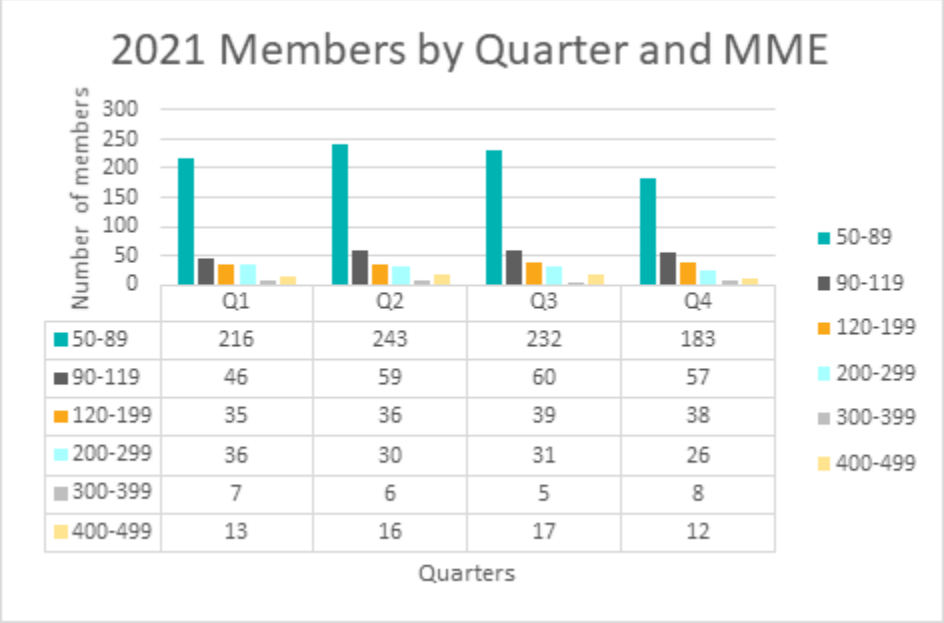


Table 10: 2021 Members per quarter on >50MME

MME (MORPHINE MILLIGRAM EQUIVALENTS)						
Month	**50-89**	**90-119**	**120-199**	**200-299**	**300-399**	**>400**
Q1	216	46	35	36	7	13
Q2	243	59	36	30	6	16
Q3	232	60	39	31	5	17
Q4	183	57	38	26	8	12





Above is a table that lists the number of members on greater than 50 MME opioids. Within 2021, this table shows a 18% (216 to 183 members from Q1 to Q4) decrease in members utilizing 50- 89 MME, 19.2% (46 to 57 members) increase in members utilizing 90-119 MME, 7.9% (35 to 38 members) decrease in members utilizing 120-199 MME, 38.4% (36 to 26 members) decrease in members utilizing 200-299 MME, no change for member utilizing 300-399 MME, and greater than 400 MME.

Below is a graph depicting how many unique providers prescribing opioids categorized by ascending MME. There is a general decrease in prescribing trend as the MME go up. In 2021, 40 providers each wrote 1 prescription for 300-399 MME and 147 providers each wrote 1 prescription greater than 400 MME. In addition, at least 8 providers wrote at least 6 prescriptions greater than 400 MME—majority are cancer providers. There is 1 internal medicine doctor that prescribed 10 prescriptions over 400 MME.

Drug Recalls

The Pharmacy Department monitors all drug recalls. In 2021, pharmacy recall information is as below:

Table 11: 2021 Pharmacy Recalls

RECALL TYPE	QUANTITY
Total number of safety notices/recalls	**78**
Total number of withdrawals	0
The number of notifications where PBM completed a claims data review	3

In 2021, there were 78 recalls. Recalls were monitored for adversely affected members. The number of notifications where the PBM completed a claims data review were 3.

The Alliance website has a continuous flow of safety resources for members and providers and includes FDA recalls, Risk Evaluation and Mitigation Strategies, a Patient Safety Resource Center, and Drug Safety Bulletins.

Potential Quality Issues (PQIs)

Potential Quality Issues (PQIs) are defined as: A individual occurrence or occurrences with a potential or suspected deviation from accepted standards of care, including diagnostic or therapeutic actions or behaviors that are considered the most favorable in affecting the patient's health outcome, which cannot be affirmed without additional review and investigation to determine whether a quality issue exists. PQI cases are classified as, **Quality of Access (QOA)**, **Quality of Care (QOC),** or **Quality of Service (QOS)** issues. **Quality of Language (QOL)** was added as a separate PQI classification as an improvement opportunity to better capture, track, trend, investigate and resolve potential quality issues related to member grievances regarding language. The Alliance QI Department investigates all PQIs referred as outlined in policy QI-104, Potential Quality Issues. PQIs may be submitted via a wide variety of sources including but not limited to members, practitioners, internal staff, and external sources. PQIs are referred to the Quality Improvement (QI) Department through a secure electronic feed or entered manually into the PQI application, for evaluation, investigation, resolution, and tracking.

Quality Review Nurses investigate PQIs and summarize their findings. QOA, and QOS cases that do not contain a clinical component are investigated and closed by the review nurse. QOL cases are reviewed and investigated by the Cultural and Linguistic Manager. The Senior Director and/or the QI RN Supervisor oversees and audits a random sample of all PQI case types. The QI Medical Director reviews all QOC cases, in addition to, any QOA, QOL, or QOS cases where the Quality Review Nurse and RN manager/director requests Medical Director case review. The QI Medical Director will refer cases to the Peer Review and Credentialing Committee (PRC) for resolution, on clinical discretion or if a case is found to be a significant quality of care issue (Clinical Severity 3, 4).

Table 12: Quality of Care (QOC) Issue Severity Level

SEVERITY LEVEL	DESCRIPTION
C0	No QOC Issue
C1	Appropriate QOC May include medical / surgical complication in the *absence of negligence* Examples: Medication or procedure side effect
C2	Borderline QOC With potential for adverse effect or outcome Examples: Delay in test with *potential* for adverse outcome
C3	Moderate QOC Actual adverse effect or outcome (non-life or limb threatening) Examples: Delay in / unnecessary test *resulting in* poor outcome
C4	Serious QOC With significant adverse effect or outcome (life or limb threatening) Examples: Life or limb threatening

Alameda Alliance for Health's Quality Department received 3051 Potential Quality Issues (PQIs), during measurement year 2021, which is a 44.0% increase from 2020. Of the 3051 PQIs received in 2021, 13%, or 389, of the PQIs were classified as a QOC. PQI monthly and quarterly totals are listed below:

Table 13: 2021 All PQI Type Monthly Totals

PQI Type	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	TOTAL	%
All Types of PQIs	143	192	275	287	230	276	179	329	396	300	220	224	**3051**	
QOA	48	70	88	80	62	91	59	125	158	112	57	74	**1024**	**34%**
QOC	14	26	53	45	24	26	26	43	48	30	30	24	**389**	**13%**
QOS	81	89	119	142	128	141	81	134	178	135	117	112	**1457**	**48%**
QOL*	0	4	11	16	13	12	8	22	12	21	13	12	**144**	**4.7%**
Other**	0	3	4	4	3	6	5	5	0	2	3	2	**37**	**1.2%**

*As of 2/2021
**Referred to Beacon or Kaiser

QI clinical management investigated reviewed and triaged all referrals both internal and external to the organization to ensure that access, clinical, language, service related PQIs were addressed through RN investigation and oversight support from Compliance and Vendor Management as applicable.

Table 14: 2021 OQC PQI Quarterly Totals

INDICATOR	Q1	Q2	Q3	Q4
Indicator 1: QOC PQIs	Denominator: **614** Numerator: **94** Rate: **15.3%**	Denominator: **792** Numerator: **95** Rate: **11.9%**	Denominator: **894** Numerator: **109** Rate: **12.2%**	Denominator: **660** Numerator: **47** Rate: **7.1%**
Indicator 2: QOC PQIs leveled at severity C2-4	Denominator: **94** Numerator: **15** Rate: **15.9%**	Denominator: **95** Numerator: **10** Rate: **10.5%**	Denominator: **109** Numerator: **13** Rate: **11.9%**	Denominator: **47** Numerator: **5** Rate: **10.6%**

QI RN management continued to conduct Exempt Grievances case audits via random sampling, to ensure that clinical PQIs are not missed and forwarded to the Quality Department. QI Department clinical management provides oversight of exempt grievances via review of randomly selected exempt grievances. In 2021 there was an increase from 30 PQI exempt grievance case file reviews per quarter to 50 case reviews with an overall performance rate of 99.5 which exceeds the established performance metric of 90%.

	Q4 2020	Q1 2021	Q2 2021	Q3
Numerator	30	50	50	49
Denominator	30	50	50	50
Performance Rate	100%	100%	100%	98%
Gap to Goal	N/A	NA	N/A	NA
Universe (n)	3954	3781	3528	3687

The Alliance IT department continues to provide support with workflow enhancements to the PQI application. The PQI application remains a robust and responsive system allowing for timely and accurate reporting, documentation, tracking, and adjudication of PQIs.

A full description of the PQI process is documented in policy QI-104.

A. Consistency in Application of Criteria in (IRR)

The Alliance QI Department assesses the consistency with which physicians, pharmacist, UM nurses, Retrospective Review nurses and non-physician reviewers apply criteria to evaluate inter-rater reliability (IRR). A full description of the testing methodology is available in policy QI-133. The QI has set the IRR passing threshold as noted below.

Table 15: Inter-rater Reliability (IRR) Thresholds

SCORE	ACTION
High – 90%-100%	IRR Pass Rate No action required.
Medium – 61%-89%	Increased training and focus by supervisors/managers.
Low – Below 60%	• Additional training provided on clinical decision-making. • If staff fails the IRR test for the second time, a Corrective Action Plan is required with reports to the Director of Health Services and the Chief Medical Officer. • If staff fails to pass the IRR test a third time, the case will be escalated to Human Resources which may result in possible further disciplinary action.

The IRR process for PQIs uses actual PQI cases. IRRs included a combination of acute and/or behavioral health IRRs. Results will be tallied as they complete the process and corrective actions implemented as needed. When opportunities for improving the consistency in applying criteria, QI staff addresses corrective actions through requiring global or individualized training or completing additional IRR case reviews.

For 2021, IRR testing was performed with QI clinical staff to evaluate consistency in classification, investigation and leveling of PQIs. All QI Review Nurse and Medical Director Reviewers passed the IRR testing with scores of 100%.

Facility Site Review (FSR)

Facility Site Review (FSR) and Medical Record Review (MRR) audits are mandated for each Health Plan under DHCS Plan Letter 14-004 to occur every three (3) years. FSRs are another way the Alliance ensures member quality of care and safety within the provider office environment. Interim monitoring and follow-up of FSR and MRR occurs between each regularly scheduled full scope reviews. Corrective Action Plans (CAPs) for non-compliance are required depending on the site FSR and MRR scores and critical element failures.

Due to public health emergency in 2020, DHCS issued APL 20-011 Governor's Executive Order N-55-20 in Response to COVID-19 allowing Alliance to temporarily suspend contractual requirement for in-person site reviews, encouraged alternative reviews, flexibilities with CAPs, and suspended APL 20-006 FSR and MRR. Although implementation of APL 20-006 has been suspended, Alliance also utilized the new FSR/MRR standards as a teaching opportunity during reviews. Providers are trained on the current AAP and USPSTF Recommendation A and B.

In July 8, 2021, APL 20-011 was updated to terminate the flexibilities effective July 1, 2021. Alliance started to conduct in-person FSRs in July 2021 and continued with virtual reviews as requested by providers. Starting January 2022, MCPs will fully resume all FSR activities in person.

In August 2021, Alliance submitted to DHCS a written plan to address FSR backlogs and projected timelines. It was provisionally approved by DHCS on August 17, 2021, and quarterly updates were submitted. In addition, the bi-annual DHCS reports were submitted to DHCS.

In 2021, there were 100 site reviews. The total number and types of audits are detailed in the table below.

Table 16: 2021 Facility Site Reviews

TYPE	Q1	Q2	Q3	Q4	TOTAL
FSR/MRR: Full Scope	2	5	4	10	**21**
Initial FSR	1	1	1	0	**3**
Initial MRR	1	2	1	1	**5**
Initial FSR/MRR	1	0	0	0	**1**
MRR: Focused	0	0	0	1	**1**
Interim Monitoring	12	7	3	1	**23**
Periodic Annual	0	0	0	0	**0**
Periodic FSR	3	2	7	13	**25**
Periodic MRR	0	3	8	10	**21**
Total Reviews	**20**	**20**	**24**	**36**	**100**

DHCS regulation requires that Critical Element (CE) CAPs be received by the Alliance within 10 business days and FSR/MRR CAPs within 45 days of the site review.

Additionally, a critical element CAP is issued for deficiencies in any of the 9 critical elements in the FSR that identify the potential for adverse effects on patient health or safety and must be corrected within 10 business days of the site review. Alliance allowed extension on CAP submission due to reduce office hours and staffing during public health emergency according to APL 20-011. FSR staff continued to work with providers in getting CAP submission. In 2021, there were 59 CAPs issued and 2 CAPs remain open for more than 120 days.

Table 17: FSR/MRR CAPs issued in 2021

TYPE	Q1	Q2	Q3	Q4	TOTAL
Total CAPs Issued	**8**	**11**	**15**	**25**	**59**
Open	0	0	1	13	14
Open >120 days	*NA*	*0*	*1*	*1*	*2*
Closed	8	11	14	12	45

Per DHCS regulation, failed periodic reviews are reported bi-annually. In 2021, the Alliance had one provider with non-passing scores below 80%. A corrective action plan was provided to DHCS.

Table 18: 2021 Audits with Non-Passing Scores

QUARTER	AUDIT DATE	FSR SCORE	MRR SCORE
Q1	N/A	N/A	N/A
Q2	N/A	N/A	N/A
Q3	N/A	N/A	N/A
Q4	12/16/2021	N/A	76.69%

A. Audit of Initial Health Assessments (IHAs) via FSR/MRR

IHA includes history and physical (H&P) and Individual Health Education Behavioral Assessment (IHEBA). An IHA must be completed within 120 days of member assignment.

Alliance continued to review records for IHA for members who were enrolled prior to December 1, 2019. IHA was also reviewed for newly enrolled members in 2021 who presented for well care visit at the providers office and where an IHEBA was completed. In 2021, medical records at 46 sites were reviewed for the presence of an IHA. Table 24 lists the results of these reviews. The 22 total non-compliant providers received CAP and re-education/training on IHA and IHEBA compliance.

