Alameda Alliance for Health

Population Health Management (PHM)

2024 Strategy

For Medi-Cal and Group Care lines of business

Presented to the Quality Improvement and Health Equity Committee
on 5/17/2024

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Overview

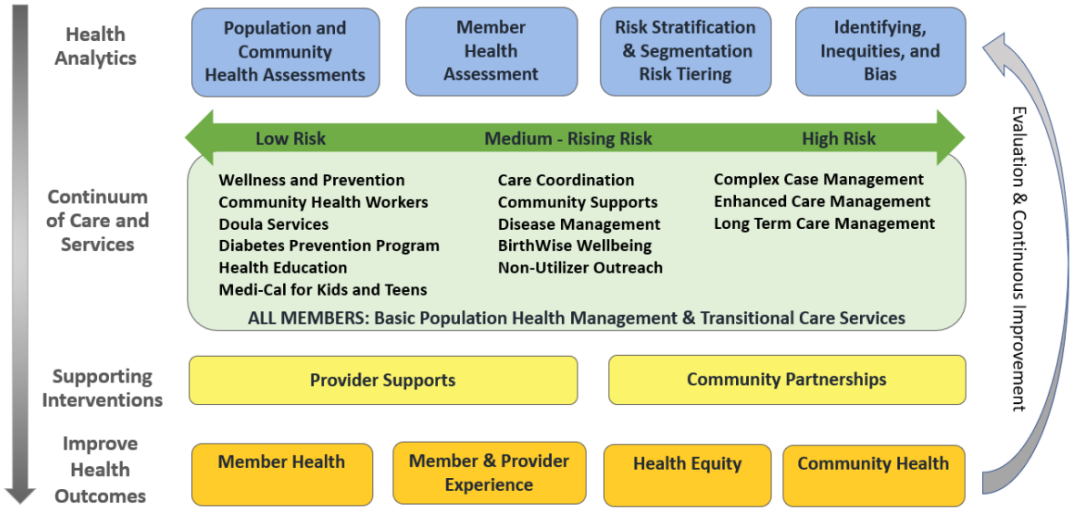
Alameda Alliance for Health (Alliance) is a local, public, not-for-profit managed care health plan committed to improving the health and well-being of our members by collaborating with our provider and community partners to deliver high quality and accessible services. Our vision is that all residents of Alameda County will achieve optimal health and well-being at every stage of life.

The Alliance has two lines of business, Medi-Cal and Group Care. Medi-Cal is California's Medicaid program for children and adults who meet income guidelines. Alliance Group Care is an employer sponsored plan that provides low-cost comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County.

The Alliance Population Health Management (PHM) Strategy identifies and addresses member needs across the continuum of care and ensures access to a comprehensive set of services with the aim of improving health and supporting enhanced quality of life. This continuum includes intensive case management support for members with the highest level of need, programs for those with emerging risk, and basic population health management and transitional care services for all members.

The Alliance Population Health Management Framework visually represents the steps taken to improve health outcomes for members, starting with health analytics, offering of services across the continuum of care, supporting provider and community interventions, and evaluation and continuous improvement. Our understanding of how social determinants of health and health inequities influence health outcomes is woven throughout our population health management activities.

Alliance Population Health Management Framework



Addressing social determinants of health to promote health equity.

The Alliance PHM Strategy aligns with the NCQA 2024 Population Health Program Standards and Guidelines and the California Department of Health Care Services (DHCS) Population Health Management Policy Guide. The PHM Strategy is updated yearly based on an annual population assessment and outcomes from the previous year.

The PHM Strategy identifies program goals and target populations and describes programs or services offered to members, activities that are not direct member interventions, how member programs are coordinated, and how members are informed about available programs.

The PHM Strategy is used to:

- Better understand the needs, social determinants of health, and risk level of our members.
- Address and reduce identified health inequities.
- Improve care management programs including Complex Case Management (CCM), Enhanced Care Management (ECM), Community Supports (CS), and Transitional Care Services (TCS).
- Inform quality improvement projects.
- Influence interventions that target member safety and outcomes across settings.
- Develop basic population health management activities to ensure care coordination and promote self-management of conditions and preventive care.
- Guide development of health education, disease management, and wellness and prevention programs and materials.

The Population Health Management (PHM) Committee convenes quarterly and is comprised of representation from across the organization to guide the development and implementation of the Alliance PHM strategy and population health program goals.

Health Equity

The Alliance is deeply committed to advancing health equity among its diverse membership. The Alliance has a Health Equity Department, led by the Chief Health Equity Officer, to ensure that health equity and DEI (diversity, equity, and inclusion) are prioritized to meet the highest possible health standards for our members. Also, the Alliance convenes a Quality Improvement and Health Equity Committee (QIHEC) that reports to the Alliance Board of Governors and as a part of its role, identifies and mitigates health disparities to advance health equity.

At the Alliance, Health Equity has four key priority focus areas: 1) enhance diversity, equity, inclusion, and belonging among Alliance staff, 2) develop a systems-based approach to leverage physical and psychosocial data to analyze, understand, and address avoidable and unjust differences in health status and well-being among historically marginalized and underserved populations, including addressing social determinants of health (SDOH); 3) ensure members

have equal access to cultural and linguistic responsive services; and 4) employ value contracting strategies to ensure equal opportunities for women and minority owned businesses to do business with the Alliance.

Also, the Health Equity Department contracted consultants and is collaborating with departments across the organization to develop an organizational equity roadmap.

One action that the Health Equity Department is planning to take starting 2024 is the development of a DEI (diversity, equity, and inclusion) training program. The DEI training program includes sensitivity, diversity, cultural competency and cultural humility, and health equity training. The training will be required for individuals managing member care. Training content will include, but is not limited to:

1) Consideration and acknowledgement of structural and institutional racism and health inequities.
2) Information about relevant health inequities and identified cultural groups in Alameda County, which includes:
    a. The groups' beliefs about illness and health;
    b. Member experience, including perceived discrimination and the impacts of implicit bias;
    c. Lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and more (LGBTQIA+) concerns;
    d. Need for gender affirming care;
    e. Traditional home remedies that may impact care; and
    f. Language and literacy needs.

Implementation timeline:

- Develop final draft by August 2024.
- Submit the DEI training program draft to DHCS for approval by September 2024.
- Pilot the DEI training program between January and July 2025.
- Implement DEI training program between July and December 2025.
- Annual evaluation of the DEI training program thereafter.

Evaluation

The Alliance conducts an annual impact evaluation of its PHM strategy that includes quantitative and qualitative analysis for evidence of program effectiveness and identifies opportunities for improvement. The PHM Strategy yearly evaluation is available in a separate document, "2023 PHM Evaluation."

Data integration

Data integration is a key component of the PHM program. The Alliance uses the below data sources for population health management functions, including but not limited to:

- Membership reports identify Medi-Cal and Group Care members by age, aid code (including Seniors and Persons with Disabilities), language, gender, race and ethnicity, and geographic location.
- Medical, behavioral health, and pharmacy claims and encounters are used to calculate HEDIS and utilization rates, identify members for case management programs, determine risk stratification and segmentation tiers, and create gaps in care reports for providers.
- Laboratory results are received from Foundation, Quest, and Novius and used to calculate HEDIS rates, share gaps in care with providers on screenings and diabetes control, and identify members for case management programs.
- Health appraisal forms including the HIF-MET (Health Information Form/Member Evaluation Tool) and HRA (Health Risk Assessment) survey results are used to inform providers of member needs, connect members to community resources, and refer members into Alliance case management programs as indicated.
- Electronic health records from Alameda Health System (AHS) and Community Health Center Network (CHCN) are used to determine HEDIS rates and inform gap in care reports shared with providers.
- Alliance data from health services programs, including utilization of case management, disease management, and health education programs, are reviewed to coordinate care and avoid duplication of services.
- Utilization management data on member inpatient stays is used to identify members eligible for Transitional Care Services.
- Advanced data sources include the CAIR registry, Alameda County Behavioral Health Care Services (BHCS), Homeless Management Information System (HMIS) of the Alameda County Health Care Services Agency, and Fee-for-Service Medi-Cal data provided by DHCS.

Many of the data sources are imported into the CareAnalyzer health analytics platform. CareAnalyzer combines elements of patient-level and group-level risk, care opportunities and provider performance to provide insight into Alameda Alliance's member population. In addition, it utilizes the industry-leading predictive modeling capabilities and analytics of The Johns Hopkins ACG System. CareAnalyzer data is viewed in their online reporting user interface as well as exported and integrated into other analyses.

The Alliance uses Microsoft Power BI to build dashboards for population health, HEDIS, risk stratification, and program and utilization management. The dashboards are interactive and allow for analysis by member demographic groups, conditions, and utilization to help identify health disparities.

Population Assessment

The Alliance annually assesses the characteristics and needs, including social determinants of health, for our member population.

Data Sources

Data sources used to identify members and priorities for supporting their care needs were:

- Alameda County Behavioral Health utilization data
- Alameda County statistics from public sources
- Alliance indicators for members experiencing homelessness
- Alliance medical and pharmacy claims and encounters
- CAHPS survey results
- CareAnalyzer
- Cotiviti HEDIS software
- DHCS monthly eligibility files
- Group Care enrollment files
- Transitional Care Services records

Methodology and results from these data sources are found in the document "2024 NCQA PHM Assessment Methods and Data." Analysis of the results is in the Member Needs section below.

Social Determinants of Health

As defined in Healthy People 2030, social determinants of health (SDOH) are conditions in the environments where people are born, live, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes. The SDOH characteristics included in this report on the county level were people living below poverty level, California Healthy Places Index, Food Insecurity Index, and access to parks. SDOH characteristics specific to individual Alliance members were homelessness and language.

Members were categorized as "housed" or "unhoused" through several indicators for potential homelessness, including diagnosis codes, Homeless Management Information System (HMIS) data, and member home addresses that indicate social services agencies or programs. This is different than the U.S. Department of Housing and Urban Development definition of homelessness that is used for programs such as ECM but helps indicate who may have experienced housing instability at some time during the year. In 2023, 6.2% of Medi-Cal members (15,621 members) and 1.7% of Group Care members (80 members) had one or more homelessness indicators.

Limited English proficiency was both a subpopulation and an SDOH characteristic. Members who preferred a language other than English were analyzed as having limited English

proficiency. In 2023, 35.6% of Medi-Cal members (89,431 members) and 37.1% of Group Care members (1,740 members) preferred a language other than English. Over a third of the Alliance membership may need interpreters, translation services, and/or bilingual staff to access health care.

Alameda County Statistics

Population and Geography

As of March 2023, Alameda County had a population of 1,666,405 persons (Healthy Alameda County, data provided by Claritas). The map below shows the cities within the county.

