ALAMEDA Alliance FOR HEALTH

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Quality Improvement Health Equity Committee Voting Packet

May 9, 2025

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

QUALITY IMPROVEMENT HEALTH EQUITYPROGRAM EVALUATION 2024

QUALITY IMPROVEMENT HEALTH EQUITY PROGRAM DESCRIPTION 2025

QI 2025 Workplan

Population Health Management (PHM) 2024 Evaluation

Population Health Management (PHM) 2025 Evaluation

Availability of Practitioners
Cultural Needs and Preferences Analysis and Recommendations
2024

ALAMEDA ALLIANCE FOR HEALTH

QUALITY IMPROVEMENT HEALTH EQUITY PROGRAM EVALUATION

2024

ALAMEDA Alliance FOR HEALTH

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2024 Quality Improvement Health Equity Program Evaluation Signature Page

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Introduction

Alameda Alliance for Health (Alliance) is a local, public, not-for-profit managed care health plan committed to making high-quality health care services accessible and affordable to County residents. The Alliance staff and provider network reflect the county's cultural and linguistic diversity. Established in January 1996, the Alliance was created by the Alameda County Board of Supervisors for county residents. The Alliance currently provides health care coverage to over 412,732 children and adults through its programs.

Under the leadership and strategic direction established by the Board of Governors (BOG), senior management and the Quality Improvement Health Equity Committee (QIHE), the 2024 Quality Improvement Health Equity (QIHE) Program was successfully implemented. This report serves as the annual evaluation of the effectiveness of the program activities.

The processes and data reported covers activities conducted from January 1, 2024, through December 31, 2024.

Mission, Vision, and Values

Mission

Improving the health and well-being of our members by collaborating with our provider and community partners to deliver high quality and accessible services.

Vision

All residents of Alameda County will achieve optimal health and well-being at every stage of life.

Values

Teamwork: We actively participate, support each other, develop local talent, and interact as one team.

Respect: We put people first, embracing diversity and equity, striving to create a positive work environment, excellent customer service, and value all people's health and well-being.

Accountability: We work to create and maintain efficient processes and systems that minimize barriers, maximize access, and sustain high quality.

Commitment & Compassion: We are empathic and care for the communities we serve including our members, providers, community partners and staff.

Knowledge & Innovation: We collaborate to find better ways to address the needs of our members and providers by proactively focusing innovative resources on population health and clinical quality.

Scope of the 2024 Quality Improvement Health Equity Program Evaluation

The Alliance's Quality Department is designed to monitor the quality of clinical care and health care service delivery to all Alliance members. The structure provides ongoing reviews of activities and identifies opportunities to improve the quality of care provided, fosters financial stewardship to the health plan, and collaborates with internal and external stakeholders to deliver high quality and accessible health care. Further, the department fosters consistency in quality assessment and improvement to the health care system while:

- Adopting and integrating community health priorities, standards, and goals that impact the health of Alliance's members.
- Identify and target improvement to improve access, care, and service.
- Identify overuse, misuse, and underuse of health care services.
- Identify opportunities to improve patient safety and care.
- Address quality issues, both potential and tangible.
- Monitor data trends that display variations in services or disparities in care.

The Quality Department set goals designed to improve quality and the effectiveness of clinical care served to our members:

- Primary goal: to objectively monitor and evaluate the quality, appropriateness, health equity, and outcome of care and services delivered to members of the Alliance.
- Overall goal: to ensure that members have access to quality health care services that are safe, effective, equitable, and meet their needs.

The Quality Department is structured to continuously pursue opportunities for improvement and problem resolution by:

- Monitoring services and care provided.
- Improving data and analytics to validate care outcomes.
- Peruse opportunities for improvement in areas that are important to Alliance members' care and health.
- Identify interventions when opportunities for improvement are identified.
- Improving member experience through provider access to care.

Quality Improvement Structure

QIHE Structure

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

Governing Committee

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

The QIHEC develops and implements the QIHE program and oversees the QIHE functions within the Alliance.

The QIHEC:

- Recommends policies or revisions to policies for the operational effectiveness of the QIHE Program and the achievement of QI program objectives.
- Oversees the analysis, evaluation, and monitoring of the QI, Utilization Management (UM), Behavioral Health and Case Management (CM) programs and Work Plan activities and assesses the results.
- Ensures practitioner participation in the QIHE program activities through attendance and discussion in relevant QI committee or QI subcommittee meetings.
- Identifies needed actions, and ensures follow-up to improve quality, prioritizing actions based on their significance and provides guidance on which to choose and pursue as appropriate.
- The QIHEC meets a minimum of four times per year or as often as needed, to follow-up on findings and required actions.
- Oversees the actions of the Internal Quality Sub-Committee, Utilization Management Sub-Committee, Access, and Availability Sub-Committee, and the Cultural and Linguistics Sub-Committee.

Committee Structure

The BOG appoints and oversees the QIHEC which, in turn, provides the authority, direction, guidance, and resources to enable Alliance staff to carry out the QIHE Programs. The BOG also

oversees the Peer Review Committee (PRC) and Credentialing Committee (CC), which provides a peer review platform and a platform to review provider credentialing and re-credentialing. Committee membership is made up of provider representatives from the Alliance contracted networks and the Alliance community including, those who provide health care services to members with Mental Health and Behavioral Health Treatment, Seniors, and Persons with Disabilities (SPD) and chronic conditions.