Table 19: 2021 MRR Results

TYPE	Q1	Q2	Q3	Q4	TOTAL
# of MRRs with Compliant* IHAs	0 (0%)	3 (30%)	6 (50%)	13 (65%)	22
# of MRRs with Non-Compliant IHAs (CAPs)	4	7	3	7	21
Total IHAs Audited via FSR	4	10	12	20	46

*Compliant = Per DHCS CAP guidelines, no CAP issued if MRR score is 90% or greater and 80% or greater on Pediatric/Adult Preventive section.

Peer Review and Credentialing Committee (PRCC)

In 2021, 34 practitioners were reviewed for lack of board certification. If there were complaints about a practitioner's office, facility site reviews were conducted, and the outcome was reviewed by the PRCC. There were no site reviews conducted based on complaints in 2021. All grievances, complaints, and PQIs that required investigation were forwarded to this committee for review. In 2021, 87 practitioner grievances, complaints, or PQIs were investigated by the committee. There were no practitioners that required reporting to National Practitioner Data Bank (NPDB) by the Alliance.

In 2021, the PRCC granted one-year reappointment for one practitioner for grievances filed regarding office procedures and granted two-year reappointment for two practitioners for grievances filed regarding office procedures. The table below shows evidence of practitioner review by the PRCC prior to credentialing and re-credentialing decisions.

Table 20: Count of Practitioners Reviewed for Quality Issues at PRCC in 2021

Count of Practitioners Reviewed for Quality Issues At PRCC in 2021										
PRCC Date	PRC	NPDB	Attestation	Malpractice (pending/dismissed)	Facility Site Review	Grievance, Complaints, PQI	License Action	Board Certification	CAP	Total
January		4		1		5		7	2	19
February				2		8		1	3	14
March						9		1	3	13
April		2				7	1		1	11
May	1	2				7	1			11
June				1		6	1	1	1	10
July		2		1		6		1		10
August No Committee Meeting										0
September	1	4				7		3	1	16
October		1		3		9		9	1	23
November	1					15		8	1	25
December		5				8		3	2	18
Total	**3**	**20**	**0**	**8**	**0**	**87**	**3**	**34**	**15**	**170**

Delegation Oversight

As a part of its compliance program and strategy, the Alliance deploys an array of auditing and monitoring exercises throughout the year. Annually, First-tier subcontracted entities, called delegates, undergo an annual delegation oversight audit. The audits are conducted in accordance with California Department of Health Care Services (DHCS); California Department of Managed Health Care (DMHC), and the National Committee for Quality Assurance (NCQA) regulations. Audit results are reported to the Delegation Oversight Committee, which is an underreporting committee of the Compliance Committee.

In Calendar Year 2021, the Alliance conducted annual delegation oversight audits for the entities included in Table 26.

To supplement its approach to Compliance, the Alliance holds quarterly Joint Operations Meetings (JOMs) with delegates, as necessary. JOMs cover a variety of topics, to include: individual Access and Timeliness of Care survey results; HEDIS rate performance and opportunities for improvement; strategies for score improvement, and; HEDIS timelines for reporting in the current year. In addition to JOMs, the Alliance holds regular Executive Team meetings with its strategic partners Community Health Center Network (CHCN) and Alameda Health Systems.

Table 21: Alameda Alliance Delegated Entities Compliance

Delegate	Quality Improvement		Utilization Management		Credentialing		Grievances & Appeals		Claims		Call Center		Case Management		Cultural & Linguistic Services		Provider Training	
	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care
Beacon Health Strategies LLC	X	X	X	X	X	X			X	X	X	X	X		X	X	X	
Community Health Center Network (CHCN)			X	X					X	X			X	X			X	X
March Vision Care Group, Inc.					X				X									
Children's First Medical Group (CFMG)			X		X				X									
PerformRx			X	X	X	X			X	X					X	X		
Kaiser	X		X		X		X		X		X		X		X		X	
UCSF					X	X												
Physical Therapy PN					X	X												
Lucile Packard					X	X												
Teledoc					X	X												

The Alliance will continue to conduct oversight of the delegated groups, review thresholds to ensure they are aligned with industry standards and will issue corrective actions when warranted. After review of the QI delegates, no actions were specifically identified or taken. The QI Delegates Program Evaluation will be reviewed by the HCQC in Q1 of 2021.

Population Health Strategy

In accordance with NCQA 2020 Standards and Guidelines for the Accreditation of the Health Plans, Alameda Alliance for Health has developed a basic framework to support a cohesive plan of action for addressing member needs across the continuum of care. This continuum includes the community setting, through participation, engagements, and targeted interventions for a defined population.

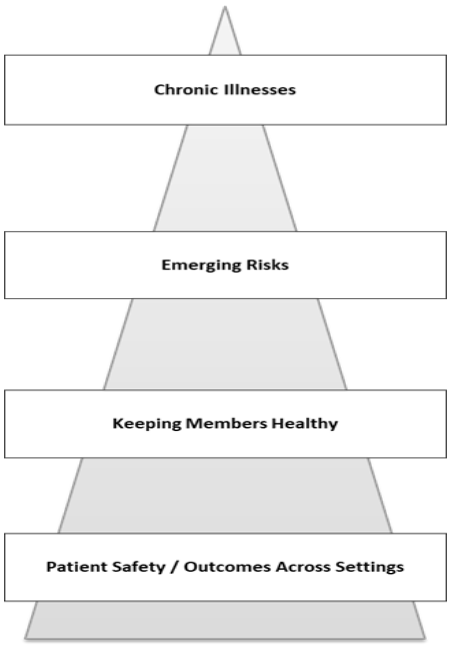
The Population Health Program aims to influence the health outcomes of the Alameda Alliance membership. The program oversees the health management system by ensuing that the system caters to the health needs of the enrolled member population. The goal of the Alliance Population Health Program is to improve health outcomes of the Alliance membership across the continuum of care, close gaps between identified disparities, and address SDOH that cause those disparities.

The following four areas of this strategy focus on a whole-person approach to identify members at risk, and to provide strategies, programs, and services to mitigate or reduce that risk.

The Alliance also aims to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored solutions.

The 4 areas of focus are:

1. Members with Chronic Illness
2. Members with Emerging Risk
3. Keeping Members Healthy
4. Patient Safety



The 2021 Population Health Program objectives centered on the 4 areas of focus:

Multiple Chronic Illnesses: Multiple Chronic Illnesses were addressed through our Complex Case Management, Transitions of Care and Health Homes programs. Our Health Homes program was successful in decreasing admits (-16.1%), average length of stay -.05 days), and emergency room visits (-22.4%), while experiencing a modest increase in readmits (1.7%). Outcomes for CCM and TOC programs need improved tracking mechanisms to monitor goals. The Health Homes program in particular experienced challenges in building trust with members and maintaining regular contact.

Rising Risk: Programs that addressed Alliance members with rising risk included a pediatric asthma case management program, Asthma Start, and equity project, Asthma Affinity, focused on improving the asthma medication ratio for black adults ages 19-64. that reached its objectives of reducing ER visits from pre to post services (61% reduction). Our goal of increasing engagement for our Latino and Black pediatric members with asthma was not met due to an overall reduction in services due to COVID.

The Alliance also launched successful collaborative to address hypertension among our Asian and Pacific Islander members with hypertension. 150 members received blood pressure cuffs and hypertension self-management education through our community clinic partner, Asian Health Services. We began groundwork for Pediatric obesity education objectives, completing a new childhood exercise and nutrition book. Covid-19 also negatively impacted our school-based nutrition collaboration. The program closed while schools were meeting remotely.

Keeping Members Healthy: Initiatives for cancer screenings and well child visits were a focus for 2021, including cervical cancer screening, breast cancer screening, and well child visits ages 3 - 21. Groundwork was laid in 2021 with clinics to begin education and incentive programs in 2022. Outcomes will be measured in 2022. Pregnant members were also a continued focus for the Alliance, where as 100% of members identified as pregnant or recently giving birth received pregnancy and baby care resources and referrals. All members enjoyed access to a comprehensive system of health education program and educational resources supporting healthy lifestyles and disease management topics ranging from diabetes to injury prevention.

Patient Safety/Outcomes Across Settings: The Alliance launched a substance use intervention for chronic users. All identified high risk and rising risk members and their providers received a packet with education on safe practices, and alternative pain management provider referrals. This initiative was successfully implemented and 75 members and their providers received resources.

Additional information can be found in the plans population health management strategy and effectiveness report.

Quality Improvement Projects

Improve Compliance Rate for WCV through HEDIS Crunch 2021

In September 2021, the Plan decided to continue the HEDIS Crunch initiative that was started in 2019 to improve well-child compliance rates for WCV for members 3-21 years of age. 20 pediatric providers within the CFMG network agreed to provide $25 member incentive at the completion of a well-child visit that is completed prior to December 31, 2021. A total of 1,511 gift cards were provided this year, which is an increase of 1,502 gift cards from 2020. CFMG network provider scores increased 9.34% from baseline MY2020 48.01%.

Improve Compliance Rate for African American Males Colon Cancer Screening Rates

July 2021, AAH partnered with a Federally Qualified Health Center, West Oakland Health Council (WOHC), to improve colon cancer screening rates in African American men between the ages of 45-75 years of age. AAH developed a two tired approach to engage the target population by offering a $10 member incentive to be given at the completion of an office visit with their assigned PCP at WOHC to discuss the importance of receiving screening for a colorectal cancer screening and a $50 member incentive when the FIT-DNA test has been completed. The goal of this project was to increase colon cancer screening rates in African American males at WOHC from 22.79 to 37.10%.

As of December 2021, 72 Alameda Alliance members completed a FIT-DNA test for colorectal cancer, of which 6 members had a positive result.

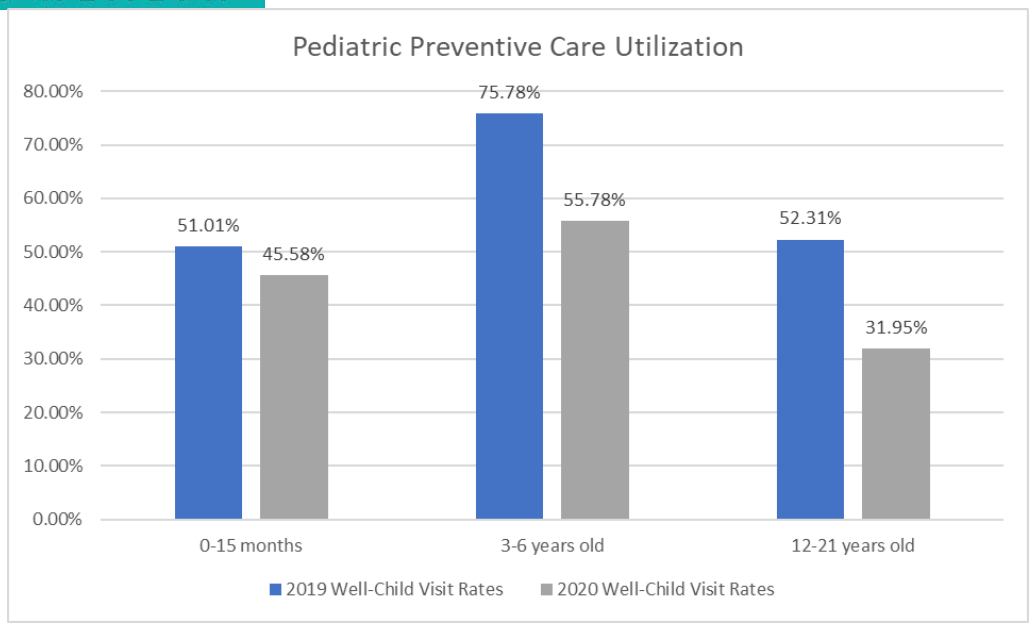
DHCS PDSA WCV

In California, it has been identified that children are not accessing comprehensive pediatric services consistently. The California State Auditor Report identified that, "an annual average of 2.4 million children enrolled in Medi-Cal do not receive all required preventive services."[1] Additionally, this report confirms utilization rates for children in Medi-Cal have remained below 50 percent. As a result, Alameda Alliance for Health (the Alliance), had a targeted focus on increasing pediatric access through its Pediatric Care Coordination Project. The goal of the pilot is to engage the Alliance's pediatric members to seek regular check-ups at age-appropriate intervals that follows the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule and anticipatory guidance with increased screenings and referrals to improve member health functional status and/or care satisfaction. This includes Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for Medical, Dental, Vision, Hearing, and Mental Health, Substance Use Disorders, Developmental and Specialty Services for pediatric population less than 21 years of age.

The intervention focused on the HEDIS measure: WCV -- the percentage of members 3–21 years of age who had one or more well-child visits with a PCP during the measurement year. Well-child visits provide a critical opportunity for screening, referrals, and counseling as children develop physical activity, social, nutritional, and behavioral habits that often continue into adulthood. With these visits, providers conduct comprehensive physicals, connect patients to important EPSDT services, provide vaccinations and medications, as well as help answer any health-related questions patients and their families may have.

Alameda Alliance for Health (AAH) selected the MCAS WCV measure because the Plan has identified an opportunity for improvement based on administrative results for measurement year 2020. Given the Public Health COVID-19 emergency, the Plan saw a decrease in pediatric utilization of preventive care services. Below is a graph that illustrates the decline in children receiving the appropriate preventive well-child exams by different age bands.

[1] California Department of Health Care Services. (2020, December). 2020 preventive services report. Retrieved from www.dhcs.ca.gov/Documents/MCQMD/2020-Preventive-Services-Report.pdf.



For children ages 3-6 and 12-21, the Alliance has seen a 20% decrease in utilization of preventive care in 2020 due to COVID-19.