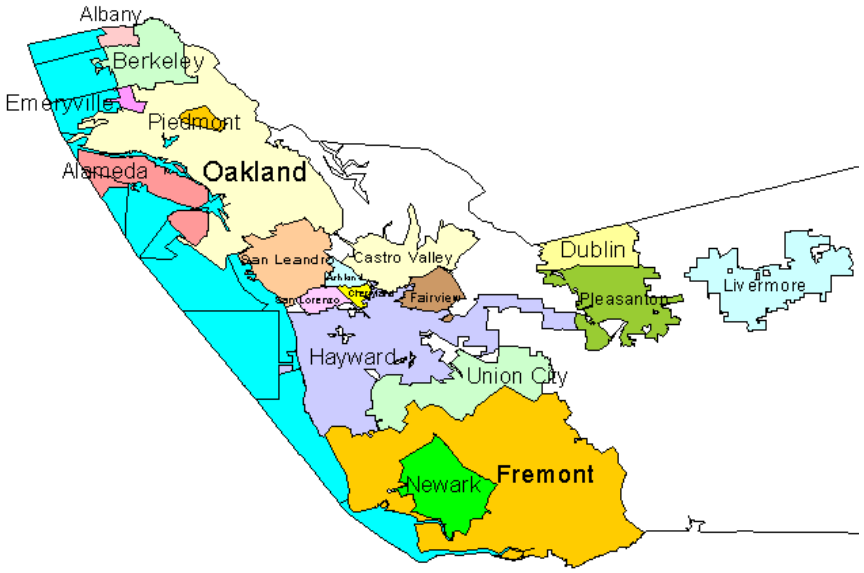


Figure 1: Map of Alameda County (Image source: UC Berkeley Library)

Four regions of the county are defined for this report to summarize the Alliance membership by location:

County Region	Cities included
North County	Alameda, Albany, Berkeley, Emeryville, Oakland, Piedmont
Central County	Castro Valley, Hayward, San Leandro, San Lorenzo (Note: Ashland, Cherryland, and Fairview are unincorporated areas and not in member addresses.)
East County	Dublin, Livermore, Pleasanton
South County	Fremont, Newark, Union City

People Living Below Poverty Level

This indicator shows the percentage by census tract of estimated people who had income in the past 12 months below the federal poverty level according to the American Community Survey 5-Year, 2017-2021. Adults qualify for Medi-Cal with a household income of less than 138% of federal poverty level. In Alameda County, 8.9% of county residents were living below poverty level. There were three census tracts in Berkeley with percentages in the highest range. The census tracts in the next highest range were in Oakland.

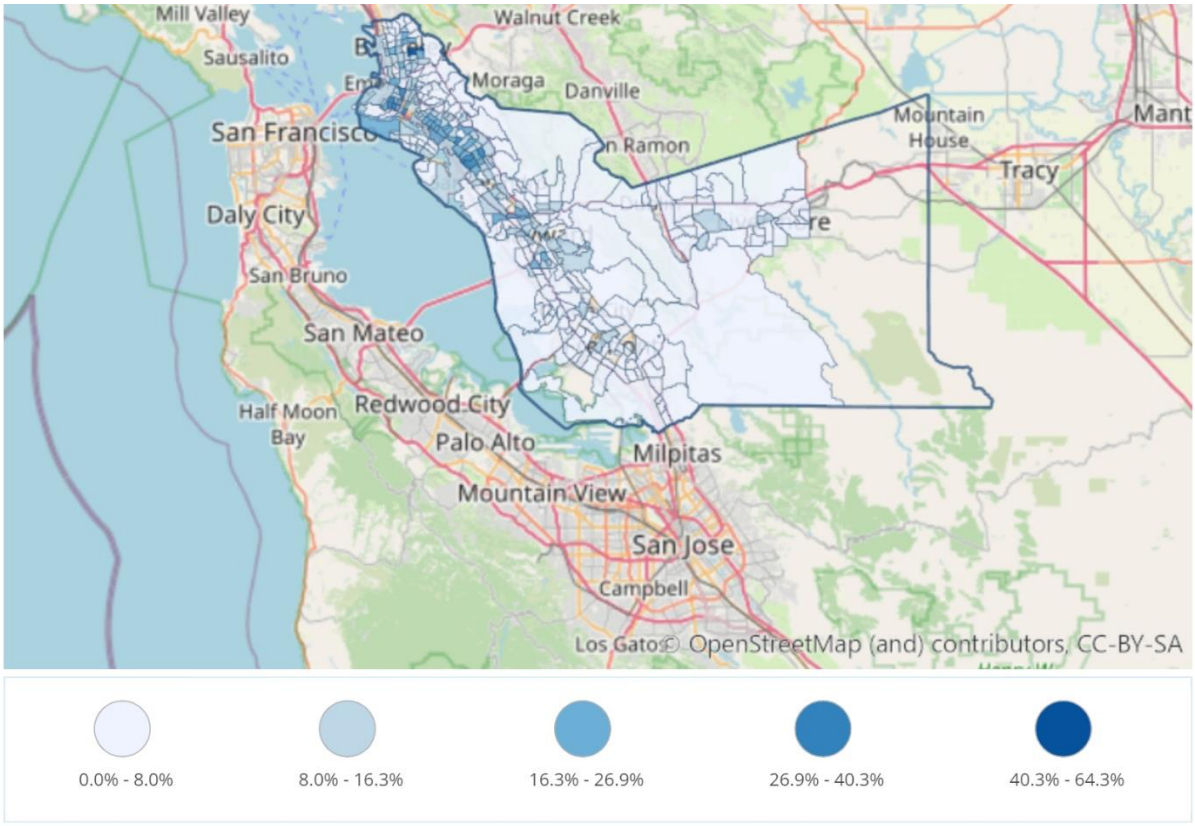


Figure 2: People Living Below Poverty Level, 2017-2021 (Image source: Healthy Alameda County)

California Healthy Places Index

The California Healthy Places Index, developed by the Public Health Alliance of Southern California, combines 25 community characteristics, like access to healthcare, housing, education, and more, into a single indexed HPI score. Oakland has the highest concentration of census tracts with low HPI scores, followed by Hayward and the unincorporated communities of Ashland and Cherryland. Other cities in Alameda County are shaded in green.

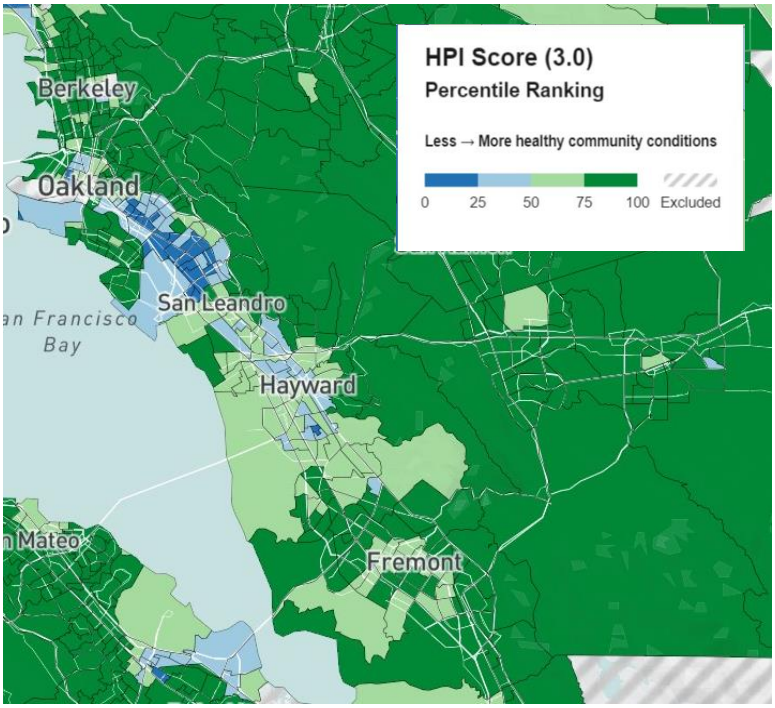


Figure 3: California Healthy Places Index, 2022 (Image source: Healthy Places Index)

Food Insecurity Index

The 2023 Food Insecurity Index, created by Conduent Healthy Communities Institute, is a measure of economic and household hardship correlated with poor food access. Overall, Alameda County's index score was 3.4 out of 5. In Alameda County, the zip codes with the greatest need related to food insecurity were in East Oakland.

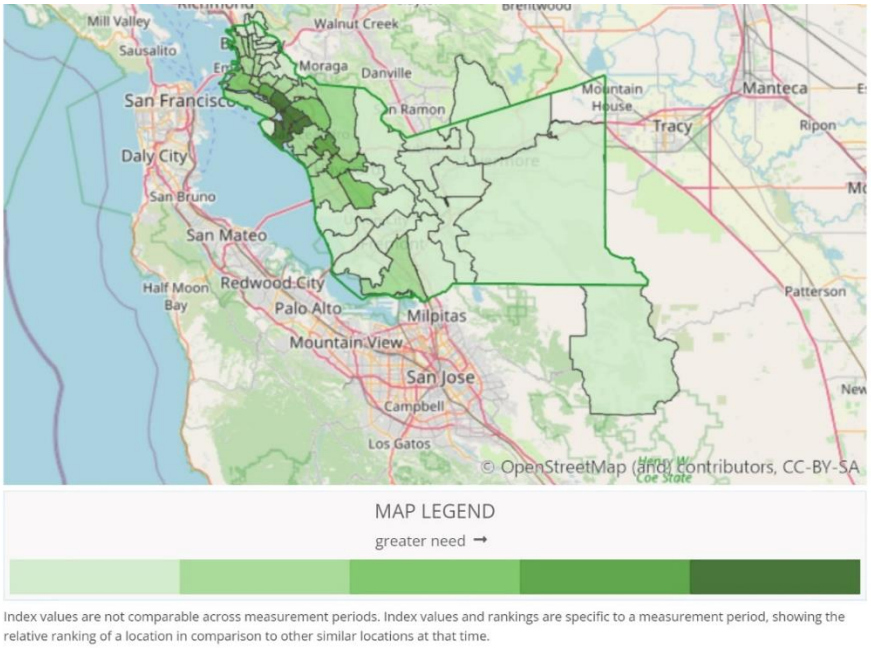


Figure 4: Food Insecurity Index, 2023 (Image source: Healthy Alameda County)

Access to Parks

The California Department of Parks and Recreation provides 2020 neighborhood-level park access information. The map identifies neighborhood areas that do not have a park within a half mile. Only 5% of Alameda County residents live further than a half mile from a park.

