Quality Improvement Health Equity Utilization Managment Committee Voting Packet

April 10, 2026

Committee Meeting Minutes

Please click on the hyperlink(s) below to direct you to the corresponding material.

QIHEC Minutes 2/13/2026

IQIC Minutes 1/14/2026 & 3/18/2026

CLSS Minutes 1/28/2026

CAC Minutes 12/04/2025

Quality Improvement Health Equity Committee

2/13/2026

Committee Member Name and Title	Specialty	Present
Donna Carey MD, Chief Medical Officer, Alameda Alliance for Health		☒
Lao Paul Vang, Chief Health Equity Officer, Alameda Alliance for Health		☒
Stephanie Brown, MD, Medical Director, Quality Improvement, Alameda Alliance for Health	Psychiatry	☒
James Florey, MD, Chief Medical Officer, Children First Medical Group	Pediatrician	☐
Peter Currie, Ph.D. Senior Director, Behavioral Health, Alameda Alliance for Health		☒
Michelle Stott, Senior Director, Quality, Alameda Alliance for Health		☒
Anchita Venkatesh, DMD MA, Program Director, General Practice Residency, Highland Hospital		☒
Parag Sharma, MD, Medical Director, Utilization Management, Alameda Alliance for Health		☒
~~Chaunise "Chaun" Powell, MD, Sr. Chief of Student Services, Alameda County Office of Education~~		~~☐~~
~~Anthony Cesspooch Guzman, MSW Chief Cultural Officer, NAHC~~		~~☐~~
Deka Dike CEO, Omotochi		☒
Lisa Laurent, MD, Chief Medical Officer, Alameda Health System		☐
Raj Davda, MD, Chief Medical Officer, Community Health Center Network		☐
Sirina Keesara, MD, Medical Director, Community Health Center Network		☐
La Toshia Palmer, MD, Executive Director, Alameda County Office of Education		☐

Staff Member Name and Title	Present
Allison Lam, Senior Director, Health Care Services	☒
Alma Pena. Senior Manager, Grievance and Appeals	☐
Ami Ambu, Quality Improvement Project Specialist II	☒
Andrea DeRochi, Behavioral Health Manager	☐
Ang Yen, Director Health Equity	☒

Angela Moses, Quality Review Nurse	☒
Ashley Asejo, Clinical Quality Programs Coordinator	☒
Beverly Juan, Medical Director Community Health	☒
Bob Hendrix, Quality Improvement Outreach Coordinator	☐
Cecilia Gomez, Senior Manager Provider Services	☐
Dani Staub, Director, Incentives & Reporting	☐
Daphne Lo, Medical Director Long Term Supportive Services	☐
Dona Doran, Manager, Risk Adjustment	☒
Eileen Ahn, Accreditation and Regulatory Compliance Specialist	☐
Emily Erhardt, Population Health and Equity Specialist	☐
Falmata Abatcha, Quality Improvement Project Specialist II	☐
Farashta Zainal, Quality Improvement Manager	☒
Fiona Quan, Quality Improvement Project Specialist I	☒
Gil Duran, Manager, Population, Health and Equity	☒
Grace St. Clair, Director, Compliance & Special Investigations	☐
Hellai Momen, Quality Review Nurse	☐
Homaira Momen, Quality Review Nurse	☒
Jaini Goradia, Director, Stars Strategy and Program Manager	☒
James Burke, Lead Quality Improvement Project Specialist	☒
Jennifer Karmelich, Director, Quality Assurance	☐
Jessica Adams, Accreditation and Regulatory Compliance Specialist	☐
Jessica Jew, Population Health and Equity Specialist	☒
Jessica Pedden	☒
Kalkidan Asrat, Quality Improvement Project Specialist II	☒
Kathy Ebido, Senior Quality Improvement Nurse Specialist	☒
Katrina Vo, Senior Communications & Content Specialist	☐
Kayla Williams, Manager, Member Experience & Programs	☐
Kimberly Glasby, Director, Long Term Services and Supports	☒
Kisha Gerena, Accreditation Manager	☐
Lily Hunter, Director, Social Determinants of Health	☒
Linda Ayala, Director of Population Health and Equity	☒

Loc Tran, Manager, Access to Care	☒
Luke Lim	☒
Mao Moua, Manager, Cultural and Linguistic Services	☐
Matthew Woodruff, Chief Executive Officer	☐
Megan Hils, Quality Improvement Project Specialist II	☐
Michelle Findlater, Director, Utilization Management	☒
Michelle Lewis, Senior Manager Communications & Outreach	☐
MyLe Hillard, Manager, HEDIS Strategy & Program Management	☒
Patricia Carrillo, Quality Improvement Project Specialist I	☒
Richard Golfin III, Chief Compliance Officer & Chief Privacy Officer	☒
Rosa Carrodus, Disease Management Health Educator	☒
Sangeeta Singh, Quality Improvement Project Specialist I	☐
Sanya Grewal, Healthcare Services Specialist	☐
Sarbjit Lal, Quality Improvement Project Specialist	☒
Sean Pepper, Compliance Special Investigator	☐
Shatae Jones, Director Housing & Community Services Program	☒
Stephen Smythe, Director, Program Compliance & Privacy Operations	☒
Tanisha Shepard, Quality Improvement Project Specialist	☒
Tiffany Cheang, Chief Analytics Officer	☒
Tome Meyers	☒
Yemaya Teague, Senior Analyst of Health Equity	☐
Community Members in Attendance	☐
Linda Franklin, Public Health, OOD	
Carolina Guzman	

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
I. Call to Order	D. Carey	The meeting was called to order at 9:01am		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
II. Alameda Alliance Updates	D. Carey	**Committee Structure Changes:** • Dr. Carey explained that the committee now combines meetings for Quality Improvement, Health Equity and Utilization Management reflecting the addition of the DSNP (Dual Special Needs Plan) line of business. This change aims to streamline internal meetings while ensuring all required information is presented. **DMHC Quality Findings and Corrective Actions** • **Quality Findings Overview:** M. Stott reported that the DMHC identified issues with the resolution of corrective action plans (CAP) for Potential Quality Issues (PQIs), particularly cases where provider responses were not received despite escalation processes. • **Process Improvements:** Actions taken include revising the CAP letter and template, implementing ongoing presentation of findings to the committee, and ensuring documentation and evidence of follow-up for each quality of care issue. • **Corrective Action Plan Tracking:** The staff tracks the types of cases receiving corrective action plans, with most CAPs issued for moderate (C3) or serious quality of care issues (C4). Providers with trends in these areas are monitored, and ongoing collaboration with entities like Modiv Care is emphasized.		
III. Chief of Health Equity Updates	LP. Vang	**Health Equity and DHCS DEI Training Update** • **DEI Training Extension:** LP. Vang announced that DHCS intends to extend the deadline for the DEI training (originally APL 24-025) to December 31, 2026, providing an additional year for compliance.		

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		• **Stakeholder Feedback:** Feedback from MCPs and FQHC providers regarding challenges with the training, including concerns about federal funding, was collected and will be considered in the revised APL. • **Internal Collaboration:** LP. Vang plans to work with the compliance department and key division personnel to review the revised APL and submit comprehensive feedback, supplementing group input already provided. • **Ongoing Health Equity Activities:** The committee continues to focus on milestones five and six, collaborating with DSNP colleagues to implement mechanisms for improved star ratings and health equity for vulnerable populations.		
IV. QIHEC/UMC Charter Review & Annual Confidentiality Statement	M. Stott	**QIHE/UMC Charter and Policy Updates** • **Charter Key Changes:** The revised charter now includes all lines of business (Medi-Cal, Group Care, DSNP), incorporates utilization management responsibilities, and ensures oversight of delegated and downstream subcontractors. Membership requirements were updated to ensure most practicing physicians. • **Voting Timeline:** D. Carey reiterated that voting on the charter and policy updates will take place at the next committee meeting once quorum is established.		
V. Policies & Procedures	D. Carey	The Policies & Procedures packet was sent out prior to QIHEC for committee review. • QI-104: Potential Quality of Care Issues (PQI) • QI-125: Blood Lead Screening for Children • QI-135: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services • UM-001: Utilization Management Program		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• UM-002: Coordination of Care • UM-003: Concurrent Review and Discharge Planning Process • UM-018: Targeted Case Management (TCM) and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Kids and Teens) • UM-032: Therapeutic Enteral Formulas • UM-033: Topical Fluoride Varnish • UM-051: Timeliness of UM Decision Making and Notification • UM-056: standing Referrals • UM-057: Authorization Service Requested • UM-059: CoC for Medi-Cal Beneficiaries who transition into an MCP • UM-060: Delegation of Utilization Management • UM-063: Gender Affirming Surgery and Services • UM-068: Tertiary and Quaternary Review Process • UM-D-005: Review of Admissions, Discharge and Transfer Files • UM-D-009: Integrated Organization Determinations		
VI. Meeting Minutes	D. Carey	The meeting Minutes packet was sent out prior to QIHEC for committee review. • QIHEC: 11/14/25 • A&A: 11/05/25 • UMC: 12/19/25	Move to Approve: 1st: P. Currie 2nd: D. Dike	
VII. D-SNP Overview	T. Meyers	**Medicare D-SNP Program Launch and Updates:** • **Product Launch and Enrollment:** The D-SNP product launched on January 1, 2026, with 165 effectuated enrollments and over 5,000 applications pending review. The launch experienced minor issues but nothing requiring state or CMS reporting. • **Open Enrollment and Member Retention:** The first three months post-launch constitute an open enrollment period,		

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		during which member satisfaction is critical to prevent switching. A post-deployment command center remains active throughout March. • **Provider Engagement and Training:** A pilot program with CHCN and Bay Well focuses on provider training, workflow identification, and model of care education. Over 630 providers completed model of care training. • **Strategic Initiatives and Future Plans:** The team is preparing an RFQ for a marketing and sales vendor, aiming to select a partner by July or August. Plans for growth in subsequent years are underway, with ongoing collaboration with Millman partners for 2027 bid design. **<u>Findings & Recommendations</u>** **Key Findings:** **Launch and Enrollment** The D-SNP product went live on January 1, 2026 with 165 effectuated members and 5,000+ applications pending review, reflecting strong early demand. Launch issues were minor and did not require state or CMS reporting. **Open Enrollment and Retention** The first three months remain a high-risk period for member switching. A post-deployment command center is active through March to monitor issues, support member experience, and stabilize operations. **Provider Engagement** A pilot with CHCN and Bay Well is underway to strengthen provider readiness. 630+ providers have completed Model of Care training, and workflow mapping is helping identify operational improvements.		

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		Strategic Planning An RFQ for a marketing and sales vendor is in development, with vendor selection targeted for July–August. Planning for future growth continues, including collaboration with Milliman on the 2027 bid. **Key Recommendations:** • **Accelerate application processing** to reduce the pending backlog and support timely onboarding. • **Prioritize member experience** during open enrollment through proactive outreach and rapid issue resolution. • **Expand provider engagement** by scaling pilot learnings and continuing MOC training cycles. • **Advance strategic vendor selection** and align 2027 bid planning with early utilization and operational insights.		
VIII. UM Workplan Update	M. Findlater	**Utilization Management Work Plan and Metrics Review** • **Paid Days and Length of Stay:** Paid days per 1,000 and average length of stay both decreased compared to the previous year, reflecting efforts to improve discharge processes and appropriate care transitions. • **Admissions and Readmissions:** Admissions per 1,000 showed a slight decrease, while readmission rates increased slightly, remaining above the 18% goal. The highest readmission rates were observed in SPD-LTC aid categories and certain delegates. • **Inpatient Nurse Pilot:** A nurse was placed on-site at Washington Hospital to provide face-to-face care coordination in the emergency department and inpatient units, aiming to reduce admissions and expedite discharges.		

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		• **Denial Rates:** Inpatient and outpatient denial rates increased slightly, with stricter radiology authorization criteria contributing to higher outpatient denials. Most inpatient stays were deemed medically necessary. **<u>Findings & Recommendations</u>** **Key Findings:** **Paid Days & Length of Stay:** Both metrics decreased year over year, indicating improved discharge planning and more efficient care transitions. **Admissions & Readmissions:** Admissions per 1,000 declined slightly, but readmissions increased and remain above the 18% goal, with the highest rates in SPD-LTC populations and certain delegates. **Inpatient Nurse Pilot:** On-site nurse presence at Washington Hospital is supporting real-time care coordination, with early signs of improved discharge timeliness and reduced avoidable admissions. **Denial Rates:** Slight increases in inpatient and outpatient denials, largely driven by stricter radiology criteria. Most inpatient stays continued to meet medical necessity. **Key Recommendations:** • **Reduce Readmissions:** Focus interventions on SPD-LTC members, strengthen post-discharge follow-up, and address performance gaps with high-readmission delegates.		