In partnership with Osita, a low performing provider, the Alliance tested member outreach by sending out postcards. The postcard served as a method to gently, and unobtrusively, remind members to visit their PCP for preventive care services. The postcards were sent out to members (parents) between the ages of 3-21 years old. The goal for this project was:

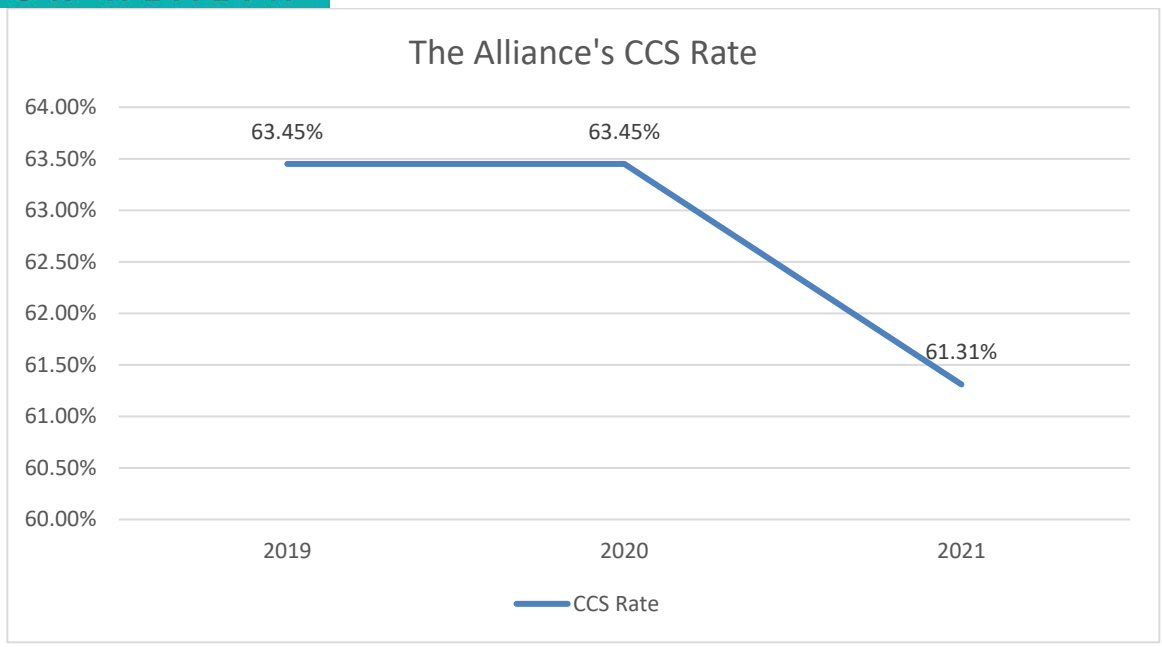
- By December 31, 2021, increase Well-Child Visits (WCV) for noncompliant Osita members ages 3 to 21 from 6.08% as of September 2021 to 16% through the implementation of color-coded postcards mailed to identified members.

The Alliance did not meet the SMART Aim goal of raising the WCV rate to 16% by 12/31/2021. A major barrier encountered included the continuous strain COVID put on healthcare systems, including shortage in staffing. As a result, providers ability to outreach and communicate with members about preventive measures was limited. The Alliance ran a 2nd PDSA with Osita; the 2nd cycle included outreach phone calls to 20 members to understand if they received the postcard and to serve as a second reminder to visit their provider. The data does not show evidence of improvement and therefore both interventions are abandoned.

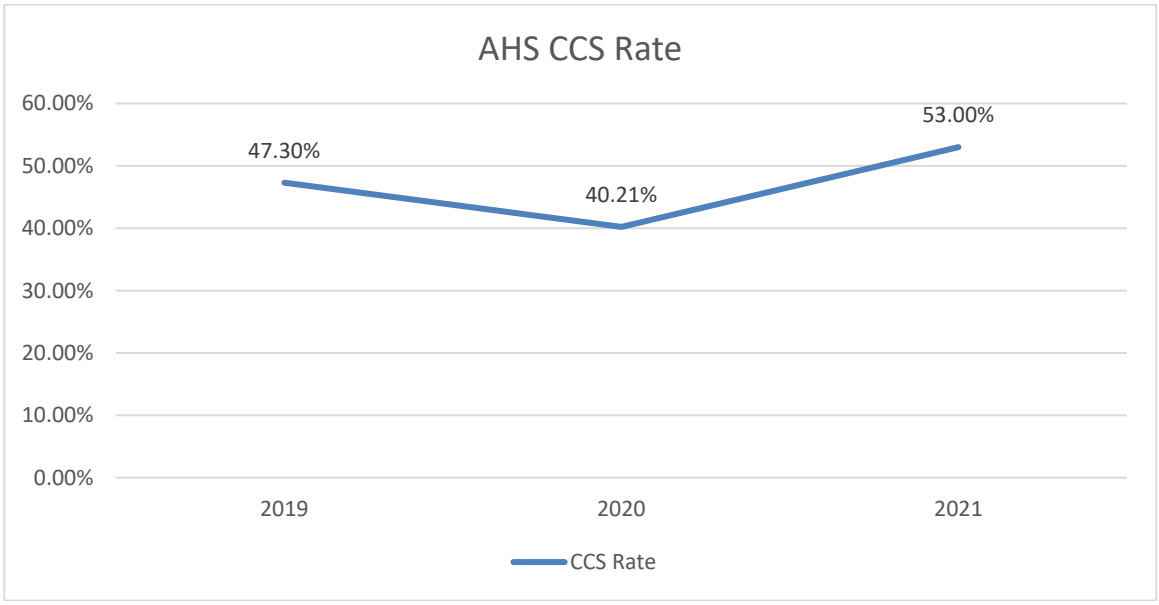
DHCS PDSA

Cervical cancer screening is recommended for all women aged 21 to 65 years old for early detection and treatment of cervical cancer. Regular cervical cancer screening is associated with a 67% reduction in cervical cancer and a 70% reduction in deaths from the disease.

The graph below illustrates the Alliance's reported hybrid CCS rates from RY2019 – 2021. CCS rates saw over a 2% decrease during the COVID-19 public health emergency.



The graph below illustrates Alameda Health System's (AHS) hybrid CCS rates from RY2019 – 2021.



Historically, Alameda Health System (AHS) has fallen below national benchmarks and comparable health systems' rates for cervical cancer screening. This has further been exacerbated by the COVID-19 pandemic and transition from a predominately in-person model of care to a telehealth model that prevented the completion of in-person services such as cervical cancer screening. As a result, The Alliance identified an opportunity to partner with AHS to improve CCS rates for MY2021/RY2022.

The SMART aim goal for this project was: by December 31, 2021, Alameda Alliance for Health will increase its delegate, Alameda Health System's (AHS), Cervical Cancer Screening rates among their 16,340 eligible female members ages 21 to 64 from 23.50% (3,840/16,340 members) as of September 2021, to 31.43% (5,136/16,340 members) through the development of Pap focused clinic days across all four of AHS' ambulatory clinic locations.

The intervention the Alliance tested was to offer Pap clinic days that focused on completing cervical cancer screenings. Pap Clinic days had the potential to increase AHS CCS compliance rates by adding 12 additional appointment slots per month at each clinic location. By offering pap focused clinic days, it increased the appointment availability for cervical cancer screening visits at Alameda Health System (AHS), which we predicted it would increase AHS' CCS rate.

This intervention was a multi-pronged approach to increase capacity to complete CCS screenings, create awareness among identified members through AHS' outreach through calls and text messaging, and create motivation to complete the preventive exam by offering a member incentive. To meet cervical cancer screening targets, AHS opened clinics dedicated only to cervical cancer screening. These pap smear clinics were offered at all four of AHS' ambulatory sites. AHS used text messaging outreach campaigns and telephone outreach by their community health workers (CHWs). At the completion of the cervical cancer screening, the member received a $25 incentive by AHS staff.

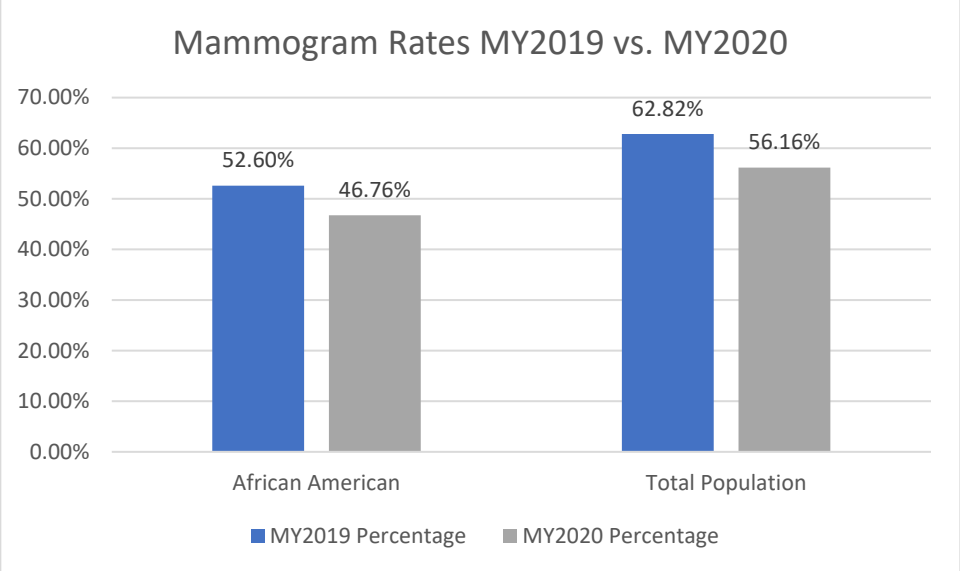
The goal of increasing AHS' rate to 40.39% by 12/31/2021 was not met. Not every slot was filled due to COVID hesitancies, and staff shortages made outreach and data collection difficult for AHS during the months of September through December 2021. While there was a slight increase in rates, it is difficult to correlate the increase to this intervention (see rates below). The intervention was promising however, external factors created unforeseen challenges. This intervention will be abandoned and perhaps tested later when staffing is at full capacity for both the Alliance and AHS.

Clinic	Sep-21	Oct-21	Nov-21	Dec-21
Eastmont Wellness Center	35.22%	35.97%	37.23%	38.19%
Hayward Wellness Center	31.45%	32.03%	33.15%	34.31%
Highland Wellness Center	34.22%	35.52%	36.30%	37.72%
Newark Health Center	28.01%	28.71%	29.65%	30.64%
AHS	32.46%	33.31%	34.34%	35.51%
Goal	40.39%	40.39%	40.39%	40.39%

Improve Compliance Rate for the African American Female Population for BCS – DHCS Equity PIP

According to an American Cancer Society 2019-2020 report, approximately 1 in 8 women (13%) will be diagnosed with invasive breast cancer in their lifetime. The report also highlights and reinforces the disparities felt by African American women when it comes to receiving timely and accessible preventive care such as mammograms. African American women have the highest breast cancer death rate of 28.4 deaths per 100,000.[2] They also have higher incidence rates than non-Hispanic Whites before the age of 40 and are more likely to die from breast cancer at every age. Early detection of breast cancer is the number one way to decrease mortality rates, therefore, Alameda Alliance for Health (AAH) focused on increasing breast cancer screening rates among our members with a narrowed focus on African American women.

AAH has selected the MCAS BCS measure because there has been identified opportunities for improvement based on MY 2020 data for MY 2021. AAH has seen a decrease in breast cancer screening services as depicted in the chart below comparing MY 2019 and MY 2020 admin rates for African American women and all other eligible women for the MCAS BCS measure.



There was a 5.84% decrease in mammogram rates among African American women, and a 6.66% decrease in mammogram rates among all Alliance female members that qualified for the BCS measure.

[2] https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/breast-cancer-facts-and-figures/breast-cancer-facts-and-figures-2019-2020.pdf

Increasing breast cancer screening rates among AAH's African American female members is the narrowed focus of this PIP. The MY2020 admin rate for AAH was 56.16%, and among African American women it was 46.76%.

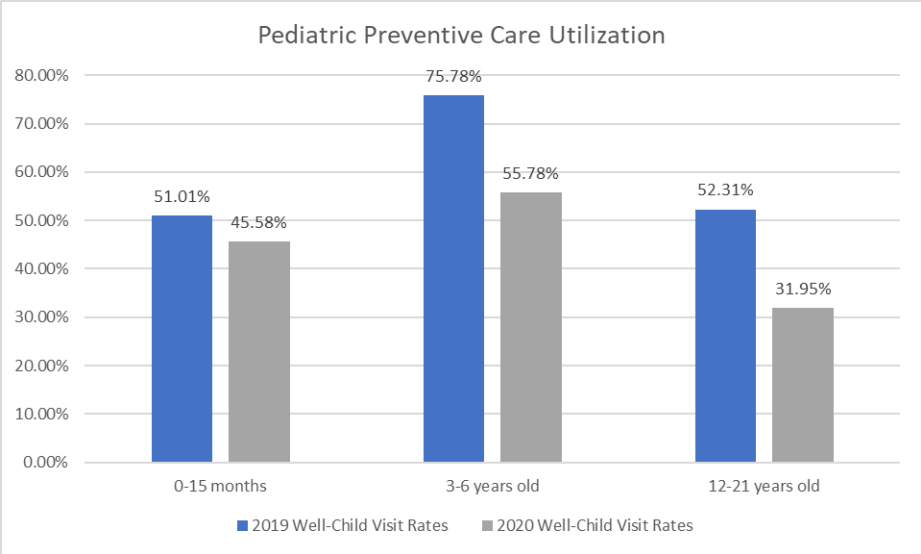
This intervention allows AAH to strengthen outreach initiatives surrounding breast cancer screening and improve access to mammograms along with other barriers members may help identify. AAH strives to increase member awareness of their rights to access preventive care in 2021/2022 and to encourage a safe return to clinics.

In partnership with Lifelong, a high volume, low performing provider, AAH is piloting an outreach and incentive project to encourage women to complete their mammography screening.

Increase Well-Child visits among members ages 3-21– DHCS Priority PIP

The intervention focuses on the HEDIS measure: MCAS WCV -- the percentage of members 3–21 years of age who had one or more well-child visits with a PCP during the measurement year. Well-child visits provide a critical opportunity for screening, referrals, and counseling as children develop physical activity, social, nutritional, and behavioral habits that often continue into adulthood. During these visits, providers conduct comprehensive physicals, connect patients to important EPSDT services, important vaccinations, and medications, as well as help answer any health-related questions patients and their families may have.

Alameda Alliance for Health (AAH) selected the MCAS WCV measure because the Plan identified an opportunity for improvement based on its current administrative results for measurement year 2020. Given the COVID-19 pandemic, the Plan has seen a decrease in pediatric utilization of preventive care services. Below is a graph that illustrates the decline in children receiving the appropriate preventive well-child exams in different age bands.



For children ages 3-6 and 12-21, the Alliance has seen a 20% decrease in utilization of preventive care in 2020 due to COVID-19.

WCV admin rates for direct providers within the AAH network is the narrowed focus of this PIP. The MY2020 admin rate for the Alliance was 38.93% and for directs, it was 38.22%.