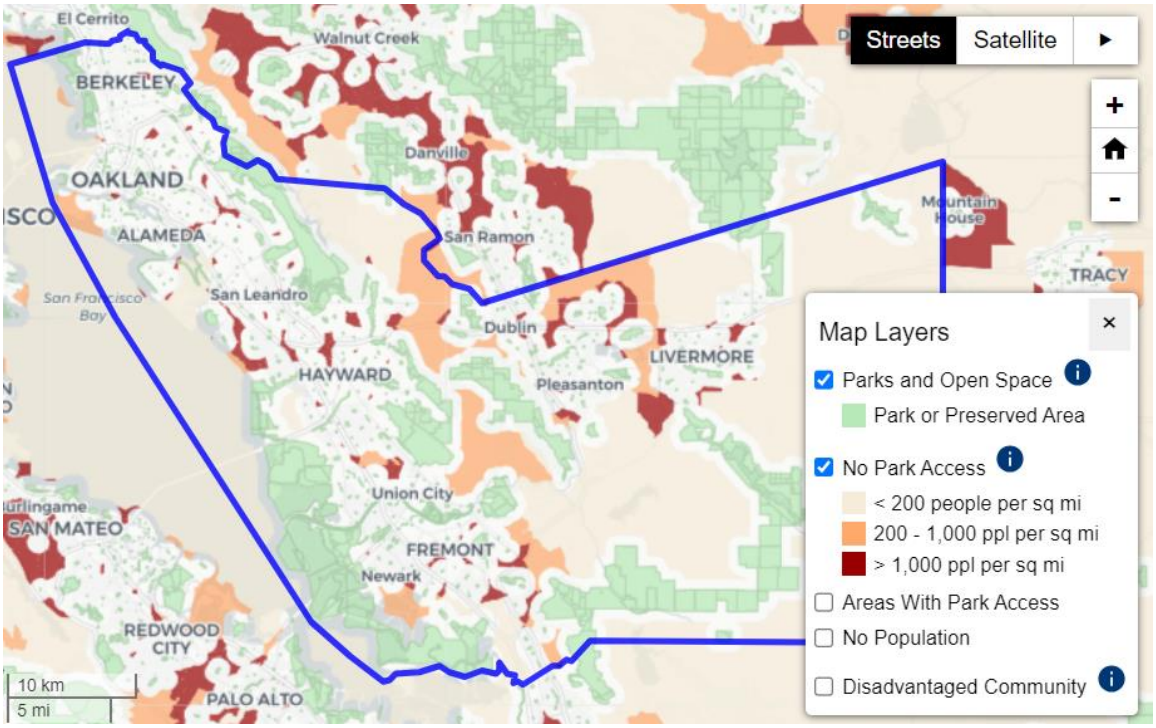


Figure 5: Living Within a Half Mile of a Park, 2020 (Image source: California Department of Parks and Recreation)

Membership

Medi-Cal Membership

There were 251,487 members enrolled in Medi-Cal for at least 11 months during 2023 and eligible in December 2023. Their characteristics are listed below.

Medi-Cal Member Demographics Table

MEDI-CAL	Count	Percent
GENDER		
Female	133,290	53.0%
Male	118,197	47.0%
AGE BAND		
0-2	5,716	2.3%
3-6	14,817	5.9%
7-11	20,922	8.3%
12-20	38,383	15.3%
21-34	50,268	20.0%
35-49	37,181	14.8%
50-64	40,797	16.2%
65+	43,403	17.3%
COUNTY REGION		
North	123,862	49.3%
Central	71,295	28.3%

MEDI-CAL	Count	Percent
South	38,878	15.5%
East	15,772	6.3%
Other	1,680	0.7%
PRIMARY RACE/ETHNICITY		
Hispanic (Latino)	76,356	30.4%
Other	58,141	23.1%
Black (African American)	34,101	13.6%
Chinese	27,280	10.8%
White	19,742	7.9%
Other Asian	11,571	4.6%
Vietnamese	9,780	3.9%
Filipino	6,847	2.7%
Pacific Islander	5,370	2.1%
Unknown	1,812	0.7%
American Indian or Alaskan Native	487	0.2%
PRIMARY LANGUAGE		
English	156,544	62.2%
Spanish	50,348	20.0%
Chinese	24,178	9.6%
Vietnamese	7,254	2.9%
Unknown	5,512	2.2%
Other Non-English	4,223	1.7%
Arabic	1,792	0.7%
Tagalog	1,636	0.7%
HOMELESSNESS		
Housed	235,866	93.8%
Unhoused	15,621	6.2%

Group Care Membership

There were 4,685 members enrolled in Group Care for at least 11 months during 2023 and eligible in December 2023. Their characteristics are listed below.

Group Care Demographics Table

GROUP CARE	Count	Percent
GENDER		
Female	3,395	72.5%
Male	1,290	27.5%
AGE BAND		
Under 21	5	0.1%
21-34	374	8.0%
35-49	1,150	24.5%
50-64	2,241	47.8%
65+	915	19.5%

GROUP CARE	Count	Percent
COUNTY REGION		
North	1,936	41.3%
Central	1,281	27.3%
South	876	18.7%
Other	377	8.0%
East	215	4.6%
PRIMARY RACE/ETHNICITY		
Other Asian	1,388	29.6%
Unknown	1,165	24.9%
Chinese	658	14.0%
Black (African American)	514	11.0%
Other	393	8.4%
Hispanic (Latino)	209	4.5%
Vietnamese	147	3.1%
White	93	2.0%
Filipino	58	1.2%
Pacific Islander	53	1.1%
American Indian or Alaskan Native	7	0.1%
PRIMARY LANGUAGE		
English	2,796	59.7%
Chinese	1,114	23.8%
Spanish	236	5.0%
Vietnamese	191	4.1%
Other Non-English	171	3.6%
Unknown	149	3.2%
Tagalog	23	0.5%
Arabic	5	0.1%
HOMELESSNESS		
Housed	4,605	98.3%
Unhoused	80	1.7%

Member Needs

The Alliance analyzed assessment data for all members and by subpopulation, which included the following for both lines of business except where noted. Subpopulations were selected to adhere to NCQA standards, align with the DHCS Bold Goals, and reflect the unique characteristics of Alameda County.

- Child and adolescent members (Medi-Cal only)
- Members with disabilities
- Members with serious mental illness or serious emotional disturbance (Medi-Cal only)
- Members of racial and ethnic groups
- Members with limited English proficiency

- Relevant subpopulations:
    - Pregnant or postpartum members
    - Members receiving long-term care (Medi-Cal only)
    - Older adult members (Group Care only)

The member needs identified from the data are described in the proceeding sections by subpopulation.

All members

A common theme across the subpopulations was primary care utilization, which in turn affects many quality measures. To improve this, members need more education on what health care services they need and how to access them as well as assistance with scheduling and completing appointments. About half of Alliance members live in the northern part of the county where Oakland is the largest city. The Healthy Places Index and Food Insecurity Index maps both show that Alliance members living in Oakland also likely need assistance with food, housing, and other needs to support their health.

Gaps and disparities:

- *No PCP visits:* About half of Medi-Cal members and a third of Group Care members had no PCP visit in 2023.
- *Getting routine care quickly:* Medi-Cal children (65.4%), Medi-Cal adults (69.7%), and Group Care (56.5%) were all significantly below benchmark on the CAHPS survey question about getting routine care quickly.
- *TCS ambulatory follow-up visit:* In Medi-Cal, 28.5% of members had an ambulatory visit within 7 days post-discharge. Across all Medi-Cal plans, this rate was one standard deviation below the mean in November 2023.
- *Women's cancer screenings:* In Group Care, breast cancer and cervical cancer screening HEDIS measures were below the 50th percentile for Commercial plans in MY2022. For both Group Care and Medi-Cal, cervical cancer screening was below the 50th percentile (minimum performance level, or MPL) for ages 21 to 34.

Child and adolescent members

There were 79,838 child and adolescent Medi-Cal members ages 0 to 20 in 2023. As was the case with the full membership, primary care visits were a gap of concern. Getting well-child visits according to the recommended schedule also helps with other quality measures like immunizations and lead screening. Parents and caregivers need education, outreach, and support with transportation and other basic needs that could be barriers especially for the youngest children with multiple visits.

Gaps and disparities:

- *Well-care visits*: Well-child visits in the first 15 months (W30-6) was below MPL overall and for multiple race/ethnic groups. Child and adolescent well-care visits (WCV) was below MPL for ages 12 to 20.

Members with disabilities

In Medi-Cal, there were 2,103 children and adolescents ages 0 to 20 and 24,590 adults ages 21 and over in the SPD (seniors and people with disabilities) aid category. In Group Care, there were 764 members with disabilities defined by a selection of CareAnalyzer diagnosis codes. Children with disabilities may need additional assistance connecting with a PCP. Seniors and people with disabilities need support with managing chronic conditions, including high blood pressure.

Gaps and disparities:

- *Chronic disease:* Chronic disease and multiple chronic disease were all higher in the various groups of members with disabilities listed above compared to overall members in the same age group. Adults with disabilities had about two times the prevalence of diabetes, hypertension, and diabetes with hypertension as adults overall.
- *Blood pressure control:* Members in the SPD aid category were below the MPL for blood pressure control at 48.12% compared to the MPL of 59.85%. They were about a third of the HEDIS sample for this measure.

Members with serious mental illness or serious emotional disturbance

Care for members with serious mental illness or serious emotional disturbance is carved out to Alameda County Behavioral Health. There were 4,017 Medi-Cal members who received services from Alameda County Behavioral Health from January to June 2023. Members need health navigation while they are in the emergency department to connect them to further assistance with health care and community services to get treatment and support with social needs and to prevent future emergency visits.

Gaps and disparities:

- *Homelessness:* Over a quarter (28.5%) of members with serious mental illness had a homelessness indicator compared to 6.2% of all Medi-Cal members.
- *Emergency visits:* Emergency department visits per 1,000 member months was 105.7, compared to 26.1 for all Medi-Cal members. The percentage of high ED use (4 or more visits) was 7.6% compared to 0.4% for all Medi-Cal members.
- *Follow-up after ED visit for mental illness*: This HEDIS measure (FUM) rate was 49.03% for all members, which was below the MPL of 54.51%.

Members of racial or ethnic groups

There were many differences seen by racial or ethnic group. Members need culturally concordant education and outreach for preventive care services, transitional care services, and chronic disease management. American Indian or Alaskan Native and Black or African American members as well as White adult members also need support with housing and other related basic needs.

Gaps and disparities:

- American Indian or Alaskan Native members are 0.2% of Medi-Cal (487 members) and 0.1% of Group Care (7 members). For Group Care the population is too small for comparison.
    - *Homelessness:* The prevalence of homelessness was 8.0% of American Indian or Alaskan Native Medi-Cal children and 15.7% of Medi-Cal adults.
    - *Depression:* The prevalence of depression by race/ethnicity was highest for American Indian or Alaskan Native members: 3.6% of Medi-Cal children and 10.4% of Medi-Cal adults.
    - *Breast cancer screening:* The rate of breast cancer screening for American Indian or Alaskan Native Medi-Cal members was 32.61%, below the MPL of 50.95%.
    - *Emergency visits and admissions:* The rates of admissions, emergency visits, and high ED use were higher for American Indian or Alaskan Native Medi-Cal adult members. The emergency visit rate was highest among children.
- Asian American and Pacific Islander members are 24.2% of Medi-Cal (55,478 Asian American and 5,370 Pacific Islander members) and 49.2% of Group Care (2,251 Asian American and 53 Pacific Islander members).
    - *Diabetes and hypertension:* The prevalence of diabetes, hypertension, and diabetes with hypertension were higher in various Asian American and Pacific Islander groups, which was expected since this is an older population. About a fifth of Other Asian, Filipino, or Pacific Islander members had both diabetes and hypertension. Other Asian American groups still had significant numbers of members with both diabetes and hypertension.
    - *Women's cancer screenings:* In Group Care, Other Asian members made up a quarter of the breast cancer and cervical cancer screening HEDIS samples and were below the 50th percentile for both. "Other Asian" is mostly Asian Indian members in the Group Care line of business.
    - *Transitional Care Services care manager contact:* Compared to 24.7% of Medi-Cal and 22.9% of Group Care transitions that had a care manager contact within 7 days, the rate for transitions for Asian members was 12.2% for Medi-Cal and 15.0% for Group Care.