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		• **Enhance Care Transitions:** Continue refining discharge workflows and partner with post-acute providers to maintain momentum in reducing length of stay. • **Assess Nurse Pilot Impact:** Review pilot metrics to determine effectiveness and consider expansion to other high-volume hospitals if results remain positive. • **Monitor Denial Trends:** Reassess radiology criteria, provide provider education, and track patterns to ensure denials align with evidence-based standards.		
IX. Alameda County Community Needs Assessment	G. Duran C. Guzman	**Alameda County Community Health Assessment Presentation** • **Assessment Process:** The assessment involved quantitative and qualitative data collection, including focus groups in multiple languages, community forums, and collaboration with local hospitals and managed care plans. • **Key Findings:** Major health needs identified were social determinants (economic and environmental factors), chronic diseases, communicable diseases, and behavioral health. Barriers included access, provider shortages, violence, economic instability, and food insecurity. • **Community Recommendations:** Suggestions included investing in health infrastructure, workforce development, culturally competent care, education, prevention programs, and addressing living wage and affordable housing. • **Next Steps:** The final Community Health Assessment report is expected in March, after which planning for the Community Health Improvement Plan will begin, with ongoing opportunities for committee participation.		
X. Quality Programs	F. Zainal J. Pedden	**Quality and Performance Measurement Updates**		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• **Pay-for-Performance Measures:** The 2024 payout was $4 million (65% of the pool), with most delegates improving HEDIS rates. For 2026, topical fluoride for children was added, and two measures were removed due to lack of improvement. • **MCAS and HEDIS Metrics:** The state increased the number of accountable MCAS measures to 20 for 2026, including new requirements for colorectal cancer and depression screening. • **Medicare Stars Program:** Provider education initiatives include webinars, a new webpage, and a comprehensive guide. Gaps in care reporting for D-SNP measures will begin, and a member incentive program using a flex card was launched to encourage preventive care. • **Performance Monitoring:** Stars ratings are based on national cut points, with all D-SNP members included in the plan's overall rating. Cross-departmental collaboration and early education are emphasized to drive quality improvement. **<u>Findings & Recommendations</u>** **Key Findings:** **Pay-for-Performance:** 2024 payouts totaled $4M (65% of pool) with broad HEDIS improvement. For 2026, topical fluoride was added and two low-performing measures were removed. **MCAS/HEDIS:** The state expanded the 2026 accountable set to 20 measures, adding colorectal cancer and depression screening requirements. **Medicare Stars:** Provider education is expanding through webinars, a new webpage, and a guide. D-SNP gaps-in-care reporting will begin, and a flex-card incentive program was launched to drive preventive care.		

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		Performance Monitoring: Ratings rely on national cut points, and all D-SNP members count toward overall Stars. Early education and cross-department collaboration remain priorities. **Key Recommendations:** • Focus provider outreach on new 2026 measures and reinforce documentation workflows. • Strengthen data quality and monitoring to support MCAS, HEDIS, and Stars performance. • Use D-SNP gap reporting and the flex-card incentive to target high-impact care gaps. • Maintain coordinated, cross-functional quality efforts with earlier annual education cycles.		
XI. Initial Health Appointment	F. Zainal K. Ebido	F. Zainal and K. Ebido presented data on initial health appointment (IHA) completion rates, provider network performance, and findings from_chart reviews, highlighting areas for provider education and process improvement. • **IHA Completion Rates:** IHA completion within 120 days remained steady compared to the previous year, with CFMG outperforming other networks. Delegated providers are implementing automation and outreach improvements. • **Chart Review Findings:** Reviews of 31 records showed high compliance with IHA requirements for children and adults, but lower rates for adolescents. Member risk assessments and use of validated screening tools for alcohol, drug, and depression screening were identified as areas needing improvement.		

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		• **Provider Education and Next Steps:** The team will continue provider education on risk assessments and validated screening tools, send audit findings to providers, and revise the provider guide. Collaboration with EMR vendors and sharing of resources are planned. • **Innovative Approaches for Fluoride Varnish:** A. Venkatesh suggested integrating registered hygienists into well-child visits and utilizing tele dentistry to improve fluoride varnish application rates and early dental home establishment. **<u>Findings & Recommendations</u>** **Key Findings:** **IHA Completion:** Completion within 120 days remained stable, with CFMG leading performance. Delegated groups are adopting automation and enhanced outreach to improve rates. **Chart Reviews:** Among 31 records, compliance was strong for children and adults, but lower for adolescents. Gaps were noted in risk assessments and use of validated screening tools for alcohol, drug, and depression screening. **Provider Education:** Continued education will focus on risk assessments and screening tools. Audit findings will be shared, the provider guide will be updated, and collaboration with EMR vendors will support workflow improvements. **Fluoride Varnish Innovation:** Integrating registered hygienists into well-child visits and exploring tele-dentistry were proposed to improve fluoride varnish rates and early dental home establishment. **Key Recommendations:** • Reinforce provider training on risk assessments, validated screening tools, and adolescent IHA requirements.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• Expand automation and outreach strategies to improve IHA completion consistency across networks. • Use audit findings to guide targeted coaching and documentation improvements. • Advance EMR integration to streamline screening workflows. • Pilot innovative fluoride varnish approaches, including hygienist involvement and tele-dentistry models.		
XII. PQI Update	M. Stott	M. Stott provided an update on the Potential Quality Issue (PQI) program, including dashboard trends, process improvements, corrective action plans, and training activities. • An increase in PQI volume was noted in Q3 2025 due to the addition of a QI Medical Director, which supported timely case closures. and then a decrease in Q4 2025 attributed to improved coordination with the Grievance team. The number of Q4 2025 PQI closed cases will be finalized once the 150 day timeframe is completed. • PQIs most frequently involve quality of access and quality of service issues. • PQI turnaround times have consistently met the 150-day requirement since November. • Most cases were classified as C0 (no quality-of-care issue), with fewer C2 and C3 cases; C4 cases remained minimal. • Process improvements implemented in September streamlined workflows, reduced duplicate referrals, aligned tracking and trending efforts, and shifted corrective actions toward system-level trends.		

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		• State-required PQI training was completed for Member Services, with additional trainings planned for other departments. • Corrective Action Plans were primarily associated with C3 cases. Modiv Care continues to be monitored due to recurring service-related issues, particularly transportation. **<u>Findings & Recommendations</u>** **Key Findings:** **PQI Volume and Coordination:** PQI volume increased in Q3 2025 due to the addition of a QI Medical Director, which supported timely case closures. and then a decrease in Q4 2025 attributed to improved coordination with the Grievance team **Issue Types:** Most PQIs involved quality of access and quality of service concerns. **Turnaround Times:** PQI processing has consistently met the 150-day requirement since November. **Case Classification:** Most cases were C0 (no quality-of-care issue), with fewer C2 and C3 cases; C4 cases remained minimal. **Process Improvements:** September workflow changes reduced duplicate referrals, improved tracking and trending, and shifted corrective actions toward system-level issues. **Training:** State-required PQI training was completed for Member Services, with additional department trainings planned. **Corrective Action Plans:** CAPs were primarily associated with C3 cases, and Motive Care continues to be monitored for recurring transportation-related service issues. **Key Recommendations:**		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• Maintain strong coordination with the Grievance team and QI Medical Director to sustain timely case closures. • Continue monitoring trends in access and service-related PQIs to identify systemic improvement opportunities. • Reinforce workflow improvements to prevent duplicate referrals and strengthen tracking consistency. • Expand PQI training to remaining departments to ensure consistent understanding of requirements. • Prioritize corrective action oversight for C3 cases and continue focused monitoring of Motive Care to address recurring transportation concerns.		
XIII. CAC Activities & Findings	L. Ayala	L. Ayala summarized feedback from the Community Advisory Committee, highlighting member concerns about access, communication, policy impacts, health inequities, and the need for action-oriented solutions. • **Access and Policy Concerns:** Members expressed worries about coverage continuity, especially for undocumented and medically complex members, and the effects of policy and funding changes on access to care and community resources. • **Outreach and Communication:** The committee recommended clearer, culturally appropriate outreach, stronger community health worker engagement, and motivational messaging for preventive screenings. • **Health Equity and Member Experience:** Persistent disparities in health outcomes were noted, with calls for improved communication, reduced survey fatigue, and strengthened community partnerships to build trust and address systemic barriers.		

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		• **Service Availability Challenges:** Members highlighted gaps in timely access to community-based adult services, sometimes requiring travel out of state, and emphasized the need for collaborative problem-solving. **<u>Findings & Recommendations</u>** **Key Findings:** • Members raised concerns about coverage continuity for undocumented and medically complex individuals, noting that policy and funding changes are affecting access to care and community resources. • The committee emphasized the need for clear, culturally appropriate communication, stronger engagement from community health workers, and motivational messaging to support preventive screenings. • Ongoing health inequities and uneven member experiences were highlighted, including communication gaps, survey fatigue, and the need for deeper community partnerships to build trust and address systemic barriers. • Significant service availability challenges persist, with delays in accessing community-based adult services and, in some cases, the need to travel out of state for care. **Key Recommendations:** • Strengthen strategies to maintain coverage continuity and monitor the impact of policy changes on vulnerable populations.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• Improve outreach and communication through culturally tailored materials, multilingual messaging, and expanded community health worker involvement. • Advance health equity efforts by reducing survey burden, improving feedback loops, and investing in long-term partnerships with trusted community organizations. • Address service access gaps by assessing capacity, coordinating across partners, and developing actionable solutions to improve timely access to community-based adult services.		
XIV. Public Comment	D. Carey	None		
XV. Adjournment	D. Carey	Meeting Adjourned at 10:35pm		

X____ Date____________________

Dr. Donna Carey
Chief Medical Officer, Alameda Alliance for Health
Chair

Minutes prepared by: Ashley Asejo - Clinical Quality Programs Coordinator

INTERNAL QUALITY IMPROVEMENT COMMITTEE
1/14/2026, 1:00pm-2:30pm
Remote

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Name	Title	Name	Title
Michelle Stott, RN, MSN	Senior Director of Quality	Dr. Donna Carey	Chief Medical Officer
Allison Lam	Director, Health Care Services	Dr. Beverly Juan	Medical Director, Utilization Management
Lilly Hunter	Director, Social Determinants of Health	Darryl Crowder	Director, Provider Relations & Provider Contracting
Jennifer Karmelich	Director of Quality Assurance	Cecilia Gomez	Sr. Manager, Provider Services
Alma Pena	Manager, Grievances & Appeals	Tiffany Cheang	Chief Analytics Officer, Healthcare Analytics
Linda Ayala	Director, Population Health	Farashta Zainal	Manager, Quality Improvement Team
Loc Tran	Manager, Access to Care	Christine Rattray	Supervisor, Quality Improvement (PQI)
Gil Duran	Manager, Population Health and Equity	Mao Moua	Manager, Cultural and Linguistic Services

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INTERNAL QUALITY IMPROVEMENT COMMITTEE
1/14/2026, 1:00pm-2:30pm
Remote

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Agenda Item	Responsible Person(s)	Discussion	Follow-Up Person(s)/Action/Due By
Call to Order/Roll Call			
I. Review agenda for 01/14/2026	F. Zainal	The agenda was reviewed by Farashta.	
II. DSNP Live	M. Stott	• Michelle announced that DSNP successfully went live on January 1st, marking a major milestone in supporting vulnerable members dually enrolled in Medi-Cal and Medicare. • Michelle reported 216 completed enrollments, 1,070 leads, and an average of 3 new enrollments per day, primarily generated through service requests and inbound calls.	
III. Policies & Procedures	Policy Owners	The following Policies were reviewed and will move to QIHEC in February. • QI-104: Potential Quality of Care Issues • QI-125: Blood Lead Screening for Children • QI-135: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services	
IV. Meeting Minutes - **IQIC 10/15/2025**	F. Zainal	Meeting Minutes submitted for review. • Minutes Approved 11/6/2025	
V. IHA Audit Results	K. Ebido	• Kathy reported that 31 records were reviewed, with 16 additional requested records not returned in time. The audit focused on appointment timeliness, documentation completeness, and evidence of outreach attempts. • Preventive Screening Findings (Children): Documentation rates were low across several measures—fluoride varnish at 17%, developmental disorders at 33%, and maternal depression screenings at 0%. Kathy noted that missing fluoride varnish	

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		documentation often stems from treatments occurring in dental settings without corresponding medical record updates. • Preventive Screening Findings (Adolescents): Incomplete documentation persisted for adolescent screenings, with hearing and vision screenings at 43% and alcohol/drug disorder screenings at 0%, largely due to the absence of validated assessment tools. Recommendations: Farashta recommended requesting risk assessments and relevant values when collecting charts, particularly from CHCN-managed records, to improve completeness for future audits.	
VI. Population Health and Health ○ **Health Education Program Description** ○ **NSMHS (Non-Specialty Mental Health Services) Outreach and Education** ○ **Quality Focused CAC Update**	M. Rubalcava/ M. Moua	• Monique presented an overview of the Alliance Health Education Program, emphasizing its role in supporting quality, equity, and population health through prevention and self-management services. • The program delivers multilingual, low-literacy materials, group classes, one-on-one education, and new supports such as community health workers and doulas. • Materials are offered in all threshold languages, reviewed for cultural and linguistic appropriateness, and meet DHCS and readability standards. • Population health data is used for targeted outreach, with collaboration across internal teams and community partners. • Monique reported that only 6% of members use non-specialty mental health services, with even lower utilization among older	