After looking at AAH MY2020 WCV admin data, we established a threshold to identify providers with patient panels greater than 650, a compliance rate less than 55%, and have expressed interest in partnering with the Alliance to be included into this PIP. Based on this threshold, we identified one provider

Specifically, the target population for this initiative will be members ages 3-21 assigned to one direct

Alliance provider:

1. Rhodora De La Cruz MD (3-21 years of age with a denominator of 1160)

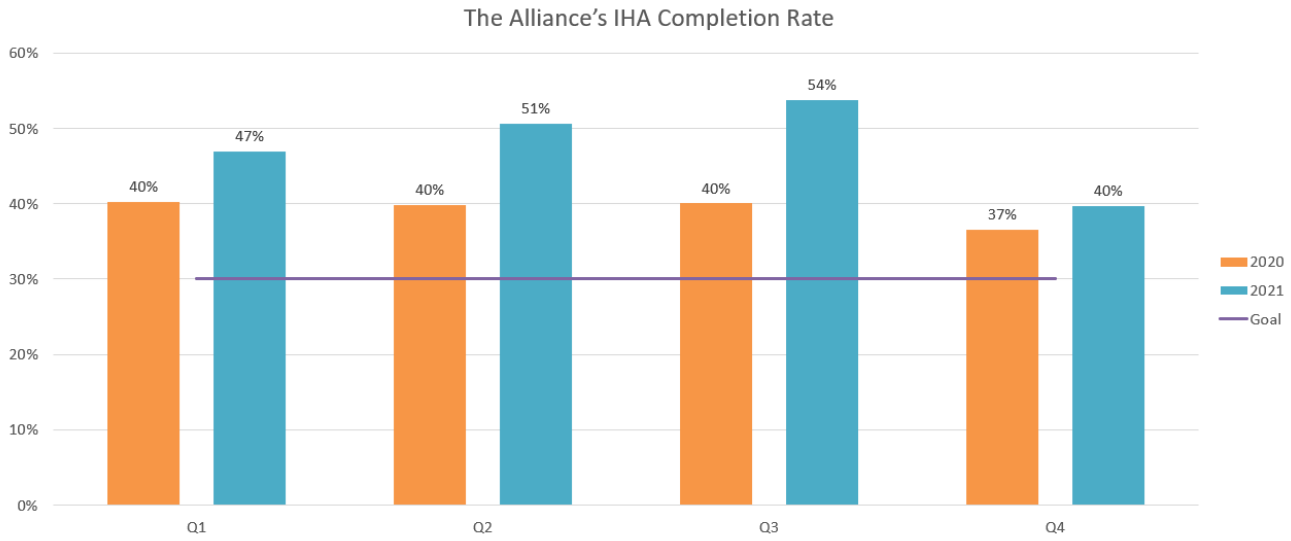
The SMART aim goal for this PIP is by December 31, 2022, use key driver diagram interventions to increase the percentage of WCV admin visit rate for Dr. Rhodora De La Cruz from 40.94% to 45%. The intervention AAH plans to implement is outreach and incentive using a birthday card mailer. The birthday card will serve as a reminder to members (parents) to make an appointment with their provider. AAH is in the process of finalizing the mailers to be sent out to members assigned to Dr. Rhodora De La Cruz.

Improving Initial Health Assessment (IHA) Rates

The past 1 year of IHA rates is outlined below.

Table 22: 2021 IHA Completion Rates – Medi-Cal

Total	New Enrollee	Re-Enrollee
Denominator: 41,944 Numerator: 1,5787 Rate: 37.6% Goal: 30% Gap to goal: Goal Met	Denominator: 25,588 Numerator: 9,491 Rate: 37.1% Goal: 30% Gap to goal: Goal Met	Denominator: 16,356 Numerator: 6,296 Rate: 38.5% Goal: 30% Gap to goal: Goal Met



Annually AAH conducts an audit of the Initial Health Assessment (IHA). A random sample of 90 members are selected and medical records are requested to review if the six elements of the IHA has been completed, including:

1. Patient history
2. Review of organ systems
3. Physical and mental examination
4. Preventive care
5. Diagnoses and plan of care
6. Staying Healthy Assessment (SHA)

In 2021, 90 charts were requested, 37 received. In all 51 components of the IHA was missing, with the Staying Healthy Assessment (SHA) missed most often. As a response to COVID-19, DHCS implemented APL 20-004, which suspended the requirement to complete an IHA in 120 days for newly enrolled members between December 1, 2019 – September 1, 2021. As a results AAH did not issue caps in 2021 however, the plan sent out educational letters to providers who were missing elements of the IHA.

To improve IHA compliance rates, the Alliance is working to:

- Ensure member education – through mailings and member orientation
- Improve provider education – through faxes, the PR team and provider handbook.
- Improve data sharing – by sharing gaps in care lists with our delegates and providers
- Monitor records to ensure compliance with all components of the IHA
- Given the 6 month claims lag, data will be reviewed and analyzed in Q3 – Q4 of 2022.

Pediatric Care Coordination Pilot

In 2018 CA State Auditor Report cited the following:

- "90% of children in MCL receive services through managed care plans
- "An annual average of 2.4 million children who were enrolled in MCL over the past five (5) years have not received all of the preventive health services that the State has committed to provider them."
- "Under-utilization of children's preventive health in CA MCL has been consistently below 50% and is ranked 40th in the country, 10% below the national average."
- Alameda Alliance for Health Direct and Delegate Network providers are performing below 50% on several pediatric HEDIS measures

The Pediatric Care Coordination Pilot launched October of 2019

Goal of effective partnerships will result in value-add outcomes for the Alliance and its pediatric members that include:

- A shared vision
- Improved access to care (quality initiatives with delegates)
- Increased utilization rates for preventive health services (quality initiatives)
- Improved data sharing
- Improved care coordination (clinical initiatives with delegates)
- Improved health outcomes, (clinical initiatives with delegates)
- Improved HEDIS rates to MCAS 50% MPL (quality initiatives with delegates)
- Enriched member and provider experience/satisfaction (quality initiatives)

In 2021, the Alliance continued to address the important issue of under-utilization and improve pediatric access to care for preventive health services. Health Care Services (HCS) QI department developed deployed strategies for enhanced integration of pediatric health care services for the children and adolescent population enrolled in the Alameda Alliance (AA) for Heath Medi-Cal program. The Alliance sought to constructively influence and impact care delivery for this identified population in three (3) ways:

- Quality Initiatives
- Clinical Initiatives
- Pediatric Care Management Program

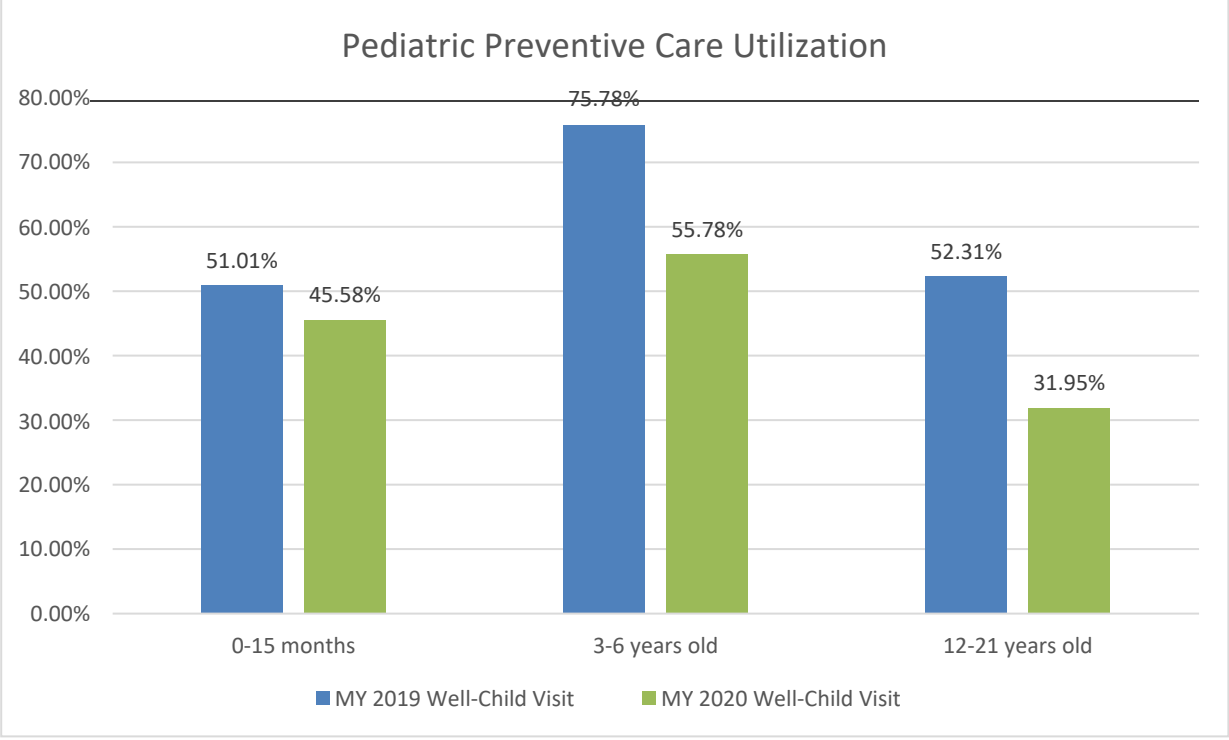
The HCS strategy proposed leveraging “whole child wellness” integration through:

- Improved screening and referrals as part of Medi-Cal Early and Periodic Screening, and Diagnostic and Treatment (EPSDT) supplement benefit
- Reporting via data segmentation and visualization
- Member and provider incentives
- Community based program funding
- Provider P4P
- Health Education engagement
- QI Initiatives
- DHCS Performance Improvement Initiatives
- Direct Provider collaboration
- Delegate Provider collaboration

  - Children's First Medical Group (29K Pediatric Members)
  - Community Health Care Network (31K Pediatric Members)
- Community Based Organizations (CBOs)
  - Alameda County Public Health Asthma Start
  - Alameda County Healthy Homes Lead Poisoning Prevention
  - First 5 Alameda County
  - Benioff Children's Hospital Oakland (FINDconnect Resource and Referral Platform)
  - Pediatric HEDIS Performance Measures selected for improvement

In MY2020, there were changes made to the HEDIS Pediatric Measures by combining two existing measures (W34 and AWC) to form WCV and the expansion of W15 to W30. As a result, the Plan was able to evaluate pediatric utilization of preventive care services by examining utilization in the following age bands, 0-15 months, 3-6 years old, and 12-21 years of age.

Table 23: Pediatric Preventive Care Utilization



Based on the underutilization of preventive care services, the Plan identified the following two HEDIS measures need to be a focus of the Pediatric Care Coordination Program:

- WCV – Well Child-Visits for Children 3 – 21 years of age
  - Alliance focused on well care visit (WCV) for ages 3-21 members to complete a comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner and receive member incentive upon completion of visit before December

31, 2021. Starting in September, Providers started outreaching to members to schedule appointments and provide member incentives at completion of well-care visit. The Alliance partnered with 20 provider sites, resulting in a 9.34% increase from baseline 48.01. As a result of this initiative, Alliance will be discussing the option of moving to start outreach in the summer because it is a good time for children to get well-care visit before school starts. Provider Groups mentioned that cancellations of visits happen during the holiday season.

First 5 Alameda Integrated Pediatric Care – Well Child Visit 0 – 5 years

Alameda Alliance for Health established a partnership with First 5 Alameda in July 2021. The goal of the initiative was to engage, assess, and connect Medi-Cal enrolled children, ages 0-5 and their families to appropriate clinical and community-based services and support to improve their health and well-being through an integrated community-based care management program. First 5 Alameda served as a key care management entity for Alliance pediatric members, ages 0 to 5 and worked in partnership with the Alliance to:

- Conduct outreach and engagement to increase child access to well-child preventative care for select Alliance members, ages 0-5
- Provide pediatric health education to families in a culturally appropriate and accessible manner
- Bolster pediatric health provider capacity to deliver DHCS/Bright Futures mandated pediatric screenings, with an emphasis developmental screening, ACES, and social determinants of health; and
- Coordinate family-centered access to well-child care, as well as needed developmental/behavioral services, mental health services, community-based services and supports, and social support needs, to enhance and supplement practice-based care coordination services and comply with EPSDT requirements.

While the project will continue through June 2022, mid-year results shows that 753 members between the ages of 0-5 years were contacted successfully and 69% of those members completed or showed pending appointments for well visits exam.

Clinical Improvement Trends: HEDIS

The Alliance is committed to ensuring the level of care provided to all enrollees meets professionally recognized standards of care and is not withheld or delayed for any reason. The Alliance adopts, re-adopts, and evaluates recognized standards of care for preventive, chronic and behavioral health care conditions. The Alliance also approves the guidelines used by delegated entities. Guidelines are approved through the HCQC. Adherence to practice guidelines and clinical performance is evaluated primarily using standard HEDIS measures. HEDIS is a set of national standardized performance measures used to report on health plan performance in preventive health, chronic condition care, access, and utilization measures. DHCS requires all Medicaid plans to report a subset of the HEDIS measures. Two years of Medicaid administrative rates are noted below. Reporting year is noted and reflects prior calendar year. Minimum Performance Level and High-Performance Level are determined by the Medi-Cal Managed Care Division.

Note: 2021 rates are preliminary as of April 2022. Final rates will be available July 2022.

Table 24: Medicaid Administrative HEDIS Rates

NCQA Acronym	Measure	Admin Final MY2020	2021 April Admin	2021 April Hybrid	MY2021 MPL
CBP	Controlling High Blood Pressure	25.57%	33.91%	54.47%	55.35%
CCS	Cervical Cancer Screening	58.32%	55.55%	61.02%	59.12%
CDC	HbA1c Poor Control (>9.0%)	42.87%	37.30%	32.85%	43.19%
CIS	Combo 10	46.81%	44.31%	47.15%	38.20%
IMA	Combo 2	50.04%	45.14%	46.72%	36.74%
PPC	Timeliness of Prenatal Care	86.91%	86.33%	92.00%	85.89%
PPC	Postpartum Care	78.95%	78.98%	83.60%	76.40%
WCC	BMI Percentile	34.89%	63.74%	86.61%	76.64%
WCC	Counseling for Nutrition	35.09%	48.72%	84.97%	70.11%
WCC	Counseling for Physical Activity	33.23%	46.36%	83.88%	66.18%
BCS	Breast Cancer Screening	56.19%	53.02%		53.93%
CHL	Chlamydia Screening in Women - Total	59.09%	63.46%		54.91%
W30	Well Child Visits in the First 15 Months	45.64%	44.08%		54.92%
W30	Well Child Visits for age 15 Months- 30 Months	69.34%	63.73%		70.67%
WCV	Child and Adolescent Well-Care Visit	39.47%	51.64%		45.31%

Analysis Of HEDIS MEDICAID Managed Care Accountability Set (MCA)

The above tables represent the Medicaid HEDIS measures for the DHCS' Managed Care Accountability Set. Of the trended measures 12 out of the 15 measures met the Minimum Performance Level (MPL). Furthermore, of the reported HEDIS measures in table 34 there is an increase in rates over MY2020 for 11 of the 15 measures. There is significant improvement in HEDIS rates over MY2020 however, there are three measures we are performing under the MPL, Breast Cancer Screening, Well Child Visits in the first 15 months and Well Child Visits 15 – 30 months.

The Aggregated Quality Factor Score (AQFS) is a single score that accounts for plan performance on all DHCS-selected Health Effectiveness Data and Information Set (HEDIS) indicators. It is a composite rate calculated as a percent of the National High-Performance Level (HPL). The Alliance goal is to increase Aggregated Quality Factor Score rates by 5% each year. If a minimum performance level is not met, an in-depth analysis occurs to identify barriers to access and care.