  - *No PCP visits:* While Chinese and Vietnamese groups had lower rates of no PCP Visits, Filipino Medi-Cal members had higher no PCP visit rates for children (53.3%) and adults (65.0%), and Pacific Islander members had higher rates for Medi-Cal children (48.4%) and Group Care (43.4%). Filipino members were below MPL for Well-Child Visits in the First 15 Months (W30-6), and Pacific Islander members were below for Child and Adolescent Well-Care Visits (WCV).
- Black or African American members are 13.6% of Medi-Cal (34,101 members) and 11% of Group Care (514 members).
  - *Homelessness:* The prevalence of homelessness indicators was 10.2% of Medi-Cal children, 17.6% of Medi-Cal adults, and 4.9% of Group Care. By count they were the largest group for Medi-Cal adults and Group Care.
  - *Well-child visits:* Well-Child Visits in the First 15 Months (W30-6) and Ages 15 to 30 Months (W30-2) were both below MPL. In addition, they had the highest rate of no PCP visits for children and adolescents at 56.7%.
  - *Breast cancer screening:* Breast cancer screening in Black (African American) members was below the 50th percentile for both Medi-Cal and Group Care.
  - *Chronic disease:* Asthma had both high prevalence and count for Black (African American) members. The prevalence of diabetes and hypertension were similar to the overall population but still had large numbers.
  - *Emergency visits and admissions:* Black (African American) adult Medi-Cal members had the highest rates of admissions, readmissions, emergency, and high ED use. ED use and admissions were also high for Medi-Cal children and Group Care members. One fifth of members used the ED more than primary care.
  - *Perinatal health:* Black (African American) perinatal Medi-Cal members had a higher prevalence of premature birth (1.1% compared to 0.8% overall). For both lines of business about 15% of Black (African American) pregnant members had depression compared to 11.4% for Medi-Cal and 8.9% for Group Care pregnant members.
- Hispanic (Latino) members were 30.4% of Medi-Cal (76,356 members) and 4.5% of Group Care (209 members).
  - *Chronic disease:* Although Hispanic (Latino) members had a lower prevalence of chronic diseases, in Medi-Cal they are still the largest group after Other ethnicity.
  - *Perinatal health:* Hispanic (Latino) members are also the largest group after Other ethnicity among perinatal members. They had the highest count (21 members) and rate of prematurity (1.2%).
- White members were 7.9% of Medi-Cal (19,742 members) and 2.0% of Group Care (93 members).

- *Homelessness:* The prevalence of homelessness indicators was highest for White Medi-Cal adults (17.7%) and Group Care (5.2%).
- *Primary care:* White Medi-Cal adults had a higher rate of no PCP visits (70.4%) and admissions (10.3 admits/1000). Almost one fifth of members used the ED more than primary care.
- *Depression:* The prevalence of depression was 9.3% for White Medi-Cal adults and 10.8% for Group Care compared to 6.0% for all Medi-Cal adults and 4.7% for all Group Care members.

Members with limited English proficiency

In 2023, 89,431 Medi-Cal members (35.6%) and 1,740 Group Care members (37.1%) preferred a language other than English. Members with limited English proficiency often were the same as or better than English-speaking members for the assessment measures. They need culturally and linguistically concordant chronic disease management and transitional care services support.

Gaps or disparities:

- *Diabetes and hypertension:* There was a slightly higher prevalence of diabetes, hypertension, and diabetes with hypertension for non-English speaking Medi-Cal adults, which correlates with the higher prevalence of these diseases in Chinese and Vietnamese adults. These ethnic groups have a high proportion of non-English speakers.
- *Transitional Care Services care manager contact:* Compared to 24.7% of Medi-Cal and 22.9% of Group Care transitions that had a care manager contact within 7 days, the rate was 2.9% and 0.0% respectively for Cantonese-speaking members and 13.6% and 16.7% respectively for languages other than English, Spanish, and Cantonese.

Pregnant or postpartum members

There were 4,968 pregnant or postpartum Medi-Cal members and 45 Group Care members ages 12 to 55. Pregnant and postpartum members need education and connection to services and treatment, screenings and referrals by their providers, and outreach and awareness about holistic care programs (e.g., doulas, Enhanced Care Management).

Gaps or disparities:

- *Family and social problems:* "Family and social problems" was the fifth most common CareAnalyzer diagnosis in pregnant or postpartum Medi-Cal members at 23.0% and tied for eighth most common diagnosis for Group Care at 20.0%. In addition, the prevalence of homelessness indicators was 9.0% for Medi-Cal and 6.7% in Group Care compared to 6.2% for all Medi-Cal members and 4.7% for all Group Care members.

- *Depression:* The prevalence of depression for pregnant or postpartum Medi-Cal members was 11.4% and for Group Care 8.9%, which were both higher than overall members (4.8% Medi-Cal and 4.7% Group Care).

Members receiving long-term care (LTC)

There were 1,480 Medi-Cal members receiving LTC services. This group of members have intensive health care needs that are provided by LTC facilities. Members who are transitioning from LTC may need more care management and connection to behavioral health services.

- *Chronic disease:* Chronic disease prevalence was the highest among this subpopulation compared to the others. For multiple chronic conditions, 16.4% of LTC members had diabetes and depression and 35.7% had diabetes and hypertension. The prevalence of these single conditions was 36.5% for depression, 43.0% for diabetes, and 72.2% for hypertension.
- *Emergency visits and admissions:* Admissions, readmissions, emergency visits, and high ED use were all higher than for all Alliance members.

Older adult members in Group Care

There were 3,156 older adult members ages 50 and up in Group Care (2,241 ages 50-64 and 915 ages 65 and older), which is two-thirds of the Group Care population. Older adult members need education and encouragement to get preventive cancer screenings as well as resources for chronic disease management.

- *Diabetes and hypertension:* About 90% of the Group Care members with diabetes, hypertension, or both were older adults. There were 579 members with diabetes, 1,087 with hypertension, and 393 with both, which was a prevalence of 18.3%, 34.4%, and 12.5%, respectively.
- *Women's cancer screenings:* Members ages 50-64 were below the 50th percentile for both breast cancer and cervical cancer screenings. Members ages 65 and over were below the 50th percentile for breast cancer screening.

Population Assessment Analysis

Alliance conducts an annual comprehensive analysis of its population assessment needs for evidence of program effectiveness and opportunity. The Alliance uses assessment results to review and update PHM programs, services, and activities. Additionally, the assessment is used to update needed resources including staffing, systems, and community resources.

Programs, Services, and Activities

The Alliance has programs and activities to address the areas of member needs described, but programs may have limited capacity or reach compared to the number of members who would

be eligible for the programs and services. Chronic disease management programs have been recently expanded, so improved outreach efforts, culturally appropriate approaches, and other program development are still underway. Quality improvement and non-utilizer outreach efforts have had challenges with no responses or no shows. There are plans to expand education and outreach with members and add other services such as community health workers to support these programs. Additional plans include coupling member outreach with provider incentives to increase appointment availability.

Staffing, Systems, and Community Resources

The Alliance is increasing staffing for quality improvement engagement, care management, and transitional care services. Because there is a need for culturally and linguistically concordant outreach and services, the Alliance is also working on building a community health worker and doula network, partnering with community organizations for education, hiring staff with language and cultural backgrounds reflective of the Alliance membership, and assessing barriers for members to increase capacity for culturally competent care. In response to disparities for pregnant members, particularly Black (African American), Hispanic (Latino), and American Indian and Alaskan Native racial or ethnic groups, the Alliance is increasing its capacity to support pregnant members with mental health and other services that address both health and social needs through expansion of doula services, participation in Alameda County birth equity initiatives, and collaboration with local WIC agencies. The PHM Strategy section "Integration of Community Resources" describes the ways that the Alliance collaborates with other organizations and refers members to community resources. Programs are working with delegates and clinics on scheduling challenges, data exchange, and member and provider education. There are also opportunities to improve data tracking and integration for non-utilizers, transitions of care, and chronic disease management.

Population Risk Stratification and Segmentation

The Alliance has developed a risk stratification and segmentation (RSS) methodology to categorize all eligible members into risk tiers based on all data sets currently available, including clinical and behavioral health utilization, risk scores, and social needs data. The risk stratification is used to highlight specific member needs and assists with determining the appropriate levels of care management or other services a member may need.

The Alliance RSS methodology includes predictive and status metrics from CareAnalyzer, which uses The Johns Hopkins ACG System. Metrics include probabilities for persistent high utilizers, high cost, and inpatient or ED utilization. In addition, criteria utilized for Enhanced Care Management (ECM) and Complex Case Management (CCM) identification are incorporated into the methodology. Members are stratified into three main tiers: High Risk, Medium-Rising Risk and Low Risk. As members are identified and assessed for needs, they may move to a higher tier for more intensive support. Members in one tier may be eligible for or receive interventions listed in other tiers based on individual need.

The Alliance assesses its RSS methodology to identify and address racial bias that may exacerbate health disparities. First, the Alliance reviews the latest Johns Hopkins ACG System Bias Assessment that describes their analysis of potential racial bias in their predictive models. Then, the Alliance uses the population assessment data to see whether the racial and ethnic breakdown of the membership into risk tiers corresponds with inpatient and ED utilization as predicted by the CareAnalyzer models. The rate of no PCP visit for the racial and ethnic groups is also taken into consideration to assess whether groups may be underrepresented in higher risk tiers due to lack of data or may also need more support even when they are not high risk. This data is analyzed by Medi-Cal adults, Medi-Cal children, and Group Care.

In 2022, Johns Hopkins conducted a racial bias assessment for the ACG System and concluded that their models for events currently do not show evidence of bias for racial groups. Their cost-prediction models have some potential for bias that may be related to chronic condition management and use of medications.

According to the population assessment data on risk tiers as of December 2023, there is an association between racial/ethnic group and risk tier. For Medi-Cal adults and children, the groups at higher versus lower risk corresponded well with utilization. For Medi-Cal children, a potential area for concern with underutilization was Filipino children, almost all of whom (96.5%) were in the low-risk tier but also had a higher no PCP visit rate. However, their emergency visits and admissions were still low. Group Care has fewer members, making the racial/ethnic groups less reliable for comparison. It would have been expected to see more Black (African American) and Pacific Islander members in higher risk tiers relative to other

groups based on their emergency and inpatient utilization. Overall, the Alliance RSS appears to correlate well with events in agreement with the Johns Hopkins analysis.

Although the RSS bias analysis did not conclusively identify bias, the Alliance is committed to continuous monitoring and re-tiering of members as new information is available. The Alliance maintains reports and dashboards that allow for regular review of member stratification and segmentation by race/ethnicity and language for identification of any concerns. The Alliance continues to use various inputs in addition to the RSS to connect members to the appropriate level of care. This includes member assessments, clinical review of member health status and social needs, provider referrals and input, and re-stratification as appropriate. In addition, Alliance under-utilizer outreach efforts help identify members who may not have been included in the high-risk tier because of under-utilization. As additional data becomes available on social determinants of health, it will be incorporated into the RSS as needed to address racial bias.

The tables below show the risk tiers and number of eligible members by line of business. They also provide an overview of Alliance programs and services, with definitions found in the sections to follow.