INTERNAL QUALITY IMPROVEMENT COMMITTEE
1/14/2026, 1:00pm-2:30pm
Remote

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		adults, certain linguistic groups, and members with disabilities or in long-term care. • The annual outreach and education plan was developed with community input to increase awareness and reduce stigma. • Outreach strategies include multilingual communications, stigma-reduction messaging, social media, community events, provider education, and partnerships with local agencies. • Ongoing efforts focus on educating primary care providers through collaborations with Asian Health Services, Lifelong Medical Care, and Alameda County Behavioral Health. • Linda noted that behavioral health, communications, and outreach teams play a central role in implementing the annual mental health outreach plan submitted to the state. • Mao provided an overview of the Quality-Focused CAC, which gathers member input on access, quality, and health equity. Participants were invited to the next meeting in March. • CAC members expressed worries about serving undocumented residents due to recent legislative changes, citing issues with coverage loss, medication access, IHSS support, and reduced funding for community organizations. • Members requested clearer explanations of the community health worker program and stronger education and motivational outreach for blood pressure and cancer screenings, including support for returning screening kits. • Recommendations included simplifying messaging, using community-based outreach sites, providing warm hand-offs from PCPs to mental health providers, offering outreach incentives,	

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Remote

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		and educating younger bilingual individuals to help families navigate services. • Members raised concerns about housing for older adults, encouraged collaboration with the City of Oakland on homelessness, and requested updates on the Alliance's community support efforts. • Members expressed interest in supporting outreach through faith-based engagement, suggested enhancements to member ID cards (including digital options), and noted survey fatigue from frequent requests. • Concerns were raised about the grievance and appeals process, including a request for six-month follow-up on serious cases. The G&A team will present more information at the March meeting.	
VII. P4P Update, Medi-Cal HEDIS Update	F. Zainal/ K. Williams/ J. Pedden	• Farashta reported that $6M was allocated and $4M was paid out based on HEDIS and other incentive measures. She reviewed the metrics used to determine provider payments. • Most HEDIS measures will remain the same, with topical fluoride for children added and primary care visit and readmission rate measures removed due to limited improvement. • Five measures are currently below minimum performance levels, including topical fluoride. Additional data and chart reviews are expected to improve rates. • Four new measures will be added in 2026—colorectal cancer screening, depression screening and follow-up for adolescents and adults, postpartum depression screening and follow-up, and prenatal depression screening and follow-up—bringing the total to 20.	

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Agenda Item	Responsible Person(s)	Discussion	Follow-Up Person(s)/Action/Due By
2025, Medicare Stars Update		• Jessica and Kayla provided a high-level overview of Stars measures (HEDIS, CAHPS, pharmacy, and operations). More detailed performance data will be shared in future meetings. • Kayla highlighted ongoing provider training for the Stars program, including QI presentations, a webinar next month, and an upcoming guide with measure details and best practices. • Member-facing English materials for DSNP flex card incentives have been approved and are being translated into threshold languages for distribution.	
VIII. PQI • **Annual Training** • **PQI Dashboard** • **PQI Cap**	M. Stott/H.Momen	• Michelle reported that process improvements with the GNA team resulted in fewer PQI referrals in Q4, particularly for quality-of-service cases, as more issues were resolved upstream. • Corrective action plans continue for C3 and C4 cases, and a recent DMHC CAP finding requires enhanced documentation and revised processes to ensure all issues are fully addressed. • Weekly meetings between the grievance and PQI teams have strengthened collaboration through cross-training and improved understanding of workflows and handoffs. • Jennifer updated the Grievance SOP and worked with the PQI team to clarify definitions and refine the PQI cheat sheet. • Angie received cross-training as a QI nurse to review grievances, which improved case classification and contributed to reducing quality-of-service cases.	
IX. NCQA Update	E. Ahn	• Annual NCQA reports are due June 1st and will be reviewed and approved at the May 8 QIHEC meeting.	

INTERNAL QUALITY IMPROVEMENT COMMITTEE

1/14/2026, 1:00pm-2:30pm

Remote

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		• Eileen reviewed upcoming 2026 NCQA standards, noting the need to update PM PS and related documents to ensure compliance. • Mock NCQA surveys are tentatively planned for September 2026, with outreach to participating teams closer to the date. • The CAP survey involving the G&A team will occur at the end of Q1, with universe submission due at the end of March and survey activities continuing into April.	
Adjournment	F. Zainal	Next meeting: March 2026	

Meeting Minutes submitted by: Anne Villareal Date: 1/16/2026

Approved by: Farashta Zainal Date:

INTERNAL QUALITY IMPROVEMENT COMMITTEE
3/18/2026, 1:00pm-2:30pm
Remote

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Name	Title	Name	Title
Michelle Stott, RN, MSN	Senior Director of Quality	Dr. Donna Carey	Chief Medical Officer
Allison Lam	Director, Health Care Services	Dr. Beverly Juan	Medical Director, Utilization Management
Lilly Hunter	Director, Social Determinants of Health	Darryl Crowder	Director, Provider Relations & Provider Contracting
Jennifer Karmelich	Director of Quality Assurance	Cecilia Gomez	Sr. Manager, Provider Services
Alma Pena	Manager, Grievances & Appeals	Tiffany Cheang	Chief Analytics Officer, Healthcare Analytics
Linda Ayala	Director, Population Health	Farashta Zainal	Manager, Quality Improvement Team
Loc Tran	Manager, Access to Care	Christine Rattray	Supervisor, Quality Improvement (PQI)
Gil Duran	Manager, Population Health and Equity	Mao Moua	Manager, Cultural and Linguistic Services

INTERNAL QUALITY IMPROVEMENT COMMITTEE
3/18/2026, 1:00pm-2:30pm
Remote

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Agenda Item	Responsible Person(s)	Discussion	Follow-Up Person(s)/Action/Due By
Call to Order/Roll Call			
I. Review agenda for 03/18/2026	F. Zainal	The agenda was reviewed by Farashta.	
II. IQIC meeting structure	M. Stott	• Michelle shared that the IQIC meeting structure will transition toward rapid-cycle process improvement and more discussion-focused sessions. Regulatory items such as policies and procedures will be reassigned to QIHEC to avoid duplication. • Michelle also announced plans to shift IQIC meetings to a monthly schedule and adjust attendance to include key domain experts relevant to each discussion topic.	
III. Policies & Procedures	Policy Owners	• No policies to report.	
IV. Meeting Minutes - **IQIC 01/16/2026**	F. Zainal	Meeting Minutes submitted for review. • Minutes Approved 02/10/2026	
V. Practice Coaching Evaluation	M. Stott	• Michelle highlighted Denise Armstorff's work to strengthen the QI coaching infrastructure by standardizing QI methodologies, enhancing provider facilitation, and improving overall practice coaching. • Michelle reported significant growth in QI specialists' confidence and skill levels, with most now self-rating as proficient or master following Denise's coaching and assessments.	

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		• Sangeeta shared that ongoing coaching sessions have increased team independence, allowing her to shift from hands-on guidance to reviewing completed work. • Kale described how leveraging data and journey mapping in outreach uncovered unexpected member concerns which deepened the team's understanding and informed improvements to their approach. • Michelle outlined ongoing goals to advance team members' skills for independent QI project execution, including strengthening end-to-end project planning, evaluation, and deepening expertise in population health and team-based care. • Michelle described how QI capacity at the practice level was strengthened through individualized coaching, peer-based cohort learning, and targeted organizational supports. These efforts included assigning dedicated QI specialists to clinics with support in coaching. • Michelle also reported that the internal cohort model such as the cervical cancer screening cohort with Lifelong Medical, proved effective in driving rapid-cycle improvements and enhancing provider engagement through group coaching, shared learning, and best-practice exchange. • Michelle reported that the cervical cancer screening cohort exceeded its target, improving screening rates from 52.86% in June to 60.37%, surpassing the goal of 56.86%.	

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		• Michelle also shared that 100% of cohort participants agreed or strongly agreed that the cohort experience increased their confidence and provided meaningful value to their QI work.	
VI. QI Program Trilogy Documents - **2024 Evaluation** - **2025 Program Description** - **2025 Workplan**	QI Leadership	• Michelle announced the completion of the Quality Improvement Health Equity Trilogy, recognizing it as a major organizational milestone and acknowledging Ami's work in formatting and organizing the documents. • Michelle outlined alignment with Cal AIM and the organization's quality strategy, emphasizing: ➢ Prevention and early intervention ➢ Chronic care and whole-person care ➢ Eliminating health disparities ➢ Using data-driven improvement and member engagement	
VII. QIHE Cross-Functional Operating Plan	M. Stott	• Farashta reported preliminary 2025 HEDIS improvements, including: ➢ Higher follow-up rates after ED visits for alcohol/drug dependency ➢ Child and adolescent immunizations above the 90th percentile **Member Outreach & Engagement** • Outreach coordinators contacted 8,000+ members, engaging 31% to promote preventive care.	

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		• Ongoing efforts include: ➢ Strengthening PCP connections ➢ Addressing access barriers (e.g., transportation) ➢ Expanding case and disease management **Learning Academy** • Delivered 20+ webinars and launched continuing education for nurses. • Submitted a CME pre-application to expand accreditation. **Health Equity & Well-Child Initiatives** • State-mandated project to increase well-child visits among Black/African American families, with partnerships including: ➢ First Five ➢ Alameda Health System's Beloved Black Birthing Program • Outreach, incentives, newsletters, and future in-house texting planned. **Oral Health** • Continued improvement in topical fluoride application rates through: ➢ School district and FQHC partnerships ➢ Provider education and best-practice sharing ➢ Exploration of fluoride treatment kit	

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		Performance Measure Data • Michelle asked about the impact of upcoming state data for TFL; analytics anticipate potential increases that may help surpass MPL thresholds. **Disease Management Programs** • Alliance operated programs for: ➢ Asthma ➢ Hypertension ➢ Diabetes ➢ Perinatal depression • Outreach letters and health education materials distributed; case managers trained in True Care. **Community Health Worker (CHW) Pilot** • Journey Health pilot showed 77% of members achieved high self-management confidence after 12 weeks **Chronic Condition Outreach** • Outreach for AMR, A1C, and CBP included: ➢ CHW partnerships ➢ Bay Area Community Health Collaboration ➢ Member incentives • Result: 52%+ of targeted members obtained current readings.	

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		• Provider-led outreach continues to outperform health plan or CHW outreach.
		
		CBP Remote Monitoring – AHS Project
		
		• Outreach to members lacking BP monitor orders; two pilots offered free monitors.
		• Staffing challenges shifted remote monitoring strategy
		
		Asthma, Hypertension & Diabetes
		
		• Continued asthma medication education despite HEDIS changes, with the removal of AMR measure in MY2026
		• Exploring vendor partnerships for remote monitoring.
		• Promoting CBP coding and supplemental data submission.
		
		Cancer Screening Initiatives
		
		• Breast cancer screening improved via:
		  ➢ Targeted outreach
		  ➢ Culturally tailored materials
		  ➢ Incentives
		  ➢ Mobile mammography
		• For MY2026 there will be focus on BCS for ages 40–49, who have lower screening rates.
		• Cervical cancer screening improved through:
		  ➢ Pap day events
		  ➢ Incentives
		  ➢ HPV self-swab expansion	

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		• Colorectal cancer screening increased through:
		  ➢ Exact Sciences partnership
		  ➢ Cologuard distribution
		  ➢ Staff incentives and education
		
		Perinatal Care
		
		• 6,500+ birthing members received prenatal/postpartum packets.
		• 88 members used doula benefits, with higher uptake among Black and Hispanic members.
		• Strengthened partnerships with WIC, PEI, and peer support programs.
		• Prenatal care rates remained above MPL but declined from 91.28% → ~86% due to access issues and a larger denominator.
		• Only 48.1% of members had a first prenatal appointment (target: 75%); barriers include:
		  ➢ OB shortages
		  ➢ Provider turnover
		  ➢ Outdated directories
		
		Postpartum & Well-Child Visits Pilot:
		
		• Reminder calls + $25 incentive resulted in:
		  ➢ 17% postpartum visit completion
		  ➢ 3% well-child visit completion
		  ➢ 59% postpartum visit completion overall	

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		• Future outreach will test performance without incentives. **Behavioral Health** • Compliance exceeded **75%** for non-urgent, urgent, and follow-up appointments. • Ongoing provider education and corrective action plans for non-compliance. **Member Experience** • Satisfaction decreased for care, tests, and treatment from 2023 to 2024. • Satisfaction with specialist appointments increased. **Interpreting Services** • Exceeded 95% availability, with strong growth among Spanish, Chinese, and Farsi-speaking members. **PQI & Facility Site Review** • Over 9,000 PQIs closed; improved grievance-to-PQI processes. • 112 corrective action plans issued; only one pending, none escalated beyond 120 days.	