Based on the HEDIS data presented, potential focus areas for 2022 include the following:

- BCS – Breast Cancer Screening
- CCS – Cervical Cancer Screening
- CBP – Controlling High Blood Pressure
- WCV – Well-Child Visits in the First 15 months
- WCV – Well-Child Visits for ages 15 months – 30 months

Quality of Service

Analyses of member experience information helps managed care organizations identify aspects of performance that do not meet member and provider expectations and initiate actions to improve performance. Alameda Alliance for Health (AAH) monitors multiple aspects of member and provider experience, including:

- Member Experience Survey
- Member Complaints (Grievances)
- Member Appeals

Member Experience Survey

The Medi-Cal and Commercial Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is administered by the National Committee for Quality Assurance (NCQA) a certified Health Effectives Data and Information Set (HEDIS) survey vendor. SPH Analytics was selected by the Alliance to conduct the 2020 CAHPS 5.1 survey. NCQA is used a new 5.1 version of the CAHPS survey for 2021. The HEDIS CAHPS survey included minor changes to some of the instructions and survey items to indicate the different ways in which patients may be receiving care: in person or via telehealth.

The survey method includes mail and phone responses. Members in each Alliance line of business (LOB) are surveyed separately. The table below shows the survey response rates. As of 11/30/2021, the Alliance had a total of 295,151 members.

The breakdown of member enrollment by network is as follows:

- Alameda Health Systems (AHS) 19.7%
- Alliance 17.6%
- Community Health Center Network (CHCN) 36.8%
- Children First Medical Group (CFMG) 11%,
- Kaiser 14.5%

Table 25: Survey Response Rates by Line of Business

	Medi-Cal Adult	Medi-Cal Child	Commercial Adult
2021	15.9%	18.2%	23.7%
2020	14.7%	16.5%	23.5%
2019	21.3%	21.3%	28.3%

The Medi-Cal Child, Adult Medi-Cal and Adult Commercial Trended Survey Results in the tables below, contains trended survey results for the Medi-Cal Child, Medi-Cal Adult, and Commercial Adult populations across composites. Quality Compass All Plans (QCAP) benchmark noted within the tables is a collection of CAHPS 5.1H mean summary ratings for the Medicaid and Commercial samples that were submitted to NCQA in 2021 that provides for an aggregate or national summary.
In respect to benchmark scores, Red signifies that the current year 2021 score is significantly lower than the 2020 score. Green indicates that the current year 2021 score is significantly higher than the2020 score.

Table 26: Medi-Cal Child Trended Survey Results

Summary Rate Scores: Medi-Cal Child				
Composite	**2021**	**Previous Year Comparison**	**2020**	**2019**
Getting Needed Care	82.2%	↑	81.0%	83.5%

Summary Rate Scores: Medi-Cal Child				
Composite	**2021**	**Previous Year Comparison**	**2020**	**2019**
Getting Care Quickly	78.8%	↓	82.0%	85.4%
How Well Doctors Communicate	93.2%	↑	92.7%	93.7%
Customer Service	90.2%	↑	84.0%	86.1%
Rating of Health Care (8-10)	89.1%	↑	87.3%	89.8%
Rating of Personal Doctor (8-10)	91.0%	↓	91.2%	93.6%
Rating of Specialist (8-10)	87.2%	↓	90.6%	85.5%
Rating of Health Plan (8-10)	88.1%	↑	87.5%	88.9%
Coordination of Care	73.8%	↓	82.4%	86.0%

Table 27: Medi-Cal Adult Trended Survey Results

Summary Rate Scores: Medi-Cal Adult				
Composite	**2021**	**Previous Year Comparison**	**2020**	**2019**
Getting Needed Care	79.0%	↓	82.6%	76.0%
Getting Care Quickly	72.4%	↑	71.7%	74.5%
How Well Doctors Communicate	83.5%	↓	95.7%	88.4%
Customer Service	84.1%	↓	88.8%	80.7%
Rating of Health Care (8-10)	73.1%	↓	75.4%	73.6%
Rating of Personal Doctor (8-10)	81.3%	↓	84.7%	77.1%
Rating of Specialist (8-10)	78.9%	↓	91.7%	74.5%
Rating of Health Plan (8-10)	74.9%	↓	78.4%	73.4%
Coordination of Care	83.0%	↑	80.3%	70.4%

Table 28: Commercial Adult Trended Survey Results

Summary Rate Scores: Commercial Adult				
Composite	**2021**	**Previous Year Comparison**	**2020**	**2019**
Getting Needed Care	75.2%	↑	65.6%	72.8%
Getting Care Quickly	71.1%	↑	68.7%	70.9%
How Well Doctors Communicate	87.7%	↓	90.0%	87.6%
Customer Service	77.3%	↓	80.3%	82.8%
Rating of Health Care (8-10)	70.1%	↑	66.1%	68.2%
Rating of Personal Doctor (8-10)	77.4%	↓	77.6%	80.4%
Rating of Specialist (8-10)	82.9%	↑	80.2%	75.5%
Rating of Health Plan (8-10)	67.1%	↓	68.5%	64.5%
Coordination of Care	76.8%	↓	83.5%	83.7%

Tables below contain trended survey results for the three (3) member populations and their delegate network compared to the Alliance.

Table 29: Medi-Cal Child Trended Survey Results – Delegates

		AHS			Alliance			CFMG			CHCN			Kaiser		
	2021 Plan Total	2021	2020	Year Over Year Trend	2021	2020	Year Over Year Trend	2021	2020	Year Over Year Trend	2021	2020	Year Over Year Trend	2021	2020	Year Over Year Trend
Total Respondents	**373**	**31**			**31**			**115**			**139**			**57**		
Getting Needed Care	**82.2%**	80.0%	84.0%	↓	95.5%	59.4%	↑	71.7%	91.7%	↓	92.6%	73.7%	↑	94.2 %	89.6%	↑
Getting Care Quickly	**78.8%**	69.2%	77.1%	↓	58.3%	75.0%	↓	75.6%	87.4%	↓	86.5%	74.4%	↑	89.7 %	90.2%	↓
How Well Doctors Communicate	**93.2%**	89.7%	90.1%	↓	90.6%	83.3%	↑	95.9%	95.9%	↔	91.4%	90.3%	↑	95.0 %	96.3%	↓
Rating of Health Care (8-10)	**89.1%**	90.9%	94.1%	↓	83.3%	75.0%	↑	89.1%	95.0%	↓	86.9%	80.8%	↑	96.2 %	89.5%	↑
Rating of Personal Doctor (8-10)	**91.0%**	92.0%	100%	↓	91.3%	85.0%	↑	92.4%	96.2%	↓	86.6%	85.2%	↑	96.1 %	90.7%	↑
Rating of Specialist (8-10)	**87.2%**	75.0%	100%	↓	100%	80.0%	↑	81.0%	100%	↓	91.7%	84.2%	↑	100%	91.7%	↑
Rating of Health Plan (8-10)	**88.1%**	89.7%	90.9%	↓	83.3%	76.2%	↑	89.3%	93.8%	↓	86.8%	79.7%	↑	90.9 %	94.9%	↓
Coordination of Care	**73.8%**	66.7%	50.0%	↑	62.5%	87.5%	↓	70.0%	95.5%	↓	76.2%	73.1%	↑	88.9%	93.8%	↓

Table 30: Medi-Cal Adult Trended Survey Results – Delegates

		AHS			Alliance			CHCN			KAISER		
	2021 Total Plan	2021	2020	Year Over Year Trend	2021	2020	Year Over Year Trend	2021	2020	Year Over Year Trend	2021	2020	Year Over Year Trend
Total Respondents	**210**	48			52			71			36		
Getting Needed Care	**79.0%**	72.5%	88.3%	↓	82.3%	78.6%	↑	79.7%	82.7%	↓	80.4%	79.5%	↑
Getting Care Quickly	**72.4%**	81.3%	72.2%	↑	61.5%	79.0%	↓	62.1%	96.1%	↓	87.5%	70.3%	↑
How Well Doctors Communicate	**83.5%**	73.8%	98.1%	↓	86.6%	96.4%	↓	87.9%	95.3%	↓	80.9%	94.2%	↓
Rating of Health Care (8-10)	**73.1%**	80.0%	81.0%	↓	65.5%	95.8%	↓	72.2%	73.0%	↓	76.2%	80.0%	↓
Rating of Personal Doctor (8-10)	**81.3%**	88.2%	84.2%	↑	73.0%	73.9%	↓	80.9%	89.3%	↓	82.8%	79.2%	↑
Rating of Specialist (8-10)	**78.9%**	**87.5%**	**90.9%**	↓	**64.3%**	**76.9%**	↓	**94.7%**	**93.8%**	↑	**50.0%**	**100%**	↓
Rating of Health Plan(8-10)	**74.9%**	**76.1%**	**80.0%**	↓	**68.0%**	**80.0%**	↓	**75.4%**	**78.0%**	↓	**81.3%**	**84.0%**	↓
Coordination of Care	**83.0%**	73.3%	100%	↓	83.3%	78.6%	↑	87.5%	75.8%	↑	88.9%	90.0%	↓

Table 31: Commercial Adult Trended Survey Results – Delegated Network

		Alliance			CHCN			AHS		
	2021 Plan Total	2021	2020	Year Over Year Trend	2021	2020	Year Over Year Trend	2021	2020	Year Over Year Trend
Total Respondents	**250**	**117**			**108**			**25**		
Getting Needed Care	**75.2%**	76.2%	59.8%	↑	74.7%	72.5%	↑	72.6%	52.8%	↑
Getting Care Quickly	**71.1%**	75.2%	63.5%	↑	70.5%	73.3%	↓	56.4%	68.9%	↓
How Well Doctors Communicate	**87.7%**	93.2%	86.9%	↑	84.1%	91.7%	↓	75.0%	93.5%	↓
Rating of Health Care (8-10)	**70.1%**	73.9%	62.5%	↑	69.8%	67.4%	↑	53.3%	75.0%	↓
Rating of Personal Doctor (8-10)	**77.4%**	76.4%	72.1%	↑	79.3%	81.9%	↓	73.3%	76.2%	↓
Rating of Specialist (8-10)	**82.9%**	91.5%	74.2%	↑	73.3%	89.4%	↓	60.0%	50.0%	↑
Rating of Health Plan (8-10)	**67.1%**	72.1%	66.3%	↑	62.6%	70.8%	↓	63.6%	65.5%	↓
Care Coordination	**76.8%**	78.8%	81.6%	↓	75.6%	86.3%	↓	75.0%	75.0%	↔

CAHPS Survey Qualitative and Quantitative Analysis

The 2021 CAHPS survey results year-over-year trends show variation within the **Alliance** business lines. Across LOBs, the Medi-Cal Child population had the highest composite summary rate scores in 2021. The Medi-Cal Adult population had the highest overall decrease composite summary rate scores in six (6) of nine (9) composites.

MY 2021 – 2020 Alliance and Delegate Comparative Findings

Medi-Cal Child

AHS show that seven (7) of eight (8) composites rate scores increased.

Alliance show that six (6) of eight (8) composites rate scores increased.

CFMG show that seven (7) of the eight (8) composite rate scores decreased.

CHCN show that eight (8) of eight (8) composites rate scores increased.

Kaiser shows that four (4) of eight (8) composites rate scores decreased. However, there is a noted significant increase in Rating of Personal Doctor from 2020.

Quantitative Trends:

- No overall consistent trends noted in composite scores in 2021 compared to 2020.

Medi-Cal Adult

AHS scored lower in six (6) of eight (8) composites with a significant decrease noted in Care Coordination

Alliance scored lower in six (6) of eight (8) composites

CHCN scored lower in five (5) of eight (8) composites

Kaiser scored lower in five (5) of eight (8) composites

Quantitative Trends:

- Decrease score trends noted in composite scores in 2021 compared to 2020 for all networks in:
  - How well Doctor's Communicate
  - Rating of Health Care 8-10
  - Rating of Health Plan

Commercial Adult

AHS scores increased in seven (7) of eight (8) composites.

Alliance scores increased in seven (7) of eight (8) composites.

CHCN scored decreased in six (6) of eight (8) composites.

Quantitative Trends:

- All networks showed an increase in composite scores in 2021 compared to 2020 in:
  - Getting Needed Care

Table 32: Composite Measures

Population	Top Measures	Bottom Measures
Medi-Cal Child	Rating of Specialist	Getting Needed Care
	Customer Service	Getting Care Quickly
	Rating of Health Plan	Coordination of Care
Medi-Cal Adult	Rating of Specialist	Customer Service
	Coordination of Care	Getting Care Quickly
	Getting Needed Care	How Well Doctors Communicate
Commercial Adult	Claims Processing	Getting Care Quickly
	Rating of Health Plan	How Well Doctors Communicate
	Rating of Health Care	Customer Service

One (1) composite

- Getting Care Quickly is identified for all networks as a lower scoring composite provide providing opportunities for improvement via RCA as part of the QI Work Plan for 2022.

Table 33: Composites and Key Drivers

Composite	Key Driver
Rating of Health Plan	Customer Service Providing Information and Help
	Getting Needed Care
Rating of Health Care	Health Plan Overall Rating
	Doctors Spending Enough Time with Patients
Rating of Personal Doctor	How Well Doctors Communicate
	Getting Needed Care

Next Steps

The Alliance will continue to collaborate interdepartmentally, focusing on maintaining power in top rating measures and improving member perception of care and services ranked at the bottom of composite scores. Additionally, the Alliance will continue to partner with providers on initiatives designed to improve the member experience and survey scores in 2021-2022 using the Plan-Do-Study-Act cycle to improve or maintain Member Satisfaction scores. Commercial Adult for the Alliance shows increase in scores.

Care coordination across direct and delegate networks show an opportunity for improvement. Improvement strategies for 2022 will be a part of the QI and UM Work Plan and include but not limited to:

Inform, support, remind specialty providers about coordination of care expectations, timely notification requirements, and standards of care for post-visit follow up to all PCPs. Explore options to encourage and support communications between specialists and PCPs.

- Assess the status and consistency of coordination of patient care, communication, and information shared within and across provider networks. Assure prompt feedback, standards.

- Explore potential of aligning information flow/EHRs to better integrate, support or facilitate patient care, care coordination and vital medical and personal information among providers.