Alliance Risk Stratification and Segmentation Table - Medi-Cal
(March 2024, Total Medi-Cal Membership 398,045)

Medi-Cal Subset of Population	Programs and Services for Eligible Members	Number of Eligible Members	Percentage of Membership
High Risk Tier		**9,265**	**2%**
High Risk as defined by predictive utilization metrics, or enrollment in ECM or CCM.	• Enhanced Care Management • Complex Case Management • Transitional Care Services (Higher Risk) • Long-Term Care Management		
Medium-Rising Risk Tier		**50,147**	**13%**
Not High Risk; high care coordination need.	• Multiple Chronic Disease Management • Follow-up after ED Visit for Mental Illness QI Project • BirthWise Wellbeing • Community Supports • Transitional Care Services (Higher and Lower Risk)		
Low Risk Tier		**338,633**	**85%**

Medi-Cal Subset of Population	Programs and Services for Eligible Members	Number of Eligible Members	Percentage of Membership
Low risk for care coordination.	• Non-Utilizer Outreach • Well-Child Visits QI Project • Breast Cancer Screening QI Project • Doula Services • Community Health Worker Services • Health Education • Transitional Care Services (Lower Risk)		

Alliance Risk Stratification and Segmentation Table – Group Care
(March 2024, Total Group Care Membership 5,623)

Group Care Subset of Population	Programs and Services for Eligible Members	Number of Eligible Members	Percentage of Membership
High Risk Tier		**174**	**3%**
High Risk as defined by predictive utilization metrics or enrollment in CCM.	• Complex Case Management • Transitional Care Services (Higher Risk) • Catastrophic Case Management		
Medium-Rising Risk Tier		**964**	**17%**
Not High Risk; high care coordination need.	• Multiple Chronic Disease Management • Transitional Care Services (Lower Risk)		
Low Risk Tier		**4,485**	**80%**
Low risk for care coordination.	• Non-Utilizer Outreach • Breast Cancer Screening QI Project • Community Health Worker Services • Health Education • Transitional Care Services (Higher Risk)		

Population Health Program Goals

The Alliance annually assesses its population's characteristics and needs, including utilization, risk, and quality outcomes to identify opportunities to improve population health, enhance the patient and provider experience, and mitigate disparities. The Alliance leverages the assessment to plan programs, goals, and interventions to meet the needs of subpopulations and improve health outcomes.

The PHM Committee met to analyze where our population needs, segmentation, and opportunities aligned with both the NCQA areas of focus and the DHCS Comprehensive Clinical Quality Strategy. The Alliance has identified three strategic pillars as critical to improving member health and well-being.

Alliance Strategic Pillars

ALLIANCE STRATEGIC PILLARS	
Address primary care gaps and inequities	
Support members managing health conditions	
Connect members in need to whole person care	

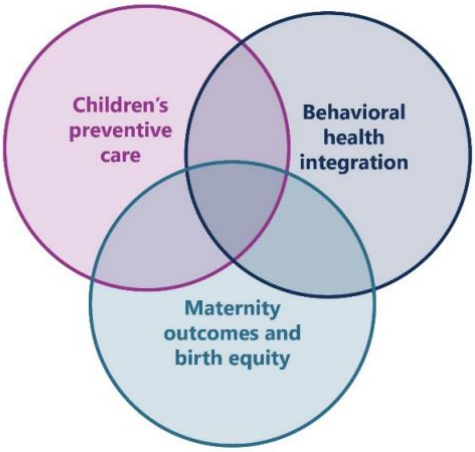
The Alliance PHM Strategy goals also align with the four areas of focus as outlined by NCQA for population health to help improve health for members across different risk tiers:

1. Keeping members healthy.
2. Managing members with emerging risk.
3. Patient safety or outcomes across settings.
4. Managing multiple chronic illnesses.

Lastly, the Department of Health Care Services (DHCS) clinical focus areas and Bold Goals for 2025 were also an important factor in prioritizing goals under each of the NCQA areas of focus. To further the DHCS Bold Goals, the Alliance PHM Strategy includes programs to reduce

disparities for well-child visits and immunizations, promote maternal depression screening, follow-up for mental health and substance use disorders after emergency department visits, and engage non-utilizers ages six and under.

DHCS Clinical Focus Areas and Bold Goals



The table below demonstrates how the Alliance PHM Population Health Program goals align with our identified strategic pillars, the NCQA areas of focus, and the DHCS clinical focus areas.

Alliance PHM Strategy Alignment

AAH Programs	Alliance Strategic Pillars			NCQA Area of Focus				DHCS Areas of Focus		
	Address primary care gaps and inequities	Support members managing health conditions	Connect members in need to whole person care	Keeping members healthy	Managing members with emerging risk	Managing multiple chronic illnesses	Patient safety or outcomes across settings	Children's Preventive Care	Behavioral Health integration	Maternity Outcomes and Birth Equity
Non-utilizer Outreach Campaigns	●			●				●		
Breast Cancer Screening - Equity	●			●						
Under 30 Months Well Visits - Equity	●			●				●		●
Multiple Chronic Disease Management		●				●				
Diabetes Prevention Program		●			●					
Post ED visit for Mental Illness		●					●		●	
BirthWise Wellbeing - Equity			●		●				●	●
Complex Case Management			●			●				
Transitional Care Services			●				●			

Programs and services related to goals in the NCQA focus areas are described below. The next section describes additional Alliance programs and services.

Managing Multiple Chronic Illnesses

Complex Case Management (Medi-Cal and Group Care)

Complex Case Management (CCM) provides ongoing chronic care coordination, interventions for temporary needs, and disease-specific management interventions for members who are high and medium-rising risk and have conditions in which the degree and complexity of illness or conditions are typically severe. The level of management necessary and the resources required for the member to regain optimal health or improved functionality is often intensive. CCM is a member-centered collaborative process between primary and/or specialty care providers, the member, and the care manager. The care manager directs the care and works with the member to prioritize and achieve goals. The Alliance's CCM services follow the National Committee for Quality Assurance (NCQA) CCM requirements.

Goal: At least 80% of members with at least 2 or more comorbidities that are enrolled in CCM between April 2024 and March 2025 will report a confidence level of at least 6 out of 10 in being able to better manage their health condition since receiving care management services on the case management satisfaction survey.

Target Population: Members with 2 or more comorbidities (diabetes, kidney failure, hypertension, congestive heart failure, COPD, or ischemic heart disease) and 2 or more inpatient admits within 6 months (excluding delivery admits) or 3 or more outpatient emergency visits within 6 months.

Programs or services:

- Complex Care Management: Nurse case managers provide intensive work with members to regain optimal health or improved functionality. The case manager directs care, assists members in understanding disease processes, and works with members and their providers to prioritize and achieve goals.

Multiple Chronic Disease Management (Medi-Cal and Group Care)

Disease Management programs target members with specific disease states. The Alliance will offer health coaching and self-management tools for diabetes, hypertension, and asthma. The Alliance will conduct mailings and outreach calls to encourage member participation. The programs will provide health education, referrals to case management programs, and assistance with connecting to community services.

Goal: At least 80% of members with 2 or more chronic conditions who enrolled in Disease Management between April 2024 and March 2025 will have a confidence score in disease self-management knowledge and behaviors of at least 24 out of 30 after receiving 2 to 3 health coaching sessions as measured by post health coaching assessment.

Target Population: Members with at least 2 of the following diagnoses: diabetes, hypertension, or asthma.

Programs or services:

- Disease management health education: Health Educator works with members in setting goals and provides education regarding disease management.
- Care coordination: Case Management health navigators will coordinate disease management care including health navigation, complex case management, or other programs.

Managing Members with Emerging Risk

BirthWise Wellbeing (Equity Focus, Medi-Cal)

BirthWise Wellbeing is a disease management program that supports members at risk for perinatal depression during pregnancy and in the first year after pregnancy. It is designed to increase wellbeing among perinatal members by providing health education materials on self-care and emotional wellbeing, referring to mental health providers, and connecting members to supportive services such as doulas.

Pregnant and postpartum members had a higher prevalence of depression (11%) than the overall Alliance population (5%). Among pregnant and postpartum members, about 15% of Black (African American) members had depression. American Indian or Alaskan Native members had few members but also a high prevalence of depression among Medi-Cal pregnant or postpartum members (23.1%). Hispanic (Latino) had the highest count of Medi-Cal members with depression (197 members, or 11.6% of Hispanic (Latino) pregnant or postpartum members).

Doulas are birth workers that provide personal, emotional, and physical support to birthing people throughout the perinatal period. According to a National Institutes of Health scoping review from May 2023, the utilization of doulas during the perinatal period was shown to decrease the rates of postpartum depression by 57.5% (Sobczak A, 2023). The BirthWise Wellbeing program will identify and outreach to Black (African American), Hispanic (Latino), and American Indian or Alaskan Native members who are

or were pregnant in the last year to promote doula services and decrease the risk of perinatal depression.

Goal: By March 2025, at least 3% of (approximately 75) Black (African American), Hispanic (Latino), or American Indian or Alaskan Native members who are or were pregnant in the last year will receive doula services.

Target Population: Black (African American), Hispanic (Latino), or American Indian or Alaskan Native Medi-Cal members who are or were pregnant in the last year.

Programs or services:

- Maternal mental health education outreach campaign: Targeted education for members in the perinatal period through member mailings with a maternal mental health flyer and Pregnancy Care Books.
- Doula services: Doulas provide development of a birth plan, health navigation, and linkages to community-based resources.
- Doula benefit outreach campaign: Community organizations inform members in target population of the availability and benefits of doula services.
- Behavioral health referrals and treatment: Alliance Member Services and Behavioral Health staff assess and refer members who respond to the mailing and are interested in behavioral health services to the appropriate level of behavioral health treatment.
- Health education resources: Referrals to prenatal classes, parenting classes, and lactation consults as needed.

Black (African American) Breast Cancer Screening QI Project (Equity Focus, Medi-Cal and Group Care)

This project will conduct outreach and education to Black (African American) members and increase access to mammograms. They are identified as a potentially high-risk group because breast cancer is often diagnosed at later stages and is more aggressive in African American women ((CDC), 2023). Although White women are more likely to get breast cancer, Black women are more likely to die from the disease. By increasing availability of breast cancer screening for the target population, Black (African American) women will screen earlier.

Goal: Increase Breast Cancer Screening (BCS) rates for Black (African American) women ages 50-74 by 3% from MY2023 (as of April 2024) to MY2024.

- Medi-Cal: 51.42% to 52.96%.
- Group Care: 64.67% to 66.61%.

Target Population: Black (African American) women ages 50-74 years of age.

Programs or services:

- Mobile mammography: Coordinate and sponsor mobile mammography services for members at target clinics with a high volume of Black women and low screening rates. Offering mobile mammography services throughout 2024.
- Mammogram incentive program: Provide gift cards to members for completing mammograms at target clinics. Program continued from 2023 and will go throughout 2024.
- Community outreach events: Educate African American members on breast cancer screening through community events. The first event is targeted in July of 2024 with Allen Temple Baptist Church.

Diabetes Prevention Program (DPP) (Medi-Cal)

DPP is an online program that helps participants adopt healthy habits, lose weight, and significantly decrease their risk of developing type 2 diabetes. The year-long program follows an approved curriculum by the Centers for Disease Control and Prevention (CDC). The curriculum teaches participants to make lasting changes by eating healthier, increasing physical activity, and managing the challenges that come with lifestyle change.

Goal: 20% of participants who have continued tracking their weight through 26 weeks between April 2024 and March 2025 will have reached and maintained at least 5% weight loss.