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Agenda Item	Responsible Person(s)	Discussion	Follow-Up Person(s)/Action/Due By
		Public Health Partnerships • Strong collaboration with Alameda County Public Health and City of Berkeley, including: ➢ Funding ➢ Resource sharing ➢ Data exchange ➢ Doula workforce development **Population Health Management** • 2025 programs focus on: ➢ Primary care gaps ➢ Cancer and well-child visits ➢ Chronic disease management ➢ Perinatal care ➢ Connecting high-risk members to whole-person care • Plans to refine frameworks and develop a 2026 PHM dashboard **NCQA Accreditation** • Two 2025 surveys completed: accreditation maintained for commercial and Medi-Cal.	

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		• Corrective action plan required for Medi-Cal appeals timeliness. • Upcoming activities: ➢ Cap universe submission (March 24) ➢ Virtual cap survey (April 20) ➢ Mock surveys later in the year **Next Steps** • Michelle announced that the cross-functional QI operating plan will be the primary focus for the next meeting and the coming year.	
Adjournment	F. Zainal	Next meeting: July 2026	

Meeting Minutes submitted by: Anne Villareal Date: 3/23/2026

Approved by: Farashta Zainal Date: 03/30/2026

Cultural and Linguistic Services Subcommittee (CLSS) Meeting
January 28, 2026

Committee Member Name	Title	Present
Allison Lam	Senior Director, Health Care Services	
Alma Pena	Manager, Grievances and Appeals Manager	x
Anastacia Swift	Chief Human Resource Officer	
Andrea DeRochi	Behavioral Health Manager	
Beverly Juan, MD	Medical Director, Case Management & Community Health	x
Carlos Lopez	Quality Assurance and Regulatory Reporting Manager	
Cecilia Gomez	Sr. Manager, Provider Services	x
Darryl Crowder	Director, Provider Services	
Donna Carey, MD	Chief Medical Officer	x
Farashta Zainal, MBA, PHP	Quality Improvement Manager	x
Gia DeGrano	Director, Member Services	
Gil Duran, MPH	Manager, Population Health and Equity	x
Jennifer Karmelich	Director, Quality Assurance	
Lao Paul Vang	Chief Health Equity Officer	x
Linda Ayala, MPH	Director, Population Health and Equity	x
Lisha Reamer-Robinson	Manager, Compliance Audits, and Investigations	x
Mao Moua, MPA	Manager, Cultural and Linguistic Services	
Marie Broadnax	Manager, Regulatory Affairs & Compliance	x
Michelle Lewis, MPH	Manager, Communications and Outreach	
Michelle Stott, MSN	Senior Director of Quality	x
Stephanie Brown, MD	Medical Director, Medical Services	x
Taumaoe Gaoteote	Director, Diversity, Equity, Inclusion	x
Tran Loc	Manager, Access to Care	x
Yen Ang	Director Health Equity	x

Staff Member Name	Title	Present
Adrina Rodriguez	Privacy Compliance Specialist	x
Alexandra Loza	Quality Assurance Specialist	x
Alexandria McGuire	Quality Assurance Analyst	x
Dani Staub	Director, Incentives and Reporting	x
Debbie Spray	Manager, IT Governance and Incident Management	
Judy Rosas	Senior Manager, Member Services	x
Kailey Mulipola	Interpreter Services Coordinator	x

Kayla Williams	Manager, Experience & Program Management	x
Krystaniece Wong	Regulatory Compliance Specialist	
Lisa Sciutto	Regulatory Compliance Specialist	
Mandy Gutierrez	Senior Communications & Media Specialist	x
Mara Macabinguil	Interpreter Services Coordinator	x
Misha Chi	Interpreter Services Coordinator	x
Osiris Rivas	Cultural and Linguistic Services	x
Robert Smith	Regulatory Compliance Specialist	x
Robert Smith	Regulatory Compliance Specialist	
Rommel Cuevas	Regulatory Compliance Specialist	
Rosa Carrodus	Disease Management Health Educator	x
Shatae Jones	Director, Community Health Strategy	
Yemaya Teague	Senior Analyst of Health Equity	x

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
1. Call to Order/Introductions	L. Ayala	L. Ayala called the meeting to order.	
2. Minutes from 10/22/2025 Meeting	L. Ayala	Minutes from the last meeting were reviewed by participants with no additional changes/comments and are attached to the meeting invite.	
3. Agenda review	L. Ayala	L. Ayala reviewed the agenda.	
4. Follow-up items from 10/22/2025	L. Ayala	L. Ayala reported on the follow-up items from the 10/22/2025 CLSS meeting. • Share STARS measures related to interpreter services availability and complaints-Kayla Williams, Manager, Experience and Program Management shared measures with Dr. Yen Ang, Director, Health Equity via email on 10/22/2025 (Completed).	
5. 2025 CLS Workplan Goals Update and Evaluation Input (Medi-Cal and Group Care)	L. Ayala	L. Ayala discussed the 2025 CLS Workplan Goals Update and Evaluation Input (Medi-Cal and Group Care). • Member Cultural Linguistic Assessment: 1.0-Assess the cultural and linguistic needs of plan enrollees and identify action items that may need addressed to ensure the cultural and linguistic needs of member are met.	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		* 1.1- Use interpreter services provision data to identify language needs for the “Other Chinese and Unknown groups.” Share with key leaders at internal and external committees (NCQA HE6). ○ Outcome(s): Not Started, will address in 2026 * 1.2- CLS Subcommittee quarterly review of member demographics trends (NCQA HE6). ○ Outcome(s): In-Progress ▪ 1.0-CLS needs assessed at CLSS meetings on 01/22/2025, 04/23/2025, 07/23/2025, and 10/22/2025. ▪ 1.1-Planned Implementation Q1 2025. ▪ 1.2-Member Demographics trends reviewed at CLSS meeting 10/22/2025. ▪ Decrease in overall membership. ▪ Slight increase in Spanish, Chinese, and Farsi-speaking members. • Language Assistance Services Fulfillment: 2.0-Reach or exceed an average fulfillment rate of ninety-five percent (95%) or more for in-person, video, and telephonic interpreter services. ○ Outcomes(s): Goal Met ▪ 2.0: Q1 2025-99%; Q2 2025-99%; Q3 2025-99%; Q4 2025-pending • Language Assistance Services Fulfillment: 3.0-Increase monthly use of on-demand vs in-person services by 2% through improvements to on-demand access. ○ Outcomes(s): In-Progress ▪ 3.0-Met with Tri-City (11/12/2025) to discuss on-demand interpreter services carts transition plan. ▪ 3.1-Provided updates regarding interpreter services carts deployment plan with the interpreter services vendor, Propio. • Language Assistance Services for Behavioral Health: 4.0-Ensure tracking, analysis and reporting of interpreter services utilization for behavioral health services.	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		◦ Outcomes(s): Goal Met ▪ 4.0-Goal completed in Q3 2025. ▪ Utilization of interpreter services for behavioral health is tracked through internal and external designated PIN #s and prescheduled interpreter services requests. • Provider Language Capacity (Member Satisfaction): 5.0-Based on the Member CGCAHPS Survey 81% of adult members and 92% of child members who need interpreter services will report receiving a non-family qualified interpreter through their doctor's office or health plan. ◦ Outcomes(s): Q1-Q3 Goal Met; Q4: Planned implementation for Q1 2026. ▪ 5.0-Q1 2025-Adult: 83.7%; Child: 91.9% ▪ 5.1-Q2 2025-Adult: 85.8%; Child: 92.3% ▪ 5.2-Q3 2025-Adult: 88.1%; Child: 93.4% ▪ 5.3- Q4 2025-Planned implementation Q1 2026. ▪ For Adult and Child surveys, satisfaction results either met or exceeded threshold benchmarks. • Language Assistance Services (Member Satisfaction): 6.0-Increase the Timely Access Requirement (TAR) Survey response rate by 2% for combined adult and child. (2024 Adult Baseline: 3.4%) (2024 Child Baseline: 5%) * 6.1-NCQA HE6 Create member facing outreach and education on access to interpreter services in additional languages and distribute through providers. ◦ Outcome(s): Not started, will begin in 2026 * 6.2-NCQA HE6 Launch multilingual education campaign reinforcing interpreter service rights. ◦ Outcomes(s): Partially Met ▪ 6.0-Goal completed in Q2 2025. ▪ 6.1-Planned implementation for Q1 2026. ▪ 6.2-Planned implementation for Q1 2026.	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		▪ Overall, 2% increase in responses from MY 2023. • Community Engagement: Community Advisory Committee (CAC): 8.0-Recruit at least one (1) committee member in each of the three (3) identified areas of representation gaps: Men, individuals aged 19-44 and those who are Limited English Proficient (LEP). ○ Outcome(s): In-progress ▪ 8.0-Connected and presented information about the CAC as part of membership recruitment efforts to the Senior Services Coalition of Alameda County (10/09/2025) and received one (1) application. ▪ 8.1-Held a CAC Selection Committee Meeting to present CAC interests (11/14/2025). ▪ 8.2-CAC Selection Committee reviewed five (5) CAC candidates and approved four (4) new CAC members from the following representation areas: Foster parents of Alliance members, advocates, and/or youth and LTSS advocates, or Alliance members participating in LTSS. ▪ 8.3-Discussed recruitment strategies with the D-SNP team for D-SNP members or caregivers. ▪ Next Steps: **D-SNP:** Ongoing CAC recruitment for D-SNP and guidance from the CAC Selection Committee. • Potential Quality Issues-Quality of Language (PQI-QOL)- 9.0-Monitor, evaluate, and conduct appropriate interventions for PQI-QOLs with a closure rate of 95% or more within 60 business days. ○ Outcome(s): Q1 Met; Q2 Unmet; Q3 Unmet; Q4 Unmet Overview: CLS Successes and Challenges • Successes ○ Maintained a 95% or above fulfillment rate for all interpreter services modalities. ○ Received favorable responses related to accessing interpreter services through member satisfaction surveys, including increasing survey response rate.	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		◦ Met all standards for Net 1A report. ◦ Solidified process to track interpreter services utilization for behavioral health. ◦ Recruited and onboarded new CAC members to reflect the population the Alliance serves. • Challenges ◦ Limited staffing capacity. ◦ Difficulty with timely responses from vendor and provider offices to address QOL-PQIs. • Next Steps: ◦ **D-SNP:** Continue with CAC recruitment to include but not limited to D-SNP and limited English Proficient members. ◦ **D-SNP:** Include tracking of interpreter services utilization for D-SNP. ◦ Streamline tracking and trending process for member grievances related to language access. ◦ Continue to explore efficiency projects related to interpreter services. ◦ Implement equity projects to ensure access to interpreter services. 2026 Focus Areas • Assessing the cultural and linguistic needs of members. • Language services for members (i.e., member satisfaction through CG-CAHPS and timely access through the Timely Access Survey) and improving completion rates. • Provider and member education on how to access interpreter services. • Community Engagement (Community Advisory Committee) and recruitment. • Improving QOL-PQI case closure rate • Improving member demographics for groups identified as “Others”. 2025 CLS Program Evaluation-Stakeholder Input • Current Status:	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		○ CLS Program Evaluation is in progress. • Why We're Gathering Input: ○ To identify what is working well and where gaps/barriers remain. ○ To ensure our CLAS efforts reflect member needs. • Input We're Seeking Today ○ Are current goals aligned with the CLAS needs you are seeing? ○ What workplan goals are working well? ○ Where should we adjust, expand focus, or add emphasis? ○ Are there priority areas that are underrepresented? • Next Steps/How This Input Will Be Used: ○ Incorporated into the final CLS program evaluation. ○ Shared with committees (e.g., QIHEC and CLSS). ○ Used to inform next year's workplan focus areas and priorities. ❖ *Comment-D. Carey: Switching high-utilizing providers to using video interpreter services is a priority for me versus having interpreters available and going to the clinics. This is because we have significant no-shows, so a priority would be increasing our on-demand capabilities.* ❖ *Comment: J. Rosas: Have we considered maybe having a satisfaction survey immediately available at the provider's office? Because I think you would get a lot more participation immediately after receiving the service versus a month or two if they get something in the mail.* ➢ *Question-Y. Ang: Do you foresee or anticipate any increase in interpreter services among Medicare population, presuming older adults more likely to have LEP?* ➢ *Response-L. Ayala: It is interesting that English-speaking members are a larger percent among our Medicare or D-SNP members to date at least than it is among our Medi-Cal population. We have projected a higher utilization rate in terms of use of interpreter services. It is too early to see the numbers, but we'll be tracking.*	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date

6. Community Advisory Committee (CAC) Update and Feedback (All Lines of Business)	L. Ayala	L. Ayala presented on the Community Advisory Committee (CAC) Update and Feedback (All Lines of Business).
		