Quality Of Access

A. Standards and Provider Education

The Alliance has continued to educate providers on, monitor, and enforce the following standards:

Table 34: Primary Care Physician (PCP) Appointment

PRIMARY CARE PHYSICIAN (PCP) APPOINTMENT	
Appointment Type:	**Appointment Within:**
Non-Urgent Appointment	10 Business Days of Request
OB/GYN Pre-natal Appointment	10 Business Days of Request
Urgent Appointment that *requires* PA	96 Hours of Request
Urgent Appointment that *does not* require PA	48 Hours of Request

Table 35: Specialty/Other Appointment

SPECIALTY/OTHER APPOINTMENT	
Appointment Type:	**Appointment Within:**
Non-Urgent Appointment with a **Specialist** Physician	15 Business Days of Request
Non-Urgent Appointment with a **Behavioral Health** Provider	10 Business Days of Request
Non-Urgent Appointment with an **Ancillary Service** Provider	15 Business Days of Request
OB/GYN Pre-natal Appointment	15 Business Days of Request
Urgent Appointment that *requires* PA	96 Hours of Request
Urgent Appointment that *does not* require PA	48 Hours of Request

Table 36: All Provider Wait Time/Telephone/Language Practices

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES	
Appointment Type:	**Appointment Within:**
In-Office Wait Time	60 Minutes
Call Return Time	1 Business Day
Time to Answer Call	10 Minutes
Telephone Access – Provide coverage 24 hours a day, 7 days a week.	
Telephone Triage and Screening – Wait time not to exceed 30 minutes.	
Emergency Instructions – Ensure proper emergency instructions.	
Language Services – Provide interpreter services 24 hours a day, 7 days a week.	

*** Per DMHC and DHCS Regulations, and NCQA HP Standards and Guidelines**

PA = Prior Authorization

Urgent Care refers to services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

Non-urgent Care refers to routine appointments for non-urgent conditions.

Triage or Screening refers to the assessment of a member's health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within their scope of practice. This individual must be trained to screen or triage and determine the urgency of the member's need for care.

Each of these standards are monitored as described in the table below. In 2019, the Alliance made changes to the CG-CAHPS instrument to ensure that the collected data was consistent with the Alliance standards which remained in place during the 2020 measurement year.
Shortening or Extending Appointment Timeframes: The applicable waiting time to obtain a particular appointment may be extended if the referring or treating licensed health care Practitioner, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the Member's medical record that a longer waiting time will not have a detrimental impact on the health of the Member

Table 37: Primary Care Physician (PCP) Appointment

PRIMARY CARE PHYSICIAN (PCP) APPOINTMENT	
Appointment Type:	**Measured By:**
Non-Urgent Appointment	PAAS, CG-CAHPS
OB/GYN Pre-natal Appointment	PAAS, First Prenatal, Confirmatory Survey
Urgent Appointment that *requires* PA	PAAS, CG-CAHPS
Urgent Appointment that *does not* require PA	PAAS, CG-CAHPS

Table 38: Specialty/Other Appointment

SPECIALTY/OTHER APPOINTMENT	
Appointment Type:	**Measured By:**
Non-Urgent Appointment with a **Specialist** Physician	PAAS
Non-Urgent Appointment with a **Behavioral Health** Provider	PAAS
Non-Urgent Appointment with an **Ancillary Service** Provider	PAAS
OB/GYN Pre-natal Appointment	PAAS, First Prenatal, Confirmatory Survey
Urgent Appointment that *requires* PA	PAAS
Urgent Appointment that *does not* require PA	PAAS

Table 39: All Provider Wait Time/Telephone/Language Practices

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES	
Appointment Type:	**Measured By:**
In-Office Wait Time	CG-CAHPS
Call Return Time	CG-CAHPS
Time to Answer Call	CG-CAHPS
Telephone Access – Provide coverage 24 hours a day, 7 days a week	Confirmatory Survey
Telephone Triage and Screening – Wait time not to exceed 30 minutes	Confirmatory Survey
Emergency Instructions – Ensure proper emergency instructions	After Hours: Emergency Instructions Survey, Confirmatory Survey

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES	
Appointment Type:	**Measured By:**
Language Services – Provide interpreter services 24 hours a day, 7 days a week	CG-CAHPS

The Alliance and the QI team adopted a PDSA approach to the access standards.

- Plan: The standards were discussed and adopted, and surveys have been aligned with our adopted standards.
- Do: The surveys are administered, per our policies and procedures (P&Ps); survey methodologies, vendors, and processes are outlined in P&Ps.
- Study: Survey results along with QI recommendations are brought forward to the A&A Committee; the Committee formalizes recommendations which are forwarded to the HCQC and Board of Governors
- Act: Dependent on non-compliant providers and study / decision of the A&A Committee, actions may include, but are not limited to, provider education/re-education and outreach, focused discussions with providers and delegates, resurveying providers to assess/reassess provider compliance with timely access standard(s), issuing of corrective action plans (CAPs), and referral to the Peer Review and Credentialing Committee.

B. Provider Capacity

The Alliance reviews network capacity reports monthly to determine whether primary care providers are reaching network capacity standards of 1:2000. In 2020, no providers exceeded the 2,000 member threshold. The Network Validation department flags the provider at 1900 and above to ensure member assignment does not reach the 2,000 capacity standard. If a provider is close to the threshold, the plan reaches out to confirm if the provider intends to recruit other providers. If not, the panel is closed to new assignment. During this time, the plan and the provider are in communication of such changes.

C. Geo Access

The geographic access reports are reviewed quarterly to ensure that the plan is meeting the geographic access standards for provided services in Alameda County. For PCPs, the Alliance has adopted standards of one provider within 30 minutes / 15 miles. For specialists, the Alliance has adopted standards of one provider within 30 minutes / 15 miles. During 2021, the Alliance continued its cross functional quarterly meeting to review access issues and concerns.

In 2021, the rural areas near Livermore were the only areas in which the plan faced geographic access issues for Primary Care Provider (PCP) services. Although, there were some deficiencies in the Livermore area for PCP services for distance, the Alliance was able to demonstrate

compliance in meeting "time" regulatory standards. The Alliance has received DHCS approval to their request for alternative access for certain Pediatric specialist.

D. Provider Appointment Availability Survey (PAAS)

The Alliance's annual Provider Appointment Availability Survey (PAAS) for MY2021 was used to review appointment wait times for the following provider types:

- Primary Care Physicians (PCPs)
- Specialist Physicians (SPCs):
  - Cardiovascular Disease
  - Endocrinology
  - Gastroenterology
- Non-Physician Mental Health (NPMH) Providers (PhD-level and Masters-level)
- Ancillary Services Providers offering Mammogram and/or Physical Therapy
- Psychiatrists

The Alliance reviewed the results of its annual PAAS for MY2021 to identify areas of deficiency and areas for potential improvement. The Alliance defines *deficiency* as a provider group scoring less than a seventy-five percent (75%) compliance rate on any survey question related to appointment wait times.

The Alliance analyzed results for Alameda County, as the majority of members live and receive care in Alameda County, the Alliance's service area. Additionally, per the MY2019 DMHC PAAS Methodology, the Alliance reported compliance rates for all counties in which its contracted providers were located, regardless of whether the providers were located outside the Alliance's service area. This included provider groups in the following counties – Contra Costa, San Joaquin, Sacramento, San Francisco, Santa Clara, San Jose, Solano, Marin, Madera, Monterey, San Mateo, Santa Cruz, San Luis Obispo, Santa Barbara, and Sonoma.

Table 40: MY 2021 Compliance Rates by Appointment Type across All Provider Types

Ancillary		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	Not applicable	94%
MCL	Not applicable	94%
PCPs		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	78.5%	84.9%
MCL	78.9%	87.8%
NPMH		

LOB	Urgent Appt	Routine Appt
IHSS	81.4%	85.6%
MCL	73.1%	77.7%
Psychiatrists		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	63.2%	82.5%
MCL	58.6%	80.5%
Specialists		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	46.0%	56.5%
MCL	45.6%	56.0%

Across all provider types, there was greater compliance with the routine appointment standards than with the urgent appointment standard, and this was evidenced for both LOBs – MCL and

IHSS for 2019, 2020, and 2021. As a result of COVID-19 PHE office visits (face-to-face and telehealth) dramatically declined. The Alliance will continue engaging in provider/delegate re-education around the timely access standards, to increase its efforts around compliance with the urgent appointment standard through the following ways:

- Dissemination of provider communications (written and posted) emphasizing the urgent appointment standards.
- Reinforcement of the urgent appointment standards by Provider Services within their interactions with providers; and
- Targeted discussions with leadership staff during Joint Operations Meetings between the Alliance and its delegate leadership.

Table 41: Percentage of Ineligible Provider Types

MY	Psychiatrists	PCPs	Specialists	Ancillary	NPMH
2021	40%	26%	34%	31%	21%
2020	41%	17%	29%	36%	18%

Across all provider types, Psychiatrists had the highest percentage of ineligible providers, followed by Ancillary providers, Specialists, and NPMH, with PCPs providers having the lowest percentage of ineligible providers. Results of the MY2020 PAAS also show Psychiatrists as having the highest percentage of ineligible providers. Psychiatrists, and Ancillary providers showed a decrease in percentage of ineligible providers from MY2020 to MY2021. While PCPs, Specialists, and NPMH providers show an increase in eligible providers. The Alliance will ensure continued

collaboration with its Analytics and Provider Services Teams, as well as with its delegate networks, to enhance accuracy of provider contact information, provider specialty, provider network status, and/or provider appointment availability, with the goal of increasing the overall percentage of ineligible providers to 75%.

Table 42: Percentage of Non-Responsive Provider Types

MY	Psychiatrists	PCPs	Specialists	Ancillary	NPMH
2021	19%	8%	30%	19%	27%
2020	30%	6%	33%	12%	28%

Across all provider types, Specialists had the highest percentage of non-responsive providers, followed by NPMH providers, Psychiatrists and Ancillary and providers, with PCPs having the lowest percentages of non-responsive providers in MY 2021(see table above). The Alliance will increase its level of provider/delegate education around survey completion and purpose, including a focus on the development of provider/delegate improvement plans, with the overall goal of lessening and/or removing barriers for non-responsiveness. These efforts will include a focus on Specialists, given they had the highest level of survey non-responsiveness across provider types year-on-year.

E. Year-Over-Year Analysis

All provider types did not show improvement in compliance rates in either appointment types for both LOBs. Specialist providers showed the biggest decrease in compliance rates for both appointment standards for both LOBs, followed by Psychiatrists and NPMH providers.

Alameda Health System

For the PCP provider type, Alameda Health System again fell short of the compliance threshold for both appointment standards for both LOBs, although they made substantial progress in their rate of compliance with routine appointments from the previous year.

CFMG

For the PCP provider type, CFMG providers maintained a stable rate of compliance with both appointment standards for LOBs. For the Specialist provider types, CFMG providers showed a significant decrease in compliance for both appointment standards for cardiology appointments. However, CFMG providers demonstrated zero compliance with endocrinology and gastroenterology appointments, providing opportunity for improvements.

CHCN

For the PCP and Ancillary provider types, CHCN providers has continued to demonstrate best practice with 100% compliance with both appointment standards for both LOBs. For Specialist provider types, CHCN providers demonstrated a slight increase and decrease in their rates of compliance with both cardiology appointments for MCL and IHSS LOBs, respectively. For endocrinology appointments, CHCN providers showed a significant decrease to zero rates of compliance for both appointment standards for both LOBs. For gastroenterology appointments, CHCN providers demonstrated some improvements with urgent appointments, however, they showed a significant decrease in compliance with routine appointments, providing opportunity for improvements.

ICP

For the PCP provider type, ICPs showed a decrease in compliance with urgent appointments but maintained 100% compliance with routines appointments for both LOBs. For cardiology and gastroenterology, ICPs demonstrated best practice by maintaining 100% compliance with both appointment standards for both LOBs. ICPs maintained 100% compliance with urgent appointments for IHSS LOB. However, ICPs showed a significant decrease in routine appointments for both LOBs and MCL urgent appointment. This represents a significant negative change from their previous year's improvements. For the Adult NPMH provider type, ICPs showed overall decrease in compliance for both appointment standards for both LOBs, anther negative change from their previous year's improvements.

F. Provider-Focused Improvement Activities

As part of the Quality Improvement strategy for 2022, the Alliance will continue its ongoing re-education of providers/delegates regarding timely access standards via various methods (e.g., quarterly provider packets, fax blasts, postings on the Alliance website, targeted outreach to providers/delegates, and in-office provider visits as appropriate), with the goal of increasing individual response and compliance rates to ≥ 75%. Additionally, by the end of Q2 2022 the Alliance A&A unit will conduct focused scheduled and confirmatory surveys/audits that assess provider compliance with timely access standards. Time-sensitive corrective action plans (CAPs) will be issued to all non-responsive and non-compliant providers. Results and corrective actions needed for improvement will be discussed with delegate leadership staff during Joint Operations Meetings between the Alliance and its delegate. The Alliance will review other survey result indicators of access and availability to identify both best practice and opportunities for improvement throughout the year for performance improvement activities.

For PAAS MY2021 all non-compliant PCPs, Specialists, NPMH providers, Ancillary providers, and Psychiatrists receive notification of their survey results and the timely access standards in which they were deficient, along with time-sensitive CAPs. All non-responsive PCPs, Specialists, NPMH providers, Ancillary providers, and Psychiatrists receive notification of their non-responsiveness reminding them of the requirement to respond to timely access surveys, along with the timely

access standards and time-sensitive CAPs.

The Alliance will share findings from the MY2021 PAAS at the Q2 2022 Access and Availability Sub-Committee for feedback and recommendations, as well as, in the Q3 Health Care Quality Committee (HCQC), which is comprised of Chief Officer leadership from delegated networks, offering additional opportunities for discussion of best practice and improvement opportunities.

G. After Hours Survey

The Alliance contracted with SPH Analytics (SPH) to conduct the annual Provider After-Hours Survey for MY2021, which measures providers' compliance with the after-hours emergency instructions standard. The MY2021 After-Hours Survey was conducted from September to October2021. SPH followed a phone-only protocol to administer the survey to the eligible provider population during closed office hours. A total of 451 Alliance providers and/or their staff were surveyed, and included 82 primary care physicians (PCPs), 222 specialists, and 147 behavioral health (BH) providers. The survey assesses for the presence of instructions for a caller with an emergency situation, either via a recording or auto-attendant, or a live person.