Target Population: Adults 18 and over who are overweight, do not have diabetes, are not pregnant, and meet the other CDC National Diabetes Prevention Program criteria.

Programs or services:

- Lifestyle change program: Year-long online and app-based programs in English and Spanish with member incentives to encourage continued program engagement.
- YumLive! health media service: Weekly live general nutrition education media service presented by a Registered Dietitian. These virtual sessions are open to Alameda County residents over the age of 18 to help inform and enroll members into the DPP. Session series will alternate being held in English and Spanish.

Keeping Members Healthy

Black (African American) Well-Child Visit QI Project (Equity Focus, Medi-Cal)

This project monitors and improves well-child visit measures to address disparities for Black (African American) members.

Goal: HEDIS well-child visit (W30) and immunization (CIS-10) rates will increase for Black (African American) members by 5% from MY2023 (as of April 2024) to MY2024.

- Well-Child Visits in the first 15 months of life (W30-6+): 40.59% to 42.62%.
- Well-Child Visits in the first 15-30 months of life (W30-2+): 60.87% to 63.91%.
- Childhood Immunization Status (CIS-10): 17.85% to 18.74% (administrative rates).

Target Population: Medi-Cal Black (African American) members up to 30 months old.

Programs or services:

- Well-child visits prenatal campaign: Send letters to members who are pregnant to inform them of the purpose, frequency, immunizations, and screenings of their child's well-visits and offer an incentive. This is targeted to launch by August 2024, dependent on internal and state review processes, including field-testing with community members.
- First 5 care coordination: Outreach coordinators at First 5 Alameda County call, educate, and help schedule well-visits for members up to 5 years of age experiencing gaps in care assigned to participating clinics. This program is launched throughout 2024.
- Well-child advertising campaign: Educate members of well-visit services and how to access these services by displaying a billboard and posters throughout the county. A billboard will be located near the highway in a zip code that has large gaps in completed well-visits for Black (African American) members. Posters will be placed throughout the county in train and bus stations. This is targeted to launch by June 30, 2024.

Non-Utilizer Outreach QI Project (Medi-Cal and Group Care)

This project will conduct outreach calls to members to encourage PCP visits.

Goal 1: Outreach to at least 20% of members ages 50 years and above who did not utilize services from October 2022 to September 2023 by June 2024 and connect 2% to primary care services.

Target Population: Members ages 50 years and above who have not utilized any paid medical or prescription services for more than 12 months.

Programs or services:

- Non-utilizer call campaign: Conduct outreach calls to eligible members to connect members to their primary care providers.

Goal 2: Outreach to at least 20% of members ages 6 years and under who did not utilize services from October 2022 to September 2023 by June 2024 and connect 2% to primary care services.

Target Population: Members ages six and under who have not utilized any paid medical or prescription services for more than 12 months.

Programs or services:

- Non-utilizer call campaign: Conduct outreach calls to parents or guardians of eligible members to connect members to their primary care providers.

Patient Safety or Outcomes Across Settings

Follow-Up After ED Visit for Mental Illness QI Project (Medi-Cal)

This project will involve efforts to improve the timely follow-up to emergency department (ED) visits for mental illness by increasing provider knowledge and developing tools to support effective follow-up processes.

Goal: Follow-up After ED Visits for Mental Illness (FUM) - 30 days HEDIS rate for Medi-Cal members will increase from 51.10% in MY2023 (as of April 2024) to 54.87% in MY2024.

Target Population: Members ages 6 and older who were seen in the ED for mental illness according to HEDIS FUM specifications.

Programs or services:

- Outreach: Alliance Quality Improvement staff will identify and call members with mental illness diagnoses based off claims and encounter data within 30 days of ED visit and conduct a warm handoff to the behavioral health team for assessment completion.

Transitional Care Services (Medi-Cal and Group Care)

Transitional Care Services (TCS) are services provided to all members transferring from one institutional care setting or level of care to another institution or lower level of care including long-term care and home settings. Once a member is identified as having had a transition from one level of care to another, they and their PCP are provided TCS team contact information for completion of screening, referrals, care planning, and all other care coordination activities. The Alliance Case Management team will continue and enhance partnerships with delegates and ECM providers to support TCS for discharged members. This program will positively impact members by assisting them in navigating through the health care system and educating our members on appropriate follow-up, reconnecting them to their medical homes, and addressing coordination of care needs thereby decreasing hospital readmissions. The Alliance is evaluating internal staffing requirements and seeking new community partners to cover the TCS program expansion.

Goal: Increase the percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7 days post-discharge from 24.7% for Medi-Cal and 22.9% for Group Care in March 2024 by 1 percentage point in March 2025.

Target Population: High-risk members defined by DHCS TCS requirements in the CalAIM: Population Health Management (PHM) Policy Guide (https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx) within 7 days after discharge from inpatient stays.

Programs or services:

- Transitional Care Services: TCS program nurse case managers and non-clinician health navigators will conduct preliminary outreach to members upon admission to inform them to expect outreach from their assigned care manager post-discharge and collect up-to-date contact information. The assigned care manager will assist them in navigating through the health care system, educate on appropriate follow-up, reconnect them to their medical homes, and address coordination of care needs.

Other Alliance Programs and Services

Programs that were not covered in the PHM program goals are listed and described below.

1. Basic Population Health Management (BPHM)
2. Community Health Worker (CHW)
3. Community Supports (CS)
4. Doula Services
5. Enhanced Care Management (ECM)
6. Health Education
7. Long-Term Care (LTC) Care Management
8. Wellness and Prevention

Basic Population Health Management (BPHM)

Formerly known as "Basic Case Management," Basic Population Health Management (BPHM) is an approach to care that ensures that needed programs and services are made available to each member, regardless of the member's risk, at the right time and in the right setting. BPHM services include access to primary care, care coordination, navigation and referrals across health and social services, information sharing, services provided by Community Health Workers (CHWs), wellness and prevention programs, chronic disease programs (Asthma, Depression, Diabetes, and Hypertension), programs focused on improving maternal health outcomes, and care management services for children under Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal Kids & Teens). BPHM services may be offered in a variety of settings, including but not limited to, primary care clinics, Alliance care management team telephonic supports, through Enhanced Care Management (ECM) community partners, or in long-term care settings.

Community Health Worker (CHW)

The Alliance offers Community Health Worker (CHW) services as a preventive health benefit to members. These services may assist with a variety of concerns including but not limited to the control and prevention of chronic conditions or infectious disease, behavioral health services, and the need for preventive services. CHW services are integrated with PHM through review of the Population Needs Assessment (PNA), member underutilization reports, input from the Community Advisory Committee, HEDIS results, and trends identified in grievances and appeals. The Alliance has developed priority areas for CHW collaborations based on the PHM Strategy and Comprehensive Quality Strategy goals to support the following:

1) PCP engagement and preventive care, with a focus on children under 21
2) Disease management programs
3) Quality measures focusing on behavioral health and preventive services, such as follow-up after ED visits for mental illness.

Community Supports (CS) *(Medi-Cal only)*
CS focuses on the social determinants of health and gives the Alliance the ability to support services to help keep members healthy and in their homes and out of hospital emergency departments (EDs), acute hospitals, and other facilities. The Community Supports currently offered are asthma remediation, housing services including deposits, navigation, tenancy sustaining services, medically supportive food, medical respite, personal care and homemaker services, caregiver respite services, and home modifications. Diversion nursing facility/transition to assisted living facilities and community transition services/nursing facility transition to a home went live in January of 2024. In July of 2024, the Alliance will launch sobering centers as a Community Support to assist members with substance use disorder. All Community Supports are available to youth and families except for medical respite and sobering centers.

Doula Services *(Medi-Cal only)*
Doulas provide holistic, person-centered, and culturally affirming care to Alliance Medi-Cal members who are pregnant or were pregnant within the past year. Services include health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum members before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion. Doulas can help with developing a birth plan, birthing techniques, provide nonmedical help with labor, and help with breastfeeding, healing, and recovery.

Enhanced Care Management (ECM): ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of members with the most complex medical and social needs through systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch, and person centered. DHCS' vision for ECM is to coordinate all care for members who receive it, including across the physical and behavioral health delivery systems. Adult populations served are adults experiencing homelessness, adults with multiple chronic conditions, adult high utilizers, adults with serious mental illness and/or substance use disorder (SUD), adults living in the community who are at risk for long-term care institutionalization, and adult nursing facility residents transitioning to the community. Pediatric populations served include homeless families or unaccompanied children/youth experiencing homelessness, individuals at risk for avoidable hospital or ED utilization, individuals with serious mental health and/or SUD needs, children and youth enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with additional needs beyond the CCS condition, and children and youth in child welfare. In January of 2024, the last two populations of focus went live: individuals transitioning from incarceration and birth equity.

Health Education

The Alliance Health Education Program maintains a system of programs, services, functions, and resources to provide health education and promotion for all members. The program seeks to promote the appropriate use of health care services, risk reduction, healthy lifestyles, and self-management of health conditions through health information, online resources, programs, and classes. Programs and materials are designed to meet the health literacy, health education, cultural, and linguistic needs of the Alliance's diverse membership.

Materials for children, adolescents, and parents cover topics such as preventive care, healthy eating, pregnancy care, parenting, and safety. Programs available include lactation consultations, positive parenting classes, and CPR and first aid training. Members receive health education resources and a form to request more wellness information with prenatal and postpartum mailings and member newsletters.

The Alliance Health Education Program uses PNA findings, PHM Strategy goals, HEDIS results, and other data sources to inform its annual workplan program priorities and target populations. Health Education priorities in 2024 include the development and distribution of targeted materials and resources for populations enrolled in disease management programs and experiencing inequities, maternal mental health, the EPSDT program, and quality improvement projects around breast cancer screening and well-child visits.

Long-Term Care (LTC) Care Management

The LTC department is responsible for the administration of the Long-Term Care program including care management services.

Intensive social work care management focuses on connecting members in LTC facilities who are interested in returning back to the community to the LTC Social Workers to assist in managing the Social Determinants of Health (SDOH) that may be impacting a member's ability to return to the community.

Intensive RN care management focuses on the Long-Term Care populations who are at high risk for readmissions due to complex medical conditions. They partner with the nursing facilities to ensure that all care is being completed timely and that the member has been evaluated and authorized for any appropriate preventative health equipment or programs.

Wellness and Prevention

The Alliance offers an online evidence-based self-management wellness and prevention program called Steps for Healthy Living provided through WebMD. The Steps for Healthy Living program walks members through a health assessment that holistically assesses various demographics, biometrics, health behaviors, and emotional and clinical self-reported wellness indicators. Members are then provided an overall wellness score based on their responses and a downloadable personalized report that identifies areas of high, medium, and low risk. Assessment and content areas include, but are not limited to, alcohol, Alzheimer's and dementia, anxiety, arthritis, asthma, coronary heart disease, depression, diabetes, healthy weight maintenance, high blood pressure, medication, pain, safety, sleep, and stress. Members are then offered various resources to take action, including developing personalized care plans and recipes, health education materials, and podcasts.

How Members are Informed about PHM Programs

The Alliance informs members about all available PHM programs and services through its website, by mail, by telephone, and/or in person.