		Role of the Community Advisory Committee
		• Community voice and partnership
		• Focus on access, quality, and equity
		• Reflects member diversity
		• Meets quarterly
		    ○ March
		    ○ June
		    ○ September
		    ○ December
		
		Access, Coverage, and Policy Concerns
		• Access and Continuity of Care
		    ○ Impact of state and federal legislation
		    ○ Coverage concerns for undocumented and vulnerable groups
		    ○ Loss of coverage leading to gaps in care
		    ○ Medication access risks, including GLP-1
		    ○ Funding cuts affecting community resources
		        ▪ Food Banks
		        ▪ Senior Centers
		
		Outreach, Mental Health & Community Health Workers
		• Outreach and Engagement
		    ○ Strong support for the Community Health Worker (CHW) model
		        ▪ Clear introductions and warm hand-offs to build trust
		    ○ Outreach tailored to high-need populations
		    ○ Engagement in trusted community locations
		        ▪ Churches, schools, stores, apartment complexes
		    ○ Screening and preventive care barriers with member-driven solutions
		    ○ Simple, culturally appropriate mental health messaging	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date

		Communications and Outreach Feedback
		• *"You do wonderful work, and I have to say, I was at the DMV getting my real ID, and I saw the Alliance poster and I took a picture. And the models are of various races, and I love seeing that, that's beautiful. I am happy to see that I keep seeing the Alliance everywhere."* –Alliance CAC Member
		
		Equity, Member Experience & Key Takeaways
		• Key Takeaways
		  ○ Persistent disparities in health outcomes
		  ○ Emphasis on action, not just data
		  ○ Improve member experience through clearer outreach
		  ○ Reduce provider surveys
		  ○ Strengthen community partnerships ω Build trust through clear communication
		
		Timely Access Standards for Community-Based Adult Services (CBAS)
		• "Some of those services are not available at all. While we have these standards, often, we don't have much to offer, which sometimes leads to people having to go to other places like Utah, to access these types of facilities." –Alliance CAC Member
		
		Community Health Assessment/ Community Health Improvement Plan (CHA/CHIP) Feedback
		• *"People are poorer and we have more food banks. We have health systems and people are getting sicker and sicker, so we need to address what the problem is and how do we solve it by working together."* –Alliance CAC Member	

7. a. Compliance Updates-DHCS/DMHC (Medi-Cal and Group Care) **7. b. Compliance Updates-CMS (D-SNP)**	L. Reamer-Robinson L. Reamer-Robinson M. Broadnax	L. Reamer-Robinson provided updates on DHCS/DMHC (Medi-Cal and Group Care) Regulatory Audits. 2026 DHCS Routine Survey • Key dates	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		○ Look-back: 3/1/25–12/31/25 ○ Virtual Interviews 3/2–3/13/26 ○ Pre-audit materials due 1/22/26 • Scope ○ Utilization Management ○ Population Health Management & Coordination of Care ○ Network and Access to Care ○ Grievance, Appeals, & Member's Rights ○ Quality Improvement & Health Equity ○ Plan Organization and Administration • Next Steps ○ Pre-audit materials submitted 1/26/26 ○ Mock Audit Prep scheduled 02/02/26 through 02/13/26 2025 DMHC Routine Survey • Key Dates ○ Final report received 12/31/25 ○ CAP due to DMHC 2/14/26 ○ Kick-offs & office hours 1/12– 1/29/26 • Scope ○ 16 deficiencies (including 2 repeat) across various categories: Quality Assurance Access & Availability Grievance & Appeals* Utilization Management Pharmacy* Behavioral Health • Next Steps ○ Office hours on going until 1/29/26; CAP response in progress 2025 DMHC Fiscal Exam • Key Dates ○ Final report received 12/17/25 ○ CAP due to DMHC 1/17/26 • Scope ○ Oversight of Forwarded Claims • Next Steps ○ CAP submitted 1/16/26	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date

		M. Broadnax discussed the CMS **(D-SNP)** Communications process in Regulatory Affairs.
		
		• Regulatory Affairs reviews all CMS communications for applicability to the Alliance (2026 HMO D-SNP)
		• Communications
		  ○ HPMS Memos
		  ○ Emails
		  ○ Transmittal
		  ○ Announcements
		  ○ Newsletters
		• CMS Communications Review
		  ○ All communications are received directly from CMS via email
		  ○ Reviewed by RAC for Alliance Applicability
		    ▪ Applicable to California D-SNP
		    ▪ Applicable to Contract(s) that started in 2026
		    ▪ Applicable to Health Plans
		  ○ Communication Categories
		    ▪ Feedback Request – Input or comments requested
		    ▪ Action Items – Tasks requiring follow-up, Policy Implementation, Regulatory Reporting
		    ▪ For awareness, no response required
		• Impacted Area SMEs Responsibilities
		  ○ Review the email from @DSNPCompliance.
		  ○ Open link to memo at the bottom of the communication.
		  ○ Share with other impacted SMEs.
		  ○ Provide feedback.
		  ○ Review and prepare for actions items and/or deliverables.
		
		CMS Communications Requiring Action	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date

		• CMS communications with deliverables will be tracked on the RAC D-SNP Tracker and RAC will reach out to the impacted SMEs directly to confirm their responsibilities.
		• CMS communications with Action Items (APL-like) will be reviewed centrally through current FAD/Policy Triage process Includes:
		  ○ Policy Implementation Memos
		  ○ Communications requiring system configurations
		  ○ HPMS Guidance with operational impact
		
		D-SNP Compliance Mailbox: DSNPCompliance@alamedaalliance.org	

8. Cultural Sensitivity Training – Staff 2025 (All Lines of Business)	A. Rodriguez	A. Rodriguez reported on the Cultural Sensitivity Training—Staff 2025 (All Lines of Business).
		
		Annual Compliance Training
		• Fraud, Waste, & Abuse (FWA)
		  ○ Not Assigned: 29
		  ○ Completed: 645
		  ○ Incomplete: 11
		  ○ On Leave: 14
		• Health Insurance Portability & Accountability Act (HIPAA)
		  ○ Not Assigned: 29
		  ○ Completed: 645
		  ○ Incomplete: 11
		  ○ On Leave: 14
		• Cultural Sensitivity Trainings (CST)
		  ○ Not Assigned: 29
		  ○ Completed: 637
		  ○ Incomplete: 14
		  ○ On Leave: 19	

9. a. Language Access Monitoring and Reporting- Alliance Bilingual Staff Yearly Report	T. Gaoteote	T. Gaoteote reported on the Alliance Bilingual Staff Yearly Report 2025. • Chinese/Cantonese: 5 (Operations-Marketing and Communications/Member Services) • Chinese/Mandarin: 2 (Operations-Member Services)	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		• Spanish: 51 (Operations/Healthcare Services-Member Services/Behavioral Health/Marketing and Communications) • Tagalog: 6 (Operations/Information Technology-Member Services/IT Infrastructure) • Vietnamese: 6 (Operations-Member Services/Marketing and Communications)	
9. b. Alternative Formats Selection (AFS) Report (Medi-Cal and Group Care)	L. Ayala	L. Ayala presented on the Alternative Format Selectins (AFS) Report Q4 2025 (Medi-Cal and Group Care). • Non AFS: 387,608 (98.10%) • Large Print: 7,253 (1.84%) • Audio CD: 65 (.02%) • Data CD: 71 (.02%) • I need a format not listed here: 32 (.01%) • County Support: 35 (.01%) • Braille: 15 (.00%) • Encrypted Data CG: 25 (.00%) • Data CD: 7 (.00%) • No Alternative Format Needed: 10 (.00%) • Encrypted Audio CD 3 (.00%) • Total: 395,118	

9. c. Grievance and Appeals Report (Medi-Cal and Group Care)	A. Loza	A. Loza presented on the Grievance and Appeals Report Q4 2025 (Medi-Cal and Group Care).
		
		Medi-Cal
		• Overview
		  ○ Total of 130 unique grievances with 40 shadow cases for a total of 170 grievances resolved during Q4 2025.
		  ○ 11% increase in complaints in Q4 2025 compared to Q3 2025.
		  ○ Thirty-one (31) grievances were related to discrimination and were forwarded to the Compliance Department for further investigation.	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		• Grievance Type ○ Access to Care: 139 ○ Quality of Service: 31 ○ Total: 170 • Grievance Filed Against ○ AAH Plan: 20 complaints against the plan regarding language Access. ▪ Members alleged lack of providers in the member's preferred language (Spanish, Cantonese, Mandarin Korean, Vietnamese, Tagalog, Farsi, and Russian) ▪ Dissatisfaction with the interpreter process, and ▪ Reaching representatives who speak their preferred language. ○ PCP/Clinic: There are 3 providers with continued language access complaints (with 3 or more complaints) filed in Q3 2025 and Q4 2025: ▪ Hayward Wellness Center ▪ Dr. Amita Sharma ▪ West Coast Medicine and Cardiology ○ Vendor ▪ Against Hanna (6 complaints): Members complained about interpreters not arriving for scheduled appointments or arriving late to appointments; not being assigned to preferred interpreters. ▪ Against Cyracom (3 complaints): Members complained about the calls getting disconnected while getting interpreter services; unable to reach the telephonic interpreter line during an appointment, the interpreter could not explain what the member was saying to the provider. ▪ Against Modivcare (3 complaints): Members face language barriers when calling to make reservations for rides because they do not have staff members who	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date

		speak their preferred language (Spanish and Cantonese).
		
		Group Care
		• Overview
		  ○ There was 1 grievance pertaining to discrimination in Q4 2025.
		  ○ There were 3 unique grievances with 6 shadow cases for a total of 6 grievances in Q4 2025 pertaining to language access complaints.
		  ○ There was a decrease in complaints for language access in Q4 compared to Q3 2025
		• Grievance Type
		  ○ Access to Care: 6
		  ○ Quality of Service: 1
		  ○ Total: 7
		• Grievance Filed Against
		  ○ Against the Plan (2 complaints):
		    ▪ The member was not provided with a list of mental health providers that only speak Mandarin.
		    ▪ The limited number of Mandarin and Cantonese speaking OB/GYN in the network.
		  ○ Against Vendor, Cyracom (2 complaints):
		    ▪ The interpreter did not interpret correctly.
		    ▪ The interpreter disconnected the call in the middle of member's conversation.
		  ○ Against Provider
		    ▪ Against Quest (1 complaint): the lab does not have Cantonese as a language option over the phone.
		    ▪ Against Newark Health Center (1 complaint): The member's assigned PCP does not speak member's preferred language, Mandarin.
		▪ No recommended actions.	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date

9. d. Quality of Language-PQI Report (Medi-Cal and Group Care)		L. Ayala discussed the Quality of Language-PQI Report (Medi-Cal and Group Care).
		
		• L. Ayala discussed recent collaboration with the Grievance and Appeals team to ensure that PQIs submitted align with our PQI definitions and to avoid duplication of work. As a result, there were fewer PQIs submitted in Q4 2025.
		
		• Total of 13 QOL-PQI cases in Q4 2025
		• Outcomes:
		  ○ No CAP was issued.
		  ○ There were no providers or vendors that had 2 or more closed QOL PQIs for 2 consecutive quarters.
		  ○ The CLS team also reviewed the 2025 Q4 member grievances regarding language access and found no patterns of language concerns.	

9. e. Member Services Representative-Multilingual Staff Report (Medi-Cal and Group Care)	J. Rosas	J. Rosas reported on the Member Services Multilingual Staff Report (Medi-Cal and Group Care).
		
		• Staff by Language
		  ○ Spanish: 33
		  ○ Vietnamese: 4
		  ○ Cantonese: 5
		  ○ Mandarin: 4
		  ○ Tagalog: 3
		  ○ Total: 49
		• A total of forty-one (45) qualified multilingual staff that have completed a non-medical evaluation.
		• Four (4) of the qualified multilingual staff speak more than one (1) non-English threshold language.
		• At least one (1) non-English threshold language call per month is monitored for each threshold language spoken by the Member Services Representative.
		• Open Positions:	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		◦ Member Services Representative I-Bilingual Spanish: 1 ◦ Member Services Representative I-Bilingual Farsi: 1 ◦ Member Services Representative I-Bilingual Cantonese: 1	
9. f. Membership Reports (All Lines of Business)	M. Macabinguil	M. Macabinguil, Interpreter Services Coordinator, presented on the Member Reports. **Medi-Cal** (Threshold Languages) • English: 220,750 (56.78%) • Spanish: 108,694 (27.96%) • Chinese: 29,983 (7.71%) • Vietnamese: 8,673 (2.23%) • Farsi: 3,243 (0.83%) **Group Care** (Threshold Languages) • English: 3,586 (57.99%) • Chinese: 1,604 (25.94%) • Spanish: 337 (5.45%) • Vietnamese: 256 (4.14%) • Farsi: 85 (1.37%) **D-SNP** (Threshold Languages) • English: 117 (70.91%) • Spanish: 21 (12.73%) • Chinese: 11 (6.6%) • Vietnamese: 3 (1.82%) • Tagalog: 3 (1.82%) • Farsi: 1 (0.61%)	
9. g. Utilization of Interpreter Services (Medi-Cal and Group Care)	O. Rivas	O. Rivas reported on the Utilization of Interpreter Services (Medi-Cal and Group Care). Q4 2025 Utilization • Fulfillment rate: 99% (exceeds metric goal of 95%)	CLS Team to report on Q4 2025 Top 10 Utilizers: On-Demand Interpreting Services at the next CLSS meeting.