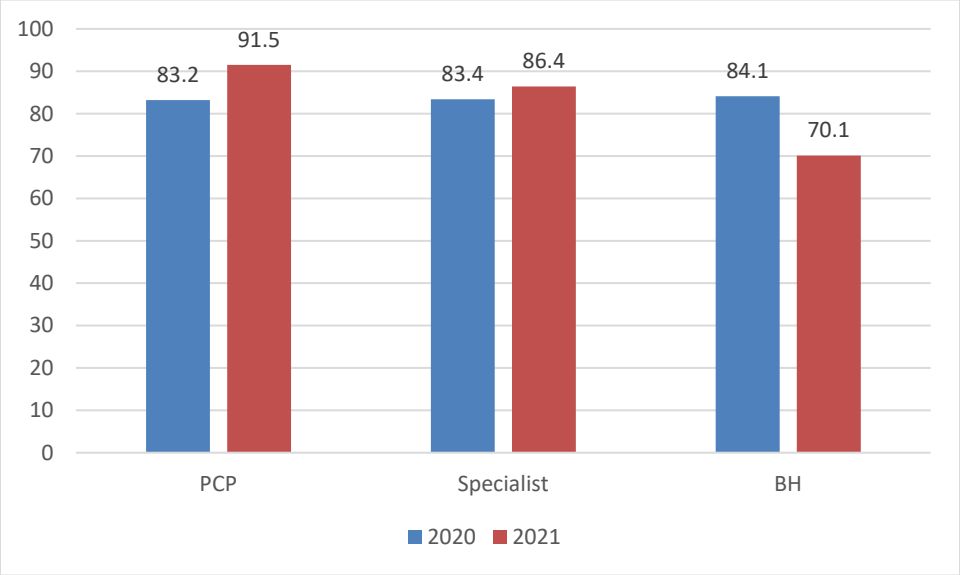
The table below presents the compliance rates for the providers surveyed in the After-Hours Survey:

Table 43: Compliance Rates for After Hours Survey

	Emergency Instructions		
Provider Type	**Total Compliant**	**Total Non-Compliant**	**Compliance Rate**
PCP	75	7	91.5%
Specialist	192	30	86.4%
BH	103	44	70.1%
Total	**370**	**81**	

A total of 58 providers (7 PCPs, 30 Specialists,44 BH) were found to be non-compliant with the emergency instructions standard as a result of the After-Hours Survey. BH providers had the highest non-compliance rate in 2021 up from 7 in 2020followed by Specialists, then PCP providers.

Table 44: After Hours Emergency Instruction and Access to Physician Compliance Rate Comparison (2020 v 2021)



The figure below presents the response rate across provider types:

Table 45: Response Rate by Provider Type

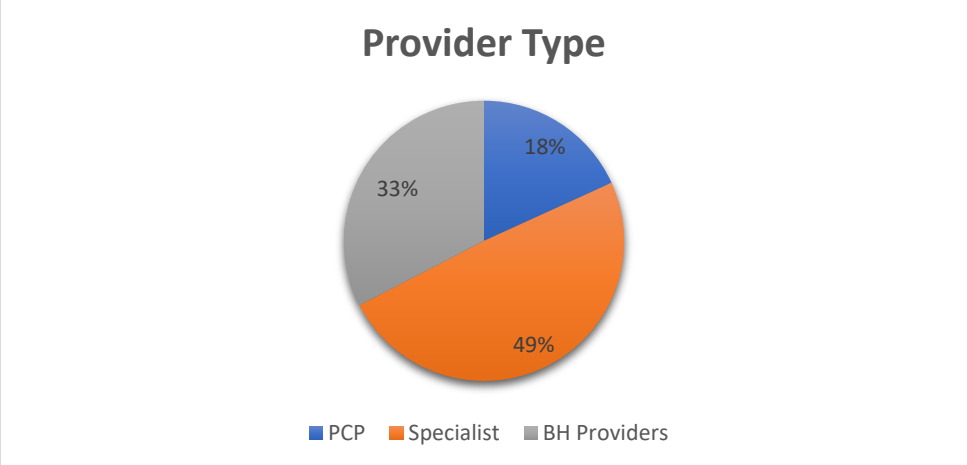


Table 46: After Hours Emergency Instruction and Access to Provider Survey Response Rate Comparison (2020 v 2021)

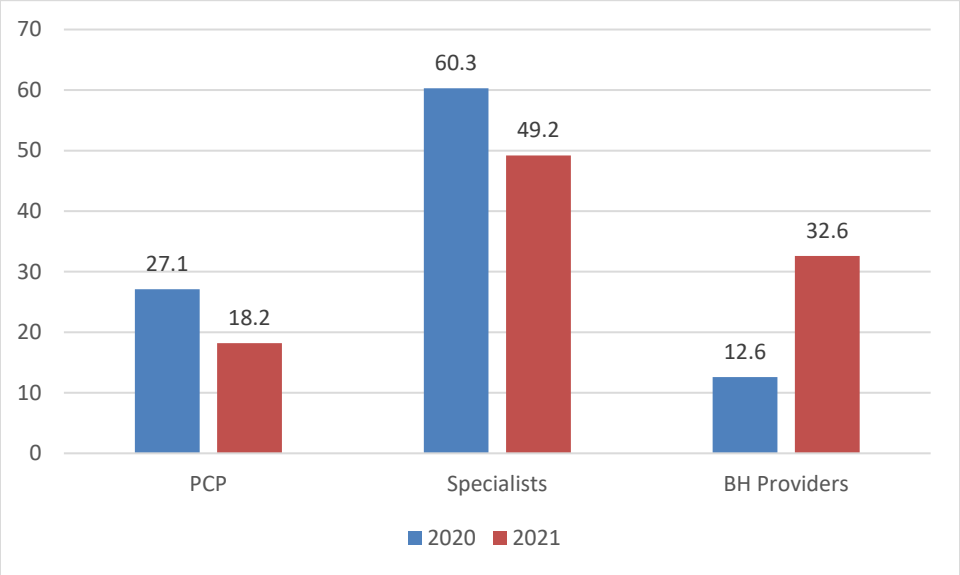
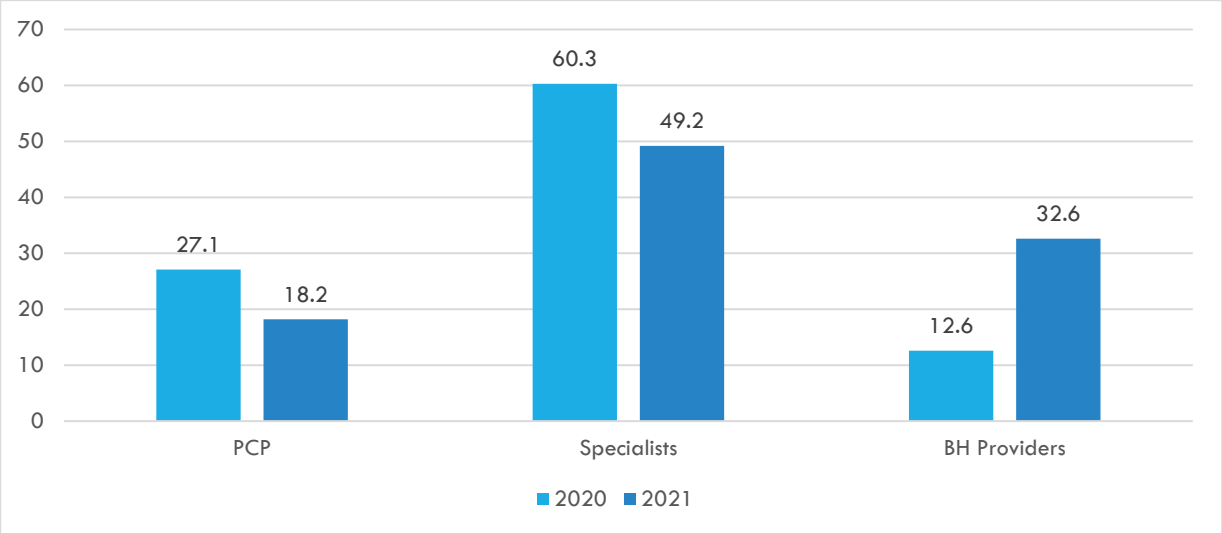


Table 47: 2020 After Hours Emergency Response Rates for 2021 when compared to 2020



- Number of survey respondents in 2020 = 350
- Number of survey respondents in 2021 = 451
- Year-over-Year Specialist providers have had the highest response rate to the survey
- BH providers response rate increased in 2021 from 2020 by 20%
- PCPs and Specialist providers response rates in 2021 decreased from 2020 by 8.9% and 11.1% respectively.

COVID-19 PHE appears to have had a negative impact on After Hours Emergency Instruction compliance for both PCPs and Specialists. Results of survey were presented at Q1 Access and Availability Committee with the following next steps for improvement:

- Share results with Delegate and Direct entities
- Share results with Provider Services and FSR staff to incorporate as part of provider and office staff education for identification of barriers and improvement opportunities.
- CAPs to be sent to non-compliant providers
  - CAPs are issued at the delegate level
  - CAPs are issued at the direct provider level

H. First Prenatal Visit Survey

The Alliance conducted the annual First Prenatal Visit Survey for MY2021, which measures providers' compliance with the first prenatal visit standard. The survey was conducted in September – November of 2021 and was administered to a random sample of eligible Alliance Obstetrics and Gynecology (OB/GYN) providers. The table below shows results of the survey.

Table 48: First Prenatal Visit Survey

Appointment Within 2 Weeks	75% Target Goal Met	Percent of Ineligibles	Precent of Non-Responsive
73.2%	No	44.4%	18.8%

The First Prenatal Visit 2021 survey results shows a compliance rate is 4.3% percentage points higher than the 2020 (68.9%) compliance rate, although the goal of 75% was not met. Corrective Action Plans (CAPs) will be issued to all non-responding and non-compliant providers within Q2 2022.

Plans (CAPs) will be issued to all non-responding and non-compliant providers within Q2 2022. Additionally, the Alliance's QI Department will continue: 1) between survey monitoring of First Prenatal Visit compliance via Quality of Access PQIs 2) ongoing provider education and discussions at delegate Joint Operations Meetings (JOMs) regarding timely access standards; 3) collaboration with Analytics, Provider Services, and delegate networks to improve the accuracy of provider data, thus decreasing the number of ineligible providers.

I. Oncology Survey

The Alliance conducted the annual Oncology Survey for MY2021, which measures providers' compliance with the urgent and non-urgent appointment standards for specialists. The survey was conducted from September – November of 2021 and was administered to a random sample of eligible Alliance oncology providers. The table below shows results of the survey.

Table 49: Oncology Survey

Urgent Appt	75% Target Goal Met	Non-Urgent Appt	75% Target Goal Met	Percent of Ineligibles	Percent of Non-Responsive
84.2%	Yes	78.9%	Yes	32.8%	34.4%

In 2021 the compliance rate for non-urgent appointments decreased from 90% in 2020 by 11.1 percentage points, as did the compliance rate for urgent appointments by 2.5 percentage points in 2020 down from 86.7%. Time-sensitive corrective action plans (CAPs) will be issued to all non-responding and non-compliant providers within Q2 2022. Additionally, the Alliance's QI Department will:

1) its ongoing provider education and discussions at delegate Joint Operations Meetings (JOMs) regarding timely access standards

2) collaboration with Analytics, Provider Services, and delegate networks to improve the accuracy of provider data, thus decreasing the number of ineligible providers.

J. CG-CAHPS SURVEY

The Alliance contracted with SPH Analytics (SPH) to conduct its quarterly Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey within 2021, which measures member perception of and experience with three timely access standards: in-office wait time; call return time; and time to answer call. The CG-CAHPS survey was fielded in Q1, Q2, Q3, Q4 of 2021. In 2019 the Alliance was given approval by DHCS to modified the CG-CAHPS survey. Per approval from DHCS, the in-office wait time standard changed from within 30 minutes to within 60 minutes. Also, the call return time standard changed from within 30 minutes

to within one business day. The time to answer call standard remained the same (within 10 minutes). SPH followed a mixed methodology of mail and phone to administer the survey to a randomized selection of eligible members who had accessed care with their PCP within the previous six months.

The table below presents the compliance rates across the three metrics for the CG-CAHPS surveys that were conducted in 2021 within each quarter.

Table 50: CG-CAHPS Survey Results 2021

Metric	Compliance Goal	Q1 2021	Q2 2021	Q3 2021	Q4 2021
In-Office Wait Time (Within 60 minutes)	80%	92.4%	91.7%	92.7%	91.8%
Call Return Time (Within 1 Business Day)	80%	76.2%	76.6%	75.9%	82.2%
Time To Answer Call (Within 10 minutes)	80%	78.5%	77.7%	71.1%	75.0%

The target compliance goal for each of the three metrics is 80%. In-office Wait Time compliance goals were met throughout 2021. Call Return Time and Time to Answer Call compliance rates trended slightly below the compliance goal of 80% ranging from 75.9% - 82.2% and 71.1% - 78.5%.

Possible Barriers:	• **6 month delay in survey fielding from date of encounter. Results are based on *member's perception* of encounter experience.** • **Survey conducted on member encounter experience during the COVID-19 PHE provider office operations restructuring.**
Next Action Steps:	• Track and Trend compliance rates • Continue to follow escalation process for providers non-compliance with CG-CAHPS: o 1Q: Track & trend o 2Qs: Letter/JOM discussion o 3Qs: CAP/Discussion with COO/CFO • Share results with Provider Services department, FSR staff, to incorporate as part of Member & Provider Satisfaction work group discussions and PDSA/Intervention planning as applicable. • Share results with delegate groups and discuss improvement strategies

	• Outreach to other HP to solicit compliance rates for comparison • Consider validity/reset of our compliance goal of 80% based on findings

Provider Satisfaction Survey Overview

The Alliance contracted with its NCQA certified vendor, SPH, to conduct a Provider Satisfaction Survey for measurement year 2021. Information obtained from these surveys allows plans to measure how well they are meeting their providers' expectations and needs. The Alliance provided SPH with a database of Primary Care Physicians (PCPs), Specialists (SPCs) and Behavioral Health (BH) providers who were part of the Alliance network. Duplicate provider names or NPIs were removed from the databased prior to submitting to survey vendor. From the database of unique providers, a sample of 815 records was drawn. A total of 114 surveys were completed between September - December 2021 (71 mail, 26 internet, 17 phone).

The table below contains the survey response rates, survey respondents, and role of survey respondents for 2021 compared to 2020.

Table 51: Survey Response Rates: 2021 vs. 2020

	Mail/Internet	Phone
2021	12%	2%
2020	15%	8%

Table 52: Survey Respondents 2021 vs. 2020

	PCPs	BH Providers	SPCs
2021	51.3%	10%	38.8%
2020	32.9%	19.3%	56.0%

Year to Year Trend Comparisons

The table below contains the trended survey results across composites.