- Information on care management, wellness and prevention, and cultural and linguistic services are on the website and member portal.
- The Alliance mails members through the member newsletter, health education mailings, and care management care plans and communications.
- Telephonic and/or mail outreach is conducted to members eligible for Complex Case Management, Transitional Care Services, Disease Management, and targeted medium-rising risk, quality improvement, and wellness programs.
- Upon referral to Community Supports services, Transitional Care Services, Complex Case Management, or Disease Management, members are also evaluated for other care management needs.
- Alliance Community Advisory Committee meetings inform and provide opportunities for members and families to give feedback regarding Alliance policies, programs, and cultural and linguistic services.

The table below details how members are eligible to participate and utilize Alliance programs and services.

How Members are Informed about PHM Programs Table

Program	Member Eligibility and How Informed	Utilizing Program Services	How to Opt In or Out
Basic Population Health Management (BPHM)	All Members are eligible. Members are informed of available BPHM services through the Alliance member handbook, newsletters, and communications with Health Education and Case Management staff or their providers.	Members receive prevention, care coordination, referrals and chronic condition supports through primary care provider routine care visits and through engagement with Alliance member services, health education, and case management teams (including delegates).	Members opt in by scheduling visits with their PCP, calling the Alliance, or accepting a call from Alliance staff or delegate offering services in response to provider or community referral. Members may opt out at any time by ending engagement.
Complex Case Management (CCM)	Member meets criteria for CCM based on	Members participate via telephone.	If they consent, the member is transferred

Program	Member Eligibility and How Informed	Utilizing Program Services	How to Opt In or Out
	hospital utilizations and co-morbidities. The monthly Population Health Report helps to identify members who meet CCM or high-risk member criteria. The CM team calls members to offer CCM.		to a RN to complete an assessment (or scheduled for a later call back date). If member declines, member has opted out.
Community Health Worker (CHW)	Member must meet eligibility criteria for CHW services, and a licensed practitioner must recommend CHW services. CHWs reach out to members through phone or community-based in-person settings.	Member may work with the CHW over the telephone, in a clinic, or in a community-based setting.	If the member consents to receiving CHW services, they receive the services. If the member declines or stops engagement, the member has opted out.
Community Supports (CS)	Member meets eligibility criteria for CS service(s). Alliance Case Management and medical or community providers offer CS services to members.	Member works with CS provider to determine the scope of services.	Members must consent to participate in CS. If the member declines, member has opted out.
Diabetes Prevention Program (DPP)	Members must meet the CDC guidelines for DPP eligibility. Members can be referred to a DPP provider from Health Education, Case Management, or Member Services staff. Clinic providers and	Members participate online in health coaching, education, and nutrition and exercise tracking.	Members opt in by taking an online survey or calling to enroll and begin services. Members are also referred directly to a DPP provider by their physicians. Members may opt out at

Program	Member Eligibility and How Informed	Utilizing Program Services	How to Opt In or Out
	primary care physicians are also referring directly to DPP programs.		any time by ending program engagement.
Disease Management - BirthWise Wellbeing	Members that are at risk for perinatal depression (pregnant or have been pregnant in the past year) are eligible for BirthWise Wellbeing. Members are informed of services through a targeted mailing campaign.	Members are provided health education materials, connected to doula services, and/or referred to mental health services, depending on need.	Members can opt in by contacting the Alliance. Members can opt out at any time by ending BirthWise services.
Disease Management-Chronic Conditions	Members identified with one or more chronic diseases (diabetes, hypertension, and/or asthma), are enrolled and sent an educational letter relevant to their chronic condition to inform them about the program. Members may be outreached to telephonically depending on their level of need and risk.	Members receive health education and based on need can receive health coaching, care coordination, or nurse case management services.	Eligible members are enrolled in the program. They contact Case and Disease Management staff to receive additional services and can opt out at any time by communicating their preference to the Alliance.
Doula Services	Medi-Cal members are eligible throughout pregnancy and one year postpartum. The Alliance proactively identifies perinatal members and sends a	Members can receive doula prenatal and postpartum visits and support during labor and delivery.	Members opt in by contacting a contracted Doula network provider listed in the provider directory or calling the Alliance. Members may

Program	Member Eligibility and How Informed	Utilizing Program Services	How to Opt In or Out
	mailer that includes information about eligibility and how to access doula services.		stop services at any time.
Enhanced Care Management (ECM)	Member meets eligibility criteria for ECM. ECM providers contact the member by telephone or face to face to offer ECM.	Member works with ECM provider for services.	If the member consents, they are enrolled in the program. If member declines, member has opted out.
Health Education	All members are offered health education materials and various classes and programs. Materials and program information are available upon request via the Wellness Request Form, which is distributed to all members when they are enrolled, through the member newsletter, and in other correspondence. These are also available to download from the Alliance website.	Members can refer themselves to programs and classes depending on the program or class. Community agencies or vendors offer some programs. Participation may be online, via mail, or in-person.	Members call the Alliance or mail a Wellness Request Form to receive program information. Depending on the program or class, members self-enroll, or the Alliance facilitates enrollment. Members may opt out at any time by ending program engagement.
Long-Term Care (LTC) Care Management	Members in LTC who are interested in transitioning back to the community are eligible for intensive social worker care management. Members	Depending on the member's level of function, activities are in collaboration with the member, family, and/or the facility.	Services are provided to eligible members. Care managers can coordinate with facilities if the member or their family does not participate.

Program	Member Eligibility and How Informed	Utilizing Program Services	How to Opt In or Out
	in LTC at high risk for readmissions are eligible for intensive nurse care management.		
Quality Improvement (QI) - Incentive Projects	Eligibility is dependent on: 1) The measure's denominator, 2) If the member has not completed the services to be in the measure's numerator, and 3) Clinic(s) that participate in this program. Members who qualify are informed by their assigned clinic.	Clinics received Gap in Care Lists of members who have not completed the services being targeted. Clinics conduct telephonic or SMS Text outreach to help schedule members.	Members opt in by scheduling and completing visits. Members can opt out by not accepting outreach, or declining scheduling the needed services.
Quality Improvement (QI) - Outreach Calls	Eligibility is dependent on: 1) The focused measure's denominator, 2) If the member has not completed the services to be in the measure's numerator. Members who qualify are informed by receiving a telephonic phone call.	Members are outreached to telephonically to help coordinate scheduling needed services.	Members opt in by accepting the telephonic outreach and scheduling needed services. Members can opt out by declining participation verbally on the telephonic outreach.
Transitional Care Services (TCS)	Member transitions from one setting to another. For high-risk	Member participates via telephone after a CM team member calls the	Members can actively participate in TCS by contacting the Alliance.

Program	Member Eligibility and How Informed	Utilizing Program Services	How to Opt In or Out
	members, the assigned care manager contacts members to offer TCS. For lower-risk members, the member is mailed a letter offering TCS services.	member or after the member receives a letter from the CM team.	Members may also choose to opt out or limit participation. In these cases, services will be coordinated as needed for members without their participation.
Wellness and Prevention	All members have access to Wellness and Prevention evidence-based self-management tools through the member portal.	Members participate by completing a comprehensive and holistic health assessment and get access to various resources to take action.	Members choose to participate online via the member portal.

How Member Programs are Coordinated

The Alliance coordinates programs across settings, providers, and levels of care to minimize duplication of services and the confusion for members being contacted from multiple sources. The following are examples of how the Alliance coordinates care across various programs, with providers, and other entities:

Case Management Programs

The Alliance Case Management (CM) team documents their work and progress in their system of record, TruCare. TruCare has an easy identification system to determine if a care manager is working with a member, to prevent internal duplication of services. This easy identification also allows for the internal team members of various disciplines to collaborate and distribute the work associated with each member.

CM works to collaborate with the member at any level of case management. To prevent duplication of services, when the CM team member is notified of additional case management services the member is receiving, outreach is made to the other team. An assessment is made of what each case manager can provide for the member, and then the work is redistributed. The distribution of work prioritizes facilitation of meeting the member's specific needs.

Community Health Center Network (CHCN), an Alliance delegate, offers basic population health management support to their members. The Alliance assists with evaluation of members for CHCN membership and basic case management services. There is communication between the Alliance and CHCN case management teams to prevent duplication of services and collaborate on cases.

Disease Management Programs

Disease Management identifies members with one or multiple chronic conditions based on claims and encounter data that include diagnoses of asthma, diabetes, hypertension, and/or depression. All members are notified by mail about services available to them in the disease management program that include care coordination, nurse case management, health coaching, and health education resources. The letter also reminds members to follow up on closing care gaps and invites members to call the Alliance Case Management (CM) team to receive additional CM services. When the member calls the CM team, the member is further assessed for additional programs the member may be eligible for and referrals are placed accordingly. Higher risk members may also receive telephonic outreach that invites them to utilize all resources available to them. Mail and telephone outreach are tracked in TruCare.

The BirthWise Wellbeing program identifies perinatal members at risk for depression based on claims and dates of service in the last four months that include perinatal diagnoses and/or delivery claims. Members will only be identified once every ten months. All members are

notified by mail about the services available to them in the BirthWise Wellbeing program that include care coordination, doula services, health education, and depression screenings and referrals to mental health providers or Alameda County Acute Crisis Care and Evaluation for Systemwide Services (ACCESS) Program. The letter invites members to call the Alliance Member Services Department to utilize all perinatal resources available to them. BirthWise services are tracked in Alliance systems of record, TruCare and HealthSuite.

Enhanced Care Management (ECM)

The Alliance contracts with ECM providers who assign lead case managers to provide in-person care coordination. ECM coordinates all levels of care, including preventative services, transitional care services, medical and behavioral health services, and referrals to Community Supports and social services. The aim is to have one point of contact based in the community to provide wraparound services to members with complex medical and social needs. The Alliance monitors ECM services to ensure non-duplication with Alliance Complex Case Management services, Transitional Care Services, the Community Health Worker benefit, 1915C waiver, Alameda County Health Care Services Agency waivers, and Targeted Case Management programs.

Health Education

The Alliance's Health Education program offers health education materials, classes and programs that are available online and upon request through any engagement with Alliance staff and providers. Health education interventions are tracked in TruCare, so other Alliance care management programs are aware of resources and referrals. Alliance Member Services and CM staff can use TruCare or Health Suite to make a referral to Health Education for outreach to the member on health concerns identified during member calls and care management assessments. In addition, Health Education staff who identify members with needs for case management support will use the same referral function to refer members to or other areas of the organization to support member needs. Health Education also refers members to community programs and resources such as nutrition classes, smoking cessation support, and diabetes self-management programs. Providers also have access to refer members via the provider portal or the provider wellness request form available on the Alliance website.

Long-Term Care (LTC) Care Management

The Long-Term Care (LTC) department is integrated within the Utilization Management program. The LTC department acts as the single point of contact for its members residing in a Long-Term Care facility. The LTC department also performs transitional care services (TCS) for members entering a Long-Term Care facility and Basic Population Health Management (BPHM) for its members. The program is designed to work collaboratively with internal staff, delegated

entities, and safety net providers within the community directly contracted with the Alliance to coordinate the delivery of appropriate, cost effective, quality-based healthcare.

QI Projects

Monthly gaps in care reports shared with primary care providers support HEDIS and non-HEDIS interventions, including well-care visits and breast cancer screening. The Alliance monitors interventions offered through the primary care providers through claims and encounter data, electronic health record feeds, and the statewide immunization database.