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date

		• On-demand vs Prescheduled
		    ○ October 2025
		        ▪ On-demand: 8,702
		        ▪ Prescheduled: 2,833
		    ○ November 2025
		        ▪ On-demand: 5,567
		        ▪ Prescheduled: 2,240
		    ○ December 2025
		        ▪ On-demand: 7,302
		        ▪ Prescheduled: 2,565
		• On-Demand interpreter services made up 75.8% of interpreter services provided in Q4 2025.
		• Scheduled interpreter services made up 24.2% of interpreter services provided in Q4 2025.
		• Q4 2025 Top 10 Utilizers: Pre-Scheduled Interpreting Services
		    1. Tri-City Physical Therapy: 1,231
		    2. Alameda Health Systems: 1,097
		    3. San Antonio Neighborhood Health Center: 677
		    4. East Bay Center for Digestive Health: 565
		    5. Allergy Asthma and Sinus Centers: 429
		    6. Benioff Children's Hospital Oakland: 356
		    7. Mission Peak Orthopedics: 344
		    8. East Bay Rheumatology Medical Group: 308
		    9. Seven Bridges Therapy: 296
		    10. *Other Providers Not Listed Here: 281
		
		• Q4 2025 Top 10 Utilizers: On-Demand Interpreting Services
		    ○ Due to data issues being resolved, report will be presented at the next CLSS meeting.
		
		• Q4 2025 Utilization: Top Languages
		    1. Spanish
		    2. Cantonese
		    3. Vietnamese	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		4. Mandarin 5. Mam 6. Arabic 7. Dari 8. Farsi 9. Punjabi 10. Khmer 2025 At a Glance • 2025 Total Requests: 125,017 ○ Q1: 28,203 ○ Q2: 32,380 ○ Q3: 32,909 ○ Q4: 31,525 • 2025 Top Languages Utilized 1. Spanish: 56,891 2. Cantonese: 17,905 3. Vietnamese: 8,246 4. Mam: 4,689 • Top Pre-Scheduled Interpreter Utilizers 1. Tri-City Physical Therapy: 5,695 2. Alameda Health Systems: 3,825 3. San Antonio Neighborhood Health Center: 2,305 4. East Bay Center for Digestive Health: 2,303 5. Benioff Children's Hospital Oakland: 1,785 ➢ *Question-K. Williams: For those practices that have a high volume of those pre-scheduled interpreter services. Do you know any processes or member education that they're doing so that those services are scheduled in advance?* ➢ *Response-L. Ayala: I think it's a little different depending on which group. Tri-city Physical Therapy and East Bay Center Digestive Health are high-volume providers and we're trying to move to on-demand using video. With physical therapy, it can be challenging to offer*	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		interpreter services by telephone without having the visual. East Bay Center for Digestive Health is a uniquely high volume impacted clinic, who perform colonoscopies. We're working to figure out how we can better support them. Alameda Health Systems and Benioff are the primary hospitals members to to for specialists and may more likely need an in-person interpreter for complex diagnosis, preparing for surgeries, or complex therapies. We also know that Alameda Health Systems and San Antonio Health Center serve a high volume of our Mam-speaking members. Since there is a scarcity of Mam interpreters, they may pre-schedule and interpreter to ensure coverage. And so, each group has its nuances.	

9. h. Utilization of Translation Services Report (All Lines of Business)	M. Gutierrez	M. Gutierrez presented on the Q4 2025 Translation Services Utilization (All Lines of Business).
		
		• The highest number is held by the G&A team as usual.
		• The C&O Team has translated well over 200 documents into our threshold and non-threshold languages.
		• Translated documents mainly consist of Alliance D-SNP materials, Medi-Cal documents, and Group Care documents.
		• Q4 2025 Language Utilization
		  ○ Spanish: 37.61%
		  ○ Chinese:17.6%
		  ○ Farsi: 13.21%
		  ○ Vietnamese: 11.48%
		  ○ Tagalog: 9.31%
		  ○ English: 9.05%
		  ○ Arabic: 0.35%
		  ○ Haitian-Creole: 0.35%	

9. i. Vendor Interpreter Quality Monitoring Reports (All Lines of Business)	L. Ayala	L. Ayala presented on the Vendor Interpreter Quality Monitoring Reports (All Lines of Business). • Q4 2025 Hanna ○ Four (4) interpreters were assessed-All completed an Interpreter Linguistic Assessment with a "Pass".	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date

		• Q4 2025 Propio/Cyracom
		  ○ Analysis: 97% of Propio's interpreters achieved a "Pass" on the Interpreter Linguistic Assessment for Q4.
		  ○ For interpreters who did not receive a passing score the following actions were taken:
		    ▪ Interpreters received coaching, feedback, and/or close monitoring from Propio's Quality Department.
		    ▪ Interpreters will be reassessed if they provided services and their updated score will reflect in the following month's report.
		    ▪ Interpreters are removed when they have three (3) executive scores that are below the threshold (80%).	

Adjournment	L. Ayala	The next CLSS meeting will be on April 22, 2026.	

Meeting Minutes Submitted by: Mara Macabinguil, Interpreter Services Coordinator Date: 03/01/2026

Approved By: Mao Moua, Manager, Cultural Linguistic Services Date: 03/18/2026

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COMMUNITY ADVISORY COMMITTEE (CAC)

Thursday, December 04, 2025, 10:00 AM – 12:00 PM

Committee Members	Role	Present
Cecelia Wynn	Alliance Member	x
Donna Griggsmurphy	Alliance Member	x
Donna Leonard-Pageau	Alliance Member	x
Erika Garner	Alliance Member	x
Irene Garcia	Alliance Member	x
Jennifer Gudiel	Alameda County Asthma Start Program	
Jody Moore	Parent of Alliance Member	x
Keith Pageau Jr.	Alliance Member	x
Kenneth Porter	Greater New Beginnings	x
Len Turner	Greater New Beginnings	x
Lenore Harris	Parent of Alliance Member	x
Kerrie Lowe	Social Worker, Alameda County Public Health	x
Marilen Biding, MSN	Alameda County Health Homes Department	
Mayra Matias Pablo	Parent of Alliance Member	
MiMi Le	Alliance Member	
Natalie Williams	Alliance Member	x
Omoniyi Omotoso	Native American Health Center	x
Reginald Jackson	Communities for a Better Environment	
Robert Williams	Alameda County Health and Human Resource Education Center	x
Shirley Tong	Parent of Alliance Member	x
Sonya Richardson	Alliance Member	
Tandra DeBose	Alliance Member	x
Valeria Brabata Gonzalez	Alliance Member	x

Other Attendees	Organization	Present
Andrea Wise	Alameda County Public Health	x
Carolina Guzman	Alameda County Public Health	x
Jesus Verduzco	Alameda County Public Health	x
Kellie Knox	City of Berkeley	x
Kristen Golden Teste	Golden Policy Partners	x
Mary Kim-Dickson	CHME	x
Melodie Shubat	CHME	x

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Alliance Staff Members	Title	Present
Beverly Juan	Medical Director, Case Management and Community Health	x
Cecilia Gomez	Senior Manager, Provider Services	x
Farashta Zainal	Manager, Quality Improvement	x
Gabriela Perez-Pablo	Outreach Coordinator	x
Gil Duran	Manager, Population Health and Equity	x
Isaac Liang	Outreach Coordinator	x
Jessica Jew	Population Health and Equity Specialist	x
Julio Sandoval	IT Service Desk Coordinator	x
Karina Rivera	Director, Public Affairs and Medica Relations	x
Katrina Vo	Senior Communications and Content Specialist	x
Kayla Williams	Manager, Member Experience and Program Management	x
Lao Paul Vang	Chief Health Equity Officer	x
Linda Ayala	Director, Population Health and Equity	x
Loc Tran	Manager, Access to Care	x
Mao Moua	Manager, Cultural and Linguistic Services	x
Mara Macabinguil	Interpreter Services Coordinator	x
Matthew Woodruff	Chief Executive Officer	x
Michelle Lewis	Senior Manager, Outreach and Communications	x
Michelle Stott	Senior Director, Quality Improvement	x
Misha Chi	Health Education Coordinator	x
Monique Rubalcava	Health Education Specialist	x
Peter Currie	Senior Director, Behavioral Health	x
Rosa Carrodus	Disease Management Health Educator	x
Shivani Pillay	Policy Analyst	x
Stephanie Brown	Medical Director, Medical Services	x
Steve Le	Outreach Coordinator	x
Thomas Dinh	Outreach Coordinator	x
Yemaya Teague	Senior Analyst, Health Equity	x
Yen Ang	Director, Health Equity	x

AGENDA ITEM SPEAKER	DISCUSSION	ACTION	FOLLOW-UP
1. WELCOME AND INTRODUCTIONS			
N. Williams	N. Willliams called the meeting to order at 10:03 am. A roll call was taken, and a quorum was established. Introduction of staff and visitors was completed.	None	None
2. a. APPROVAL OF MINUTES AND AGENDA – APPROVAL OF MINUTES FROM			
N. Williams	Motion to approve September 11, 2025, CAC Meeting Minutes.	Motion: T. Debose Second: O. Omotoso Vote: Approved by consensus.	None
2. b. APPROVAL OF MINUTES AND AGENDA – APPROVAL OF AGENDA			
N. Willams	Motion to approve December 4, 2025, CAC Meeting Agenda.	Motion: T. Debose Second: V. Gonzalez Vote: Approved by consensus.	None
3. CEO UPDATE – CEO Report			
M. Woodruff	Matthew Woodruff, Chief Executive Officer (CEO), presented on the Alliance Updates. Financials • FY 2023 and 2024: $150 million total loss. Net loss for 13 consecutive months. • Starting February 2025, net income amounted anywhere from $500,000 to $6 million per month. • Tangible Net Equity (TNE) is the amount of reserves required by the state. Healthy TNE is between 300% and 600% of the requirement. • The Alliance was at 700% before it started to lose money and took on Anthem members. Today, the Alliance is at 220% TNE, not considered to be in the healthy range despite the net incomes since February 2025. • Goal is to review the budget with the Board of Governors (BOG) on 12/12/2025. • When the budget was presented to the BOG last June 2025, it was projected to lose about $20 million but now projecting to make $21 million instead. The shift is due to all changes made and advocacy work. • Budget presentation/report to be shared with CAC members after it is presented to the Board of Governors on 12/12/2025.	None	Alliance staff to share the CEO Report-Budget with CAC members after the 12/12/2025 BOG meeting. Alliance staff to relay feedback regarding sharing information with families regarding benefits for children with special needs, with the D-SNP team.

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Quality Scores

- 10 years ago: 40% met
- 2022: 67% met
- 2023 and 2024: 83% met
- Overall improvement in quality measures.
- Need improvement in child measures including lead screening and topical fluoride treatment.

State Budget and Policy

- State budget will be released in January, revised in May, and will be effective July 2026.
- There is an $18 billion budget gap for California with just covering current services, and yet there are new services being proposed such as transitional rent and other community supports. Still unclear where the funding will come from.
- The Federal government considers community support programs as abusive spending and fraud.
- There are statewide proposals on how California can cover healthcare for undocumented immigrants. Federal government states that they should not be allowed in Medi-Cal managed care.

➢ *Member Question-N. Williams: When you say managed care, is it involving all age groups of undocumented immigrants or just a certain age group?*

➢ *Response-M.Woodruff: The federal government states that we cannot have undocumented immigrants in Medi-Cal managed care. We need to start talking with the state about the possibility of keeping them as members of the Alliance via pay-for service, and the state will pay us, however, it will not be the full range of services.*

Artificial Intelligence (AI)

- Federal government will come up with a set of rules for use of AI in healthcare. Healthcare decisions cannot be made by a computer, must be made by a live person. The Alliance is well within those rules.