Table 53: Trended Survey Results Across Composites

Summary Rate Scores					
Composite / Attribute	**MY 2021**	**Variance Compared to Previous Year**	**Variance Compared to SPH Commercial Benchmark BoB**	**2020**	**2019**
Overall Satisfaction with the Alliance	**77.3%**	Lower	Higher	85.0 %	67.8%
All Other Plans (Comparative Rating)	**50.0%**	Lower	Significantly Higher	55.6 %	43.8%
Finance Issues	**44.5%**	Stable	Higher	45.0%	36.2%
Utilization and Quality Management	**45.3%**	Lower	Significantly Higher	50.9%	48.2%
Network Coord. of Care	**37.6%**	Lower	Higher	39.1%	36.6%
Pharmacy	**35.1%**	Higher	Higher	33.0%	34.1%
Health Plan Call	**54.0%**	Stable	Significantly Higher	53.9%	44.5%
Provider Relations	**63.5%**	Higher	Significantly Higher	61.5%	57.3%

The Alliance identified significant higher composite scores in 4 of 8 composites in 2021 compared to 8 of 8 composite scores being significantly higher in 2020.

SPH Alliance POWER List:

Promote and Leverage Strengths (Top 5 Listed)

1. Overall satisfaction with the Alliance call center
2. Ease of reaching the Alliance staff over the phone
3. Helpfulness of call center staff in assisting with the referral process or referral network
4. Ability to speak with an Alliance medical director about a prior authorization
5. Variety of different formulary options

Best Practice

Below are the performance results for the past three years, for provider care coordination. AAH has exceeded the SPH Aggregate BoB value all three years. For 2022 the Alliance will consider establishing an improvement goal that is > 35% as a push goal

The timeliness of feedback/reports from specialists in the health plan's provider network	Numerator: No. ranking in top two box scores	Denominator: No. of question respondents	Rate	Performance Goal	Goal Met? (Y/N)
Measurement Y1 2019	40	120	33.3%	26.5%	Y
Measurement Y2 2020	48	124	38.7%	29.0%	Y
Measurement Y3 2021	30	86	34.9%	29.9%	Y

Next Steps: Establish a cross functional workgroup will study opportunities within SHP POWER listing to promote and leverage identified strengths for ongoing improvements using the PDSA process.

Cultural and Linguistic Needs Of Members

The Alliance QI Department conducts a quarterly review of the Alliance membership's cultural and linguistic makeup as well as the provider network with respect to member accessibility. The assessment is meant to enhance the Alliance's ability to provide access to high quality, culturally appropriate healthcare to our members and focuses on the following areas:

- Cultural and Linguistic needs of members
- Provision of interpreter services
- PCP language capacity

The Alliance strives to ensure members have access to a PCP who can speak their language or to appropriate interpreters. For members who have not chosen a PCP upon enrollment, the Alliance will assign a member to a PCP based on characteristics, including language. In 2021, the Alliance identified the following threshold languages.

Table 54: 2021 Threshold Languages

Total by Plan	Threshold Languages		
Medi-Cal **291,257**	English	182,678	62.72%
	Spanish	58,154	19.97%
	Chinese	26,257	9.02%
	Vietnamese	8,531	2.93%
	Tagalog	1,870	0.64%

Total by Plan	Threshold Languages		
Group Care **5,824**	English	3,465	59.50%
	Chinese	1,390	23.87%
	Spanish	281	4.82%

Source: Alliance Monthly Membership Report December 2021

Table 55: Member Ethnicity – Medi-Cal

MEDI-CAL	Prior Year	YTD	% Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY ETHNICITY	Jan - Dec 2020	Jan - Dec 2021	% YTD Membership in Jan - Dec 2021 (minus) % of Membership in Jan - Dec 2020	Dec 2021	Dec 2021 %
Hispanic (Latino)	27.80%	28.00%	0.19%	81,788	28.08%
Other	20.69%	21.81%	1.12%	64,535	22.16%
Black (African American)	16.88%	16.12%	-0.76%	46,317	15.90%
Chinese	10.49%	10.19%	-0.31%	29,394	10.09%
White	9.12%	9.10%	-0.01%	26,389	9.06%
Other Asian / Pacific Islander	7.38%	7.20%	-0.18%	20,701	7.11%
Vietnamese	4.09%	3.89%	-0.20%	11,081	3.80%
Filipino	2.78%	2.89%	0.11%	8,461	2.90%
Unknown	0.55%	0.59%	0.04%	1,966	0.68%
American Indian Or Alaskan Native	0.22%	0.21%	-0.00%	625	0.21%
Total Members				**291,257**	

Source: Alliance Monthly Membership Report December 2021

Medi-Cal Ethnicity Discussion: 2021 saw an overall increase in membership, but only slight changes in ethnicities as a percent of the Medi-Cal membership with the greatest increase in “Other” ethnicity. Hispanic (Latino) members make up almost 30%, all Asian members combined make up almost 25%, and Black (African American) members 16% of Medi-Cal membership.

Table 56: Member Ethnicity – Group Care

GROUP CARE	Prior Year	YTD	% Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY ETHNICITY	Jan - Dec 2020	Jan - Dec 2021	% YTD Membership in Jan - Dec 2021 (minus) % of Membership in Jan - Dec 2020	Dec 2021	Dec 2021 %
Other Asian / Pacific Islander	27.35%	29.47%	2.12%	1,765	30.31%
Unknown	30.28%	28.52%	-1.76%	1,613	27.70%
Chinese	13.21%	13.26%	0.04%	785	13.48%
Black (African American)	11.33%	11.11%	-0.22%	643	11.04%
Other	7.93%	7.60%	-0.34%	451	7.74%
Hispanic (Latino)	3.66%	3.80%	0.15%	215	3.69%
Vietnamese	3.03%	3.02%	-0.00%	177	3.04%
White	2.09%	1.99%	-0.10%	107	1.84%
Filipino	1.00%	1.11%	0.11%	62	1.06%
American Indian Or Alaskan Native	0.11%	0.11%	-0.00%	6	0.10%
Total Members				**5,824**	

Source: Alliance Monthly Membership Report December 2021

Group Care Ethnicity Discussion: The largest group who identified their ethnicity was the Other Asian/Pacific Islander, representing over 30% of the Group Care membership. These are mostly Asian Indian (27.47% of Group Care membership). The percent of Group Care members with unknown ethnicity continues to decline, although still higher than desired.

Table 57: Member Languages Spoken – Medi-Cal

MEDI-CAL	Prior Year	YTD	% Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY LANGUAGE	Jan - Dec 2020	Jan - Dec 2021	% YTD Membership in Jan - Dec 2021 (minus) % of Membership in Jan - Dec 2020	Dec 2021	Dec 2021 %
English	61.89%	62.65%	0.76%	182,678	62.72%
Spanish	19.68%	19.84%	0.16%	58,154	19.97%
Chinese	9.56%	9.12%	-0.45%	26,257	9.02%
Vietnamese	3.21%	3.01%	-0.20%	8,531	2.93%
Unknown	2.60%	2.47%	-0.13%	7,235	2.48%
Other Non-English	2.39%	2.26%	-0.12%	6,532	2.24%
Tagalog	0.67%	0.65%	-0.02%	1,870	0.64%
Total Members				**291,257**	

Source: Alliance Monthly Membership Report December 2021

Medi-Cal Language Discussion: Medi-Cal members are approximately 63% English-speaking, 20% Spanish-speaking, 9% Chinese-speaking, and 3% Vietnamese-speaking. Less than 1% speak Tagalog. There are no significant changes from last year.

Table 58: Member Languages Spoken – Group Care

GROUP CARE	Prior Year	YTD	% Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY LANGUAGE	Jan - Dec 2020	Jan - Dec 2021	% YTD Membership in Jan - Dec 2021 (minus) % of Membership in Jan - Dec 2020	Dec 2021	Dec 2021 %
English	59.80%	59.66%	-0.14%	3,465	59.50%
Chinese	23.50%	23.60%	0.10%	1,390	23.87%
Spanish	4.92%	4.81%	-0.11%	281	4.82%
Other Non-English	4.05%	4.11%	0.06%	234	4.02%
Vietnamese	3.71%	3.70%	-0.02%	216	3.71%
Unknown	3.58%	3.60%	0.02%	209	3.59%
Tagalog	0.43%	0.52%	0.09%	29	0.50%
Total Members				**5,824**	

Source: Alliance Monthly Membership Report December 2021

Group Care Language Discussion: Group Care members continue to speak predominately English (60%), followed by Chinese (almost 25%) and Spanish-speaking (5%).

A. Practitioner Language Capacity

During 2021, the Alliance's Provider Relations staff conducted in-person surveys during provider office visits to verify languages spoken by providers. The chart below is a comparison of identified languages spoken by the Plan's members to its provider network at the end of Quarter 4 2021.

Table 59: Medi-Cal Provider Network vs. Members Comparison of Identified Languages

	2020Q4			2021 Q4			Change			
Language	PCPs	Members	Members per PCP	PCPs	Members	Members per PCP	# PCPs	% PCPs	# Members	% Members
English	519	137,496	264	648	148,043	228	129	25%	10,547	8%
Spanish	121	48,715	402	139	52,449	377	18	15%	3,734	8%
Chinese	68	23,110	339	81	23,774	293	13	19%	664	3%
Vietnamese	16	8,088	505	18	8,125	451	2	13%	37	0%
Tagalog*	N/A	N/A	N/A	16	1,680	105	N/A	N/A	N/A	N/A
Arabic	6	2,203	367	6	2,257	376	0	0%	54	2%
Farsi	6	1,498	249	6	1,544	257	0	0%	46	3%
Total**	**910**	**231,656**		**1,094**	**246,684**		184	20%	15,028	6%

Source: Q4 2020 and Q4 2021 Provider Language Access Reports

*Tagalog was not tracked in 2020.
**Total also includes unknown and other languages. A number of PCPs do not have a primary language designated in the data we receive. Also, multilingual providers are counted for each language they speak. Kaiser members are not included.

Table 60: Medi-Cal PCPs & Members by Language

	2020Q4	2021Q4	Change
Language	Members per PCP	Members per PCP	Difference
English	264	228	Improvement ↓36
Spanish	402	377	Improvement ↓25
Chinese	339	293	Improvement ↓46
Vietnamese	505	451	Improvement ↓54
Tagalog	N/A	105	N/A
Arabic	367	376	Decline ↑9
Farsi	249	257	Decline ↑8

Source: Q4 2020 and Q4 2021 Provider Language Access Reports

In 2021 the Plan experienced overall slight improvements in Medi-Cal members per PCP for threshold languages due to an increase in the number of PCPs.

Table 61: Group Care Provider Network vs. Members Comparison of Identified Languages

	2020 Q4			2021 Q4			Change			
Language	PCPs	Members	Members per PCP	PCPs	Members	Members per PCP	# PCPs	% PCPs	# Members	% Members
English	402	3,545	8	526	3,465	6	124	31%	-80	-2%
Chinese	60	1,383	23	72	1,391	19	12	20%	8	1%
Spanish	93	295	3	110	283	2	17	18%	-12	-4%
Vietnamese	14	215	15	16	216	13	2	14%	1	0%
Tagalog*	N/A	N/A	N/A	15	29	1	N/A	N/A	N/A	N/A
Arabic	6	9	1	6	6	1	0	0%	-3	-33%
Farsi	5	98	19	5	92	18	0	0%	-6	-6%
Total**	**722**	**5,953**		**896**	**5,823**		174	24%	-130	-2%

Source: Q4 2020 and Q4 2021 Provider Language Access Reports

Table 62: Group Care PCPs & Members by Language

	2020Q4	2021Q4	Change
Language	Members per PCP	Members per PCP	Difference
English	8	6	Improvement ↓ 2
Chinese	23	19	Improvement ↓ 4
Spanish	3	2	Improvement ↓ 1
Vietnamese	15	13	Improvement ↓ 2
Tagalog	N/A	1	N/A
Arabic	1	1	No change
Farsi	19	18	Improvement ↓ 1

Source: Q4 2020 and Q4 2021 Provider Language Access Reports

Group Care members, while being a significantly smaller population, have access to most of our extensive Medi-Cal network of providers. As a result, all languages have at least 1 PCP per 19 members.

In addition, the Alliance continues to monitor provider language capacity levels and trends quarterly though the following:

- Review of grievances related to provider language capacity
- Monitoring of interpreter services provided

In the absence of a practitioner who speaks a member's preferred language, the Alliance ensures the provision of interpreter services at the time of appointment. In 2021, the Alliance provided almost 50,000 interpreter services. The interpreter services delivery mode in 2021 was approximately 50% pre-scheduled phone or video, 38% telephonic, and 11% in-person. The fulfillment rate for interpreter services was 99%.

Analysis Of 2021 Quality Program Evaluation and Effectiveness

The Alliance has identified the challenges and barriers to improvement throughout the 2021 QI Evaluation measurement year. Both challenges and achievements helped to inform our 2021 QI Work Plan. The COVID-19 pandemic and PHE brought unexpectant challenges that impacted our members, provider partners and staff. 2021 brought an abundance of opportunities for improvement in ensuring that our members have high quality, safe, timely, effective, efficient, equitable, patient centered care. Recommended activities and interventions for the upcoming year consider these challenges and barriers in working toward success and achievement of the Alliance's goals in 2022.

Challenges and barriers to achieving objectives encountered within the 2021 program year included but are not limited to:

- COVID-19 pandemic and PHE shelter in place resulted in multiple quality initiatives and activities paused due to PHE
- COVID-19 changes to interpreter needs from in-person to telephonic and video.
- COVID-19 caused IHA Audits to be impacted because of a delay in provider responses to medical record requests.
- Because of COVID-19, all Facility Site Reviews were halted until further notice.
- Drop in health education program participation due to pandemic and move to virtual formats for classes.
- HEDIS measurement results impeded deployment of optimal strategic rapid cycle PDSA implementation for quality improvement activities
- Member Services call center "call abandonment" rate negatively impacted by staffing challenges
- QI leadership staffing challenges in hiring a qualified Access to Care Manager

Program major accomplishments with objectives met for 2021 include but are not limited to:

- Adequate QI program resources to carry out roles, functions, and responsibilities
- A consistent and stable QI committee and program structure
- Successful administration of all timely access surveys within the expected timeframes, allowing for timely analysis and implementation of next steps with providers and within the Alliance

- Maintenance of favorable Provider Satisfaction Survey scores
- HCQC meetings held 6 times within 2021 and remains active in ensuring requirements of the QI Program were met despite PHE
- Stable and consistent Senior Level Physician involvement and Appropriate External and Internal Leadership
- Improved HEDIS performance rates for measures; above the MPL for all accountable HEDIS metrics
- Deployment of a Pediatric Care Management Program to promote access to care and EPSDT service utilization in partnership with direct, delegate, and CBOs.
- Improved turn-around times and root cause analysis of PQIs
- Robust Health Education and Cultural and Linguistic Programs adding Quality of Care (QOL) PQIs segmentation for tracking and trending
- Ongoing Member Advisory Committee and member input via virtual formats to ensure continued member input into programs and services.

- Updated grievance tracking system for capturing exempt grievances and accurate reporting and PQI referral submission to Quality department
- Comprehensive monitoring of all practitioners during credentialing / re-credentialing to ensure high quality network.