Transitional Care Services (TCS)

The Alliance currently enrolls members who are transitioning from one setting to another into the TCS program. The Alliance CM team receives notification of admission through the facility's Admission, Discharge and Transfer (ADT) report or Inpatient UM team (IP UM).

The program leverages the ADT system for timely notification of member admission and discharge and track data such as date of discharge via hospital electronic health records for admissions not requiring prior authorization or admissions where Alliance is not primary payor (i.e., Dual Medicare members). Upon receipt of the facility admission notification, the Alliance CM team will evaluate the member for enrollment into the TCS program. Evaluation occurs by reviewing the facility record and the Alliance's internal electronic medical record, checking for other external case management programs or teams.

The Alliance Case Management (CM) team works collaboratively with the IP UM team to complete the requirements associated with varying levels of transitional care services for members. The IP UM completes the discharge risk assessment which is then reviewed by the CM team to determine what coordination and follow up is needed for the member post-discharge. The CM team then facilitates referrals and coordinates care appropriately.

Alameda Health System (AHS), an Alliance provider group, also has an inpatient case management team and flags their patients for further evaluation into their case management program. The Alliance can see these notifications and confirm receipt of services to avoid duplication of services. The Alliance also collaborates with the CHCN delegated provider network to provide TCS services.

Integration of Community Resources

The Alliance uses the population assessment to review community resources for integration into program offerings to address member needs.

- **Care coordination for children ages 0 to 5** – In partnership with the Alliance, First 5 conducts telephonic outreach to members, care coordination, and provider assistance. Based on their outreach to members, First 5 will offer care coordination to help the member's family to schedule appointments and access identified community services. In collaboration with the Alliance's providers, First 5 will focus their outreach to members based on provider's resources and capacity to schedule appointments and offer correlating services related to the well-visit. First 5 will survey members to help identify barriers to completing well-child visits so the Alliance can develop an action plan based on results.

- **Care coordination for members with developmental disabilities** – The Alliance coordinates care for child and adult members with developmental disabilities who receive services from the Regional Center of the East Bay and makes referrals for members who could benefit from services. Supports may include behavior services, supported living services, and respite services.

- **Case Management referrals** - Alliance Case Management staff includes Nurse Case Managers, Social Workers and Health Navigators who assist members in accessing needed community resources. The following tools assist the case management team. Both resources are available to providers as well to facilitate referrals:
    - The Alliance maintains a listing of community resources for behavioral health; domestic violence; food, housing, and utilities assistance; LGBTQ; and older adults and people with disabilities, available to Alliance care management staff to facilitate referrals to community resources.
    - The Alliance also uses the FindHelp tool to assist with care management referrals to community resources such as food assistance, help paying bills, and other free or reduced cost programs. FindHelp is a closed loop referral platform used to direct communication with ending in 'closing the loop' to confirm that a member received services.

- **Coalition participation** – The Alliance regularly participates in community meetings that support the wellness goals of our PHM Strategy. These include the Alameda County Breastfeeding Coalition, the County Nutrition Action Partnership (CNAP), the Regional Asthma Management Advisory Committee, the Safe Kids Coalition, the Senior Injury Prevention Partnership, the Special Needs Committee, and the Perinatal Equity

Initiative. Each of these meetings include various stakeholders that work together to share resources and collaborate with county wide initiatives to address member health needs. The Alliance has collaborated with CNAP on the February Healthy Heart campaign and development of a multicultural cookbook.

- **Community Supports services**– Alliance Community Supports currently offered to members are asthma remediation; housing services, including deposits, navigation, tenancy sustaining services; medically supportive food; medical respite; personal care and homemaker services; caregiver respite services; home modifications; diversion nursing facility/transition to assisted living facilities; and community transition services/nursing facility transition to a home. The Community Supports (CS) team collaborates with the ECM team to host a monthly learning collaborative with the providers and additional community partners. At these learning collaboratives, various community resources are discussed, including the CS services and ECM populations of focus offered by the Alliance. Community Supports providers are committed to serving members on a timely basis and consistently collaborating with the plan to ensure appropriate and coordinated services. A full list of Community Supports services and providers is below:

Community Supports Services and Providers Table

Community Support Service	Provider
Asthma Remediation	• Alameda County Asthma Start • Roots Community Health
Housing Services, including: • Deposits • Navigation • Tenancy Sustaining Services	• Alameda County Health Care Services Agency • Adobe Services • Bay Area Community Services • Insight Housing • Building Futures with Women and Children • Building Opportunities for Self-Sufficiency • East Bay Innovations • East Oakland Community Project • Fred Finch Youth and Family Services • Housing Consortium of the East Bay • Lifelong Medical Care
Medically Supportive Food	• Project Open Hand • Recipe for Health • Alameda County Food Bank

Medical Respite	• Lifelong Medical Respite • Cardea Health • BACS Medical Respite
Personal Care and Homemaker Services	• 24 Home Care • Omatochi
Caregiver Respite Services	• 24 Home Care • Omatochi
Home Modifications	• East Bay Innovation • Omatochi
Diversion Nursing Facility/Transition to Assisted Living Facilities	• East Bay Innovations • Omatochi
Community Transition Services	• Omatochi

- **Doula capacity and training** – The Alliance will support, strengthen, and expand doula capacity and training in Alameda County in partnership with local community-based organizations to help ensure all perinatal members have access to doula services to feel supported throughout their pregnancy and in the postpartum period.

- **Health Education Provider Resource Guide for member referrals** – This is a listing of health education classes, condition self-management support, community programs and ancillary services available to members at no cost. The listing is on the Alliance website as a resource to Alliance staff, providers, and community partners. Resources include those available from non-profit, county, and community organizations that educate members regarding preventive care, condition self-management, behavioral health resources, and pregnancy and baby care. Community resources are verified and updated on a yearly basis.

- **Maternal and child health referrals** – The Alliance Health Education Department sends a weekly list of newly identified pregnant members and members who recently gave birth to Alameda County Women, Infants, and Children (WIC) for outreach and engagement. It also identifies Black prenatal members for referral to the Black Infant Health program who will outreach and enroll them into the program or refer them to other Alameda County maternal and child health programs as appropriate.

- **YumLive! virtual community nutrition education** – YumLive! is a nutrition-based health program that is offered virtually to all members and Alameda County residents 18 and over. YumLive! delivers weekly, live classes in English and Spanish. The class topics vary weekly. Some examples include preparing healthy meals, tips for exercise, and cooking

demos. YumLive! registration instructions are given to providers for promotion in their clinics. The Alliance also promotes this service with community organizations through the County Nutrition Action Partnership coalition.

Activities That Are Not Direct Member Interventions

The Alliance performs activities that are not direct member interventions, include sharing data and information with providers, administering a value-based payment program, and integrating with delivery systems.

Sharing data and information with providers

- Education, clinical practice guidelines, and important updates for Alliance providers are shared at Joint Operations Meetings (JOM), through provider quarterly packets, website and provider portal, quarterly provider representative visits, provider newsletter, Provider Manual, provider webinars and town halls, and new provider orientation.
- The Alliance developed maternal mental health program clinical guidelines and sent them to the provider network.
- The Alliance provides delegate and provider partners daily or weekly ED utilization reports based on claims for mental illness and substance use to encourage follow-up after ED visits. For delegates, reports will be uploaded to a secure portal, where designated staff will access the reports and disseminate information to providers for patient follow-up according to each delegate's care coordination process.
- Monthly member reports identifying the Alliance RSS assigned tier are shared with delegates to assist in their prioritization of outreach and care.
- Monthly ECM Eligibility Lists resulting from Alliance data mining shares information on patients who are eligible for ECM for outreach and engagement based on current criteria.
- Monthly Community Supports (CS) reports are shared to aid in identifying members who have been authorized for CS services.
- Monthly gaps in care reports shared with primary care providers to support HEDIS and non-HEDIS interventions, including well care visits and breast cancer screening.
- Monthly reports on ED utilization and Initial Health Appointment (IHA) eligible members are shared with primary care providers to support identification of those who may need additional care.
- Delegates receive monthly utilization data extracts for assigned members which allows them to have a more comprehensive view of their members and perform their own analyses.

Offering evidence-based or certified decision-making aids

- The Alliance website shares a link to the Mayo Clinic 'Care That Fits' patient-centered decision-making tool to help guide provider-patient interactions. This content helps patients understand a wide range of health conditions so that they make informed decisions about their care options.

Practice transformation support to PCPs

- Clinical background and best practices related to well-child visits and follow-up after ED visits for mental illness and substance use are shared with providers through provider webinars and measure highlight handouts.
- Practice facilitation through QI technical assistance by the Alliance is provided to clinics to improve well-child visits and diabetes management.
- In collaboration with the Institute for Healthcare Improvement (IHI) and the California Department of Health Care Services (DHCS), the Alliance is working with provider offices to improve access, coordination, and equity in well-child visits.

Provider training on equity, cultural competency, bias, diversity, or inclusion

- The Alliance requires providers to regularly complete cultural sensitivity training and provides training content to providers that is updated annually. The training covers health inequities in identified cultural groups in Alameda County, the impact of institutional racism and health inequities, cultural competency in healthcare, recognizing and addressing bias, and ways of working with diverse member populations. It also covers how to work effectively with members and interpreters through all means of communication. This training is required for all Alliance staff. The training is also promoted with all providers and posted on the Alliance website for easy access.

Value-based payment arrangements

- Annually, the Alliance develops and distributes a Pay-for-Performance (P4P) program that offers performance-based incentive payments for delivered services. Through this program, primary care providers are rewarded for superior performance and yearly improvement. The P4P is aligned with HEDIS measures, especially the DHCS Managed Care Accountability Set (MCAS) quality improvement measures. Additionally, the P4P program aims to reduce ED visits and improve access to care.

Collaborating with hospitals

- The Alliance receives daily feeds from facilities in network and identifies members in need of Transitional Care Services.
- In collaboration with the Alameda County Behavioral Health department, the Alliance works with providers at ED units with a high volume of mental illness-related visits to develop workflows to conduct assessment and care coordination.

Interacting with and integrating delivery systems

- Alliance Case Management staff engages with ECM providers to ensure appropriate case management through participation in ECM case rounds at provider sites and oversight of Health Assessment Plans, Community Supports referrals, and graduation checklists.
- The Alliance partners with Alameda County Health Care Services Agency for data sharing regarding housing status of members and participation in some county sponsored services.

Conclusion

The 2024 Population Health Management Strategy summarizes the Alliance's analysis and roadmap to meet the physical and mental health needs of its diverse and growing membership. This year's PHM Strategy outlines programs and services that care for higher risk members, such as members experiencing transitions of care and those with complex care needs as well as strategies to address the social determinants of health that exacerbate inequities through connections to community supports or doula services. The Alliance also provides programs designed to support members with multiple chronic conditions such as diabetes and hypertension, members at risk for diabetes, and pregnant and postpartum members at risk for depression. There is a continued focus on preventive care efforts with programs to improve rates of well-child visits, primary care visits, and breast cancer screenings. The Alliance strives to employ creative and person-centered solutions that center equitable approaches and impact relevant clinical, utilization, and member experience measures. As the membership and programs expand throughout 2024, the Alliance aspires to partner with members, providers, and the community to achieve optimal health and wellness for all members.