❖ *Member Feedback-D. Leonard-Pageau: Regarding the dental quality measures for children, it would be helpful to have information or promotion on the computer display screens at the doctor's office so that the parents can be aware.*

	➢ *Response-M. Woodruff: That's an excellent point. The weird part about the quality incentive is that the state only gives provider incentives on the services for children ages 0-5, however we are graded on ages 0-19.* ❖ *Member Feedback: When I went to apply for Medicare at 65, the good news is that my daughter who has special needs and has Medi-Cal, will also receive Medicare before she turns 65. She will receive it as soon as I start receiving Social Security benefits. But the sad thing is that they are not sharing that information with families that need that information. We shouldn't know it only when we turn 65. We should know it now, and I'm just wondering if there's any way the Alliance could start informing families in advance of the services that will be provided to them? I'm just finding out that there's so many services out there to support our children, but we are not finding out until the last minute.* ➢ *Response-M. Woodruff: I will take that back to the Medicare Team.* ➢ *Member Question-V. Gonzales: When it comes to the Alliance's financial difficulties, what are the key measures or drivers? And what are the plans to get back to a healthy financial state without sacrificing quality of care?* ➢ *Response-M. Woodruff: In 2024, the Alliance lost $68 million. The state took back $69 million saying that they paid the Alliance too much money. So, it was interesting that there was a takeback even though we had a loss of $68 million. The Anthem members that transitioned to the Alliance needed a lot of care and there was a high cost in hospitalizations.* ➢ *Member Question-T. Debose: What was the outcome of that money? Did the state give it back?* ➢ *Response-M. Woodruff: No, they did not.*		
4. FOLLOW-UP ITEMS			
M. Moua	Mao Moua, Manager of Cultural and Linguistic Services provided updates on the follow-up items from September 11, 2025 • Share Analysis on any expected changes to IHSS: information was sent to CAC members via email on 11/20/2025. • Explore possible outreach to members before their coverage expires: Department of Health Care Services (DHCS) sent letters to members in mid-September to inform them of changes to their coverage.	None	None

<table>
<tr><td></td><td>Include Alliance Grievance and Appeals as a future agenda topic, including information on their workflow, process, and staffing: added the agenda topic and details to the CAC agenda tracker a future agenda item.
Clarify what CAC members can share back to their communities or organizations from the CAC meeting. Confidentiality Guidelines:
Information discussed during the public meeting and included in the agenda or meeting materials can be shared.
The confidentiality form refers to information learned outside of the public meeting, such as conversations overheard before or after the meeting and discussions between individuals that fall outside of the scope of the public meeting agenda topics.
Any information obtained through these interactions or outside what is shared at the public meeting must remain confidential.</td><td></td><td></td></tr>
<tr><td colspan="4">5. a. NEW BUSINESS – ALLIANCE PROVIDER MANUAL</td></tr>
<tr><td>M. Lewis</td><td>Michelle Lewis, Senior Manager of Communications and Outreach presented the annual review of the Alliance Provider Manual.

Background
The annual Alliance review of the Provider Manual with the CAC to invite any suggestions or feedback.
Requirements
Solicit feedback from the contractor committees including but not limited to the CAC.
In August 2025, the Provider Manual was reviewed by the Quality Improvement Health Equity Committee (QIHEC).
Summary of Changes: 2025 Updates
New and Expanded Benefits
Launch of Alliance Wellness Dual Eligible Special Needs (D-SNP) program.
Vision services transition to Vision Service Plan (VSP)
Regulatory Compliance Updates
Timely Access Standards & Minimum Performance Levels
Continuity of Care (CoC) policy clarifications
Credentialing, Community Health Worker (CHW) requirements, Medicare opt-out rules
Timely Access Standards for D-SNP
Urgent Care: immediately</td><td>None</td><td>CAC Planning Team to add to potential CAC topics network adequacy presentation from Provider Services

Alliance staff to coordinate provision of the Alliance Provider Manual in an alternative format to CAC member, D. Leonard-Pageau.</td></tr>
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	○ Non-Urgent Primary Care: appointment within 7 business days ○ Routine and Preventive Care: appointment within 30 business days • Timely Access Standards for Long-Term Support Services (LTSS) ○ Skilled Nursing Facilities: appointment within 5 business days ○ Intermediate Care Facility for Developmentally Disabled: appointment within 5 business days • Timely Access Standards for Community-Based Adult Services (CBAS): within 5 business days ➢ *Member Question-N. Williams: Will these updates be carried on to 2026?* ➢ *Response-M. Lewis: Yes, they will be carried on to 2026.* ➢ *Member Question-J. Moore: Do you have the compliance rates for these timely access standards? Explain to me what you're saying. Is it that we are out of compliance, and we are trying to be in compliance?* ➢ *Response-M. Lewis: These standards are listed in our provider manual to let providers and members know that if someone requests an appointment, the appointment must be given within these time frames.* ❖ *Member Comment-J. Moore: Okay, now I understand. And so, I want to provide feedback on those services. Some of those services are not available at all. While we have these standards, often, we don't have much to offer, which sometimes leads to people having to go to other places like Utah, to access these types of facilities.* ➢ *Response-M. Lewis: Thak you for your feedback. So, what I'm hearing is that the standards don't reflect reality.* ❖ *Member Feedback-J. Moore: We can really put some strategies together but it's hard to provide those services when we don't have the budget, we don't have land to build facilities for these types of services for adults in Alameda County. I just wanted to offer feedback that we need to be realistic.* ➢ *Response-M. Lewis: The Provider Services team is working on increasing our network and there are some initiatives. Maybe we can do a presentation on that at another time. Network adequacy is important and we do have reports for that, and so if the CAC is interested in, we could take a deeper dive into that.* ❖ *Member Comment-D. Leonard-Pageau: It has a lot of pages, and due to my vision problems, I cannot read it. Maybe you can send it to me as a*		

	PDF. This is very important information so you need to make sure everyone can access it. ➢ *Response-M. Lewis: We do have alternative formats that we can provide the document to you in. So, if we could connect with Member Services afterwards, we can get the document to you in an alternative format.* ➢ *Response-L. Ayala: The CAC planning team will be happy to follow up to see what we can do to assist you with that.* • Operational and Process Changes ○ Claims submission: new addresses, timelines, interest rules ○ Prior Authorization: updated turn-around times (TATs), standing referrals utilization management (UM) delegation ○ Telehealth: new requirements, Centers for Medicare and Medicaid Services (CMS) guidance for D-SNP • Member Services and Communication ○ New member identification (ID) cards (samples for lines of business) ○ Interpreter and language access enhancements ○ Diversity, Equity, and Inclusion (DEI) and Transgender, Gender Diverse, and Intersex (TGI) cultural competency. • Behavioral Health: benefit carve-outs, referral/prior authorization (PA) updates • Pharmacy/Formulary: D-SNP formulary, new vendor, PA process • Care Management: California Integrated Care Management (CICM) for D-SNP, Enhanced Care management (ECM) for Medi-Cal • Resources and Contacts ○ Key phone numbers and emails (Provider Services, Member Services, Compliance) ○ Website links for forms, directories, and training ❖ *Member Feedback-K. Pageau: The numbers on the ID cards are rubbed off in the wallet. I photocopied mine and laminated it. Maybe you can have the member ID cards laminated and have them available online so they can print out a copy.* ➢ *Response-M. Lewis: We are looking at different materials to print the card on for that reason, so that it doesn't rub off, and you'll be happy to know that you can request a new one online, as well as print a temporary one through the Alliance Member Portal.*		.
5. b. NEW BUSINESS – COMMUNITY HEALTH ASSESSMENT/COMMUNITY HEALTH IMPROVEMENT PLAN ACPHD			

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<table>
<tr>
<td>G. Duran
C. Guzman
A. Weiss</td>
<td>Gil Duran, Population and Health Equity introduced presenters, Carolina Guzman and Andrea Weiss from the Alameda County Public Health, who are presenting on the results of the Alameda County Community Health Assessment.

Community Health Assessment (CHA) Purpose
Foundational plan for Alameda County (AC) and used for setting priorities, policy changes, and addressing health equity.
Data
Primarily comes from voices of the community and a range of qualitative data sources.
Conducted 36 focus groups
Conducted in 7 languages
12 community organizations hosted focus groups
Spoke with 400 residents
Quantitative Efforts: Population-Level Data
Collaboration with Community Assessment Planning and Evaluation Unit to gather data from various sources.
Quantitative data is used to supplement community stories.
Needs Identification Criteria for 2025 CHA
Severity and magnitude of need
Community priority
Clear disparities or inequities
2025 Community Health Needs List
Social determinants of health: economic and environmental factors
Chronic diseases: screening and timely treatment
Communicable diseases: awareness and education
Behavioral health: access, culturally relevant
Health Need: Social Determinants of Health
Built environment
Traffic accidents
AC motor vehicle death rates are significantly worse for people who identify as Black or Latino/a/x.</td>
<td>None</td>
<td>None</td>
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	▪ Collaboration with the different cities in AC to have better signage, more speed bumps, and other remediation processes. o Workplace accidents (special concern for workers who are undocumented) • Healthcare access and quality o Long wait-times for appointments (low availability of providers) o People who are economically unstable or those who don't have insurance may wait to get care for an injury unless it is an emergency. o "Providers don't follow up with us." o Feeling disrespect from providers o Language barriers o "Our cultural preferences and individual differences not acknowledged. o Transportation challenges o Costs o "Signing up for benefits is difficult." o Ratio of nurses for the population is worse in AC than CA overall ▪ 1 doctor exists for every 884 people ▪ 1 nurse exists for every 1,496 people • Violence (community and family) o Economic stressors o Built environment: lack of streetlights, other infrastructure o Discrimination and inadequate policing contribute to safety concerns o Black, indigenous and people of color, immigrants, and children/youth are most affected. o Homicide deaths are among the top 3 causes of death in AC for people under the age 35. • Economic security o Working multiple jobs-wages do not keep pace with rising costs o Cutting back on essentials like food or meds o Homelessness, doubling up=overcrowded homes o People forced out of the area o Disengagement from education o Rents rising, lack of affordable housing o Getting low-income housing is complicated o Lack of tenant right awareness o Broader systemic issues such as structural racism/discrimination		

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	◦ Older adults, people with disabilities, families with young children, and undocumented immigrants are most affected. ◦ Inequities in Poverty ▪ African Americans' poverty rate is 3 times more than their White counterparts. ◦ Concentrated inequities in child poverty ▪ African American children's poverty rate is 7 times more than their White counterparts. ◦ Disproportionate burden of poverty among people who are living with disabilities ▪ People living with disabilities poverty rate is 2 times higher than people not living with disabilities. • Social/community context, including racism and discrimination ◦ Negatively impacts: ▪ Neighborhoods and schools (such as digital divide, educational quality) ▪ Economic insecurity (especially for formerly incarcerated) ▪ Healthcare quality ▪ Mental health-constant stress ◦ Other forms of discrimination: against people who identify as LGBTQ+, people with disabilities people with severe mental illness ◦ Life expectancy varies depending on race/ethnicity. ▪ For people born in 2023, there is a 14-year difference between life expectancy of Asians (89) and African Americans/Blacks (75). Health Need: Behavioral Health • Mental Health • Emotional well-being • Substance use disorders • Caused by economic insecurity, loneliness/isolation, experience of discrimination, lack of education in coping skills and substance use risk. • Mental health disorders are among top 10 causes of hospitalizations in AC. • Accidental overdose is in the top 5 causes of death overall in AC and the no.1 cause for people aged 18-44, a new finding in 2023. Health Need: Communicable Diseases		

	• COVID-19 • Influenza • Sexually transmitted infections ○ Ampong people aged 10-19, chlamydia and gonorrhea rates are significantly higher in AC than CA. • Other communicable diseases Health Need: Chronic Diseases • Heart diseases/stroke • Cancer • Diabetes • Obesity • Chronic liver/cirrhosis • Asthma • Alzheimer's disease/dementias • Other chronic diseases • Chronic diseases are the leading causes for 65 years or older in Alameda County. CHA/CHIP Planning Map • September 2025-January 2026: Finalize CHA report. • February-March 2026: Share CHA report. Begin research and planning. • April-June 2026-Develop CHIP strategies. Begin drafting CHIP report. ❖ *Member Comment-D. Griggsmurphy: Thanks to Alameda County Public Health so much for this report. It was very thorough and knowing that we have voices of community that are affected by all the social determinants of health. This is my first meeting, but kudos to Alameda Alliance for making sure we have these reports that kind of help guide how we give healthcare to the community. This was very informative.* ➢ *Member Question-O. Omotoso: I have a context question, when you talk about poverty rates, how are you defining poverty level? Because I worry at times that the definition is actually low and so we're still missing data.* ➢ *Response-C. Guzman: Yes, that's a really good point. But you're right. I think that there's a lot of missing information on groups that are perhaps not even captured. The other issue we have in our team of epidemiologists is trying to disaggregate the data further by race and ethnicity. So, you saw in some of the poverty data the Pacific Islanders*		

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	for example, have disproportionately higher levels of poverty, and that is new information that we've been able to gather through the Community Health Interview Survey, alongside the census. So, no one database is perfect as we know, but we're really trying hard to discern by different types of characteristics like race, ethnicity, and gender. ❖ *Member Comment-T. Debose: I just want to say I agree with you what you said from beginning. This report was horrible and it's not going to get any better if we don't have a plan on how to get people out of poverty. I believe it's a generational problem. Family after family generation, people are staying on welfare on programs, and I don't know if they have programs that are making it aspirational to move beyond the support that they're getting because I don't understand if you're giving them limited funds and they're staying in this poverty hole, they can never get out of it. To hear that motor vehicle deaths are higher in Hispanic and Black communities, it makes no sense to me. Are you saying that we're driving bad because we're poor? I don't understand what's happening and it just seems like we need a comprehensive plan to say how do we change the dynamics because we keep talking about this year after year, and nothing is changing. Nothing is changing in the school system and the medical system, but we keep saying it's hard to be Black and it's hard to be Hispanic. It's hard to be a minority in this community, in this world we're living in and we're not addressing the problems. And so, to hear these reports, I feel so blessed that I don't feel touched by it. I feel like we're not really trying to solve the problem. The problem is like we're throwing food at people but not helping them with making their own food. It's like we're saying, here are these food banks, but we're not solving the problem of poverty. People are poorer and we have more food banks. We have health systems and people are getting sicker and sicker, so we need to address what the problem is and how do we solve it by working together. And so, it's so disheartening to see these reports year after year, and nothing is changing. And we are the voices that are saying what Alameda Alliance is doing to support these efforts, but it just goes deeper than the reporting that you're giving because the reporting that you're giving is just depressing. And I can't imagine the life that the people are living, and we're just putting it like numbers on paper, and what does it really mean? It just makes me so frustrated that we're the richest country in the world, and the most dynamic, and we are failing our people. So, I appreciate the reporting, but it seems like we just need solutions and we're not solving anything, we're just reporting that people*		

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	are getting sicker and sicker, and having trouble. That's all we hear. So, I just had to get that out. ➢ *Response-C. Guzman: I really appreciate your comment and your thinking. I think that that's right in line with where we're going. And you know, I think Andrea mentioned towards the end that this is just the first step, what we're going to do next is convene stakeholders like yourselves, with Alameda Alliance, and help us strategize what we can do for solutions. Because this is hard to hear, but that doesn't mean that there's not actually resources and brilliant ideas that come from communities in terms of motor vehicle crashes and injuries. What I would say is that, you know, you drive to some communities and they have really nice street calming strategies like speed bumps or roundabouts. Where I live in East Oakland, I've asked many, many times to get some speed bumps in my own street and they're like, no, we don't have resources for that. So, it depends on how you allocate it and how you advocate for it. So, I think we can use your passion and your thinking and your feedback so that we can have some good strategies. So, we'll make sure to send information about when we're holding those meetings, because that's going to be important.* ❖ *Member Comment-T. Debose: Thank you for that, but I don't think it's the speed bumps. It's like guns, it's not the people that are shooting people. It's about the guns that they have access to. It's not the speed bumps that are going to slow the person down. We need to find out what's wrong with that person and why they can't follow the rules.* ❖ *Member Comment-N. Williams: It seems more punitive than supportive in changing anything.* ❖ *Member Comment-J. Moore: When you don't live a life where you can plan for your future, you're in survival mode every day, every second, you don't have the same psychological foundation, so you take more risks, including turning into things like drugs because you have nothing to lose when you're so alone. Past studies suggest that by giving somebody social opportunities and activities that are engaging, they are less likely to engage in risky behaviors.* ❖ *Member Comment-D. Leonard-Pageau: I wanted to get out of poverty, I got a job, I got punished, I lost my benefits. How are you going to ever leave poverty if every time you make a dollar, they take two away?* ❖ *Member Comment-N. Williams: It is designed as a punitive system, and it needs to be reorganized, and the goals need to be realized for the people to come out of poverty.*		

<table>
<tr><td></td><td>❖ Staff Comment-G. Duran: If I may just add a final closing thought. I know the magnitude of the issue seems daunting and quite unsolvable at times, but it will require all of us here at the table today to think about how in our roles and even expanding beyond our roles today, how we direct additional resources to where the highest need is at. The purpose of showing some of these terrible statistics on these reports is to think about how we can work better together, how we involve the people that are experiencing this daily and how we use community voices to create new solutions together and then direct additional resources that way. And so, thank you again to my colleagues and all of you for engaging with the information, and we'll look forward to inviting them back next year to hear about some of those updates and including invitations to you all to participate in those work groups. Thank you.</td><td></td><td></td></tr>
<tr><td colspan="4">5. c. NEW BUSINESS – NON-SPECIALTY MENTAL HEALTH SERVICES</td></tr>
<tr><td>M. Rubalcava</td><td>Monique Rubalcava, Health Education Specialist presented on the Non-Specialty Mental Health Services (NSMHS).

What are non-Specialty Mental Health Services?
• The state separates mental health care into two levels based on how severe the condition is.
  ○ Specialty Mental Health Services: managed by AC for people with severe conditions.
  ○ Non-Specialty Mental Health Services: managed by Alameda Alliance for people with mild to moderate mental health needs.
    ▪ Assessment and screening for mild to moderate mental health conditions
    ▪ Individual or group psychotherapy
    ▪ Medication management and monitoring
    ▪ Case management or care coordination
    ▪ And more

Problem
• Many Medi-Cal members have mental health symptoms that do not get enough care each year.
• Only 6% of the Alliance members use NSMHS.
• Some key groups are not using these services as much as they need, compared to all members (6%).</td><td>None</td><td>None</td></tr>
</table>

	○ Older Adults (66+): 5% ○ Chinese members: 4% ○ Vietnamese members: 5% ○ Members with disabilities and in long-term care • Barriers include stigma, cost concerns, and lack of culturally/linguistically accessible resources. Solution • Senate Bill 1019 requires the Alliance to develop and implement an annual NSMHS Outreach and Education Plan for members and Primary Care Providers (PCPs). • The Alliance's outreach and education plan is based on data, looks at community needs and service use, and was created with input from many partners. • The goal is to increase awareness, destigmatize seeking care and increase use of covered mental health benefits. Requirements: The Outreach and Education Plan must include: • Stakeholder (partners) & Tribal Engagement ○ Developed with input from the CAC, the Native Americal Health Center (NAHC), and other community-based organizations. • Alignment with Assessments ○ Strategies based on member demographics, health issues, and use of service by race, ethnicity, language, and age. • Cultural and Linguistic Appropriateness ○ All materials are provided in threshold languages (English, Spanish, Chinese, Vietnamese, and Farsi) and other formats at no cost. • Reduce Stigma ○ Uses plain and person-centered language, and materials reviewed for cultural appropriateness to reduce mental health stigma. • Multiple Points of Contact ○ Members can access services via phone, website, member portal, Ombudsman, social media, and mailings. • PCP Outreach ○ Annual education for providers through newsletters, fax blasts, provider communications, and town halls to ensure they can effectively refer members.		

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	Alliance Outreach Strategies
	• Tailored Member Communication
	  ○ Flyers and newsletters in different languages that have stigma-reduction messaging.
	  ○ Social media campaigns for groups not using services (e.g., Chinese, Vietnamese, Spanish speakers, older adults).
	  ○ Outreach at community events (e.g., health fairs, cultural events).
	• Enhanced Provider Engagement
	  ○ Educate PCPs on NSMHS benefits and referral process.
	• Community Partnerships
	  ○ Collaborate with organizations like Asian Health Services and Lifelong Medical Care to share messages and build trust.
	• Coordinated System Approach
	  ○ Partner with Alameda County Behavioral Health Department to ensure "No Wrong Door" experience for members between specialty and non-specialty care.
	Discussion
	• How can the Alliance encourage more members to use mental health services?
	• Specific group questions:
	  ○ Older adults: What methods would help older adults learn about mental health services?
	  ○ Chinese/Vietnamese members: How can we make mental health information easier to access?
	  ○ Members with disabilities and in long-term care: Are there ways to involve caregivers in promoting mental health support?
	
	❖ *Member Feedback-D. Leonard-Pageau: You can have the information available on information boards in senior centers, supermarkets, school, and apartment complex lobbies. It is also critical that the doctors refer people to mental health services depending on the mental health screening results at each visit.*
	❖ *Member Feedback-R. Williams: I work hand in hand in senior centers and the easiest way to get someone to do something is to offer incentives such as giving $10 gift cards or providing snacks.*
	❖ *Member Feedback-K. Pageau: I just want to agree with you. I went to one of the senior centers and they had a free health screening, they took your temperature and blood pressure, and they gave us a bag of goodies. I think Alliance can do something similar in their outreach.*		

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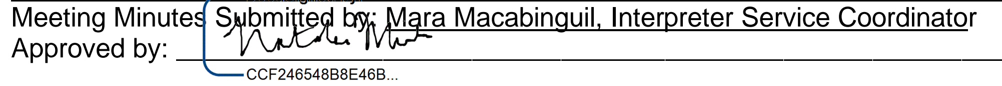
<table>
<tr><td></td><td>Member Feedback-D. Griggsmurphy: I just wanted to comment on cultural competency, how important it is to have family members involved when we try to get information to older adults, especially in different communities of color. They trust their families, so they bring their younger daughter or caregiver or whoever's in their life to kind of learn about the information. And I want to echo the sentiments of the person before me. Freebies always work. Every event I had that was the most well attended was when we gave little goodies to the older adults and they were very excited about that.</td><td></td><td></td></tr>
<tr><td colspan="4">5. d. NEW BUSINESS – ANNUAL ALLIANCE ONLINE RESOURCE SURVEY</td></tr>
<tr><td>M. Lewis</td><td>Michelle Lewis, Senior Director of Communications and Outreach discussed the annual Alliance Online Resource Survey.
All the CAC members were invited to stay after the meeting to complete the Alliance online provider directory, pharmacy, and benefits information survey. Lunch is provided and an incentive of a $50 gift card will be given after completing the survey.</td><td>None</td><td>None</td></tr>
<tr><td colspan="4">5. e. NEW BUSINESS – ALLIANCE IN THE COMMUNITY: COMMUNITY CONVERSATIONS</td></tr>
<tr><td>G. Perez-Pablo
T. Dinh</td><td>Gabriela Perez-Pablo and Thomas Dinh, Outreach Coordinators presented on the Alliance in the Community: Community Conversations Initiative.
Definition: a series of community-based dialogues bringing the Alliance, CAC, and members in the community together.
Goals
Enhance member engagement.
Provide more inclusive opportunities for members who cannot attend regularly scheduled CAC meetings.
Why It Matters
Alliance’s 30-year Anniversary: a milestone to reflect and connect.
Opportunity to:
Celebrate achievements
Build more connections with members
Gather more member feedback for future initiatives
Invitation to Join the Planning Committee
To sign-up, contact outreach@alamedalliance.org by Thursday, January 1, 2026.
Planning Committee responsibilities:</td><td>None</td><td>None</td></tr>
</table>

	▪ Set days, times, and locations ▪ Help set agenda topics		
6. CAC BUSINESS – CAC MEMBERSHIP RECRUITMENT			
L. Ayala	• This agenda item was not covered due to time constraints.	None	None
7. ALLIANCE CARE BAGS			
M. Lewis	• Pioneered by former CAC Chair, Melinda Mello and Current CAC Chair, Natalie Williams. It started with distributing 50 bags. • This year, 5,000 will be shared with people in the community who may be experiencing homelessness. • Meaningful items may include: ○ A face mask ○ A first aid kit ○ A list of local shelters and winter warming stations ○ And sanitizer ○ Non-perishable food items ○ Personal hygiene items • 2025 Care Bag Distributions ○ Alliance CAC members ○ Local Alameda County Shelters ○ Local Churches ○ Street Medicine Teams ○ Warming Centers	None	None
8. OPEN FORUM			
N. Williams	• Ian, Community Based Learning (CBL) Coordinator of the Human Resource and Education Center provided information on the CBL program. Training courses are available for providers e.g., how to better service their communities, how to take care of themselves, burnout prevention, etc. • M. Rubalcava announced a health education material review opportunity. Three new health education materials include information on taking care of your brain cognitive function, signs and symptoms of Alzheimer's and dementia, and guide for caregivers. A $30 gift card incentive will be given to members who choose to participate. CAC members were instructed to approach M. Chi after the meeting if interested. • L. Ayala announced the City of Berkeley Public Health Department's event called the "World Café". This is a part of their process for their	None	Alliance staff to send information on the City of Berkeley's "World Café" event via email.

	community assessment and community health plan work. Details will be sent to CAC members via email.		
9. ADJOURNMENT			
N. Williams	• N. Williams announced that the next meeting will be on March 12, 2026. • Motion to adjourn the meeting. • Meeting adjourned at 12:06 pm.	Motion: D. Leonard-Pagaeu Second: K. Pageau Vote: Approved by consensus.	None

Meeting Minutes Submitted by: Mara Macabinguil, Interpreter Service Coordinator Date: 12/30/2025

Approved by:  Date: 03/14/2026 | 11:01 AM PDT

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