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

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

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

- Quality Improvement Health Equity Committee (QIHEC)
- Peer Review Committee (PRC) and Credentialing Committee (CC)
- Community Advisory Committee (CAC)
- Pharmacy and Therapeutics (P&T) Sub-committee
- Utilization Management (UM) Sub-committee
- Access and Availability Sub-committee
- Internal Quality Improvement Sub-committee (IQIC)
- Cultural and Linguistic Services Sub-committee
- Additionally, Joint Operations Meetings (JOMs) support the quality improvement work of the Alliance. Each committee meets at least quarterly, some monthly, and all committees / sub- committees, except the PRCC, CAC, and P&T committees, report directly to the QIHEC. The PRC and CC, CAC, and P&T report directly to the BOG. Each committee continues to meet the goals outlined in their charters, as applicable. The QIHEC membership includes practitioners representing a broad range of specialties, as well as Alliance leadership and staff.

Evaluation of Senior-Level Physician and Behavioral Health Practitioners

The BOG delegates oversight of QI, CM and UM functions to the QIHEC which is chaired by the Alliance CMO in collaboration with the CHEO, and vice-chaired by the Medical Director of Quality. The CMO, CHEO, and Medical Director provide the authority, direction, guidance, and resources to enable Alliance staff to carry out the QIHE Program. The CMO delegates senior level physician involvement in appropriate committees to provide clinical expertise and guidance to program development.

The committee is comprised of multiple physician representatives and includes CMOs of partner delegate groups. A psychiatrist and CMO of Alameda County Behavioral Health Care (ACBH), actively participates in the QIHEC meetings and provides clinical input ensuring policies and reports considered behavioral health implications. The active involvement of senior-level physicians including the psychiatrist from Alameda County Behavioral Health (ACBH) has provided consistent input into the quality program. Their participation helped ensure that the Alliance is meeting accreditation and regulatory requirements. The Senior Director of Behavioral Health at Alameda Alliance for Health is also an active participant of the QIHE Program.

Program Structure and Operations

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

2024 QIHE Program activities included, but were not limited to the following:

- Evaluation of the effectiveness of the QIHE program structure and oversight.
- Implementation and completion of ongoing QIHE activities that addressed quality and safety or clinical care and quality of service.
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service.
- Analysis of QIHE initiatives and barriers to improvement.
- Monitoring, auditing, and evaluation of delegated entities QIHE activities for compliance with contractual requirements with the implementation of corrective action plans as appropriate.
- Internal monitoring and auditing of QIHE activities for regulatory compliance and assurance of quality and safety of clinical care and quality of service.
- Development and revision of department policies, procedures, and processes as applicable.
- Development and implementation of direct and delegate network corrective action plans because of non-compliance and identified opportunities for improvement, as applicable.

QI Resources

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

The QIHE program moved forward in providing quality improvement guidance enterprise-wide meeting regulatory and accreditation standards and promoting positive health outcomes for the Alliance membership. New positions were hired in fiscal year 24/25: 1) QI Engagement Coordinators to conduct outreach to members to complete all preventive screenings and 2) QI Review Nurse to conduct facility site reviews and support Skilled Nursing Facility/Long Term

Care quality monitoring. QI, Health Care Services, and the Alliance continue to evaluate staff turnover and strive to provide a positive work environment while creating a stable work force.

Throughout 2024, vendor partnerships were a part of the QI resource strategy. The QI department continued to augment QI resources via consultants and analytic expertise for the Healthcare Effectiveness Data and Information Set (HEDIS) program.

Additionally, the Alliance maintained its strong relationship with healthcare services support and survey vendor, Press Ganey (PG) Analytics. Press Ganey supported the QI Department work with implementation, analysis, and reporting on the following surveys:

- Afterhours and Emergency Instruction Survey
- Member Satisfaction Survey (CAHPS 5.1H, CG CAHPS)
- Provider Satisfaction Survey
- To support Dual Special Needs Population (DSNP) implementation, the following surveys were initiated as new scope of work to launch in 2025:
    - Medicare CAHPS simulation
    - Health Outcomes Questionnaire

Membership and Provider Network

Membership

The Alliance product lines include Medi-Cal managed care and Group Care commercial insurance. Medi-Cal managed care beneficiaries, eligible through one of several Medi-Cal programs, e.g. Seniors and Persons with Disability (SPD), Medi-Cal Expansion, Long-Term Care and Dually Eligible Medi-Cal members. For dually eligible Medi-Cal and Medicare beneficiaries, Medicare remains the primary insurance and Medi-Cal benefits are coordinated with the Medicare provider.

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

Trended Enrollment by Network and Aid Category

Current Membership by Network by Category of Aid						
Category of Aid	**Nov-24**	**% of Medi- Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**
Adults	62,582	15.57%	12,962	14,232	5	35,383
Child	109,832	27.33%	9,506	13,553	41,055	45,718
SPD	35,738	8.89%	11,711	5,682	1,450	16,895
ACA OE	151,520	37.71%	26,900	53,058	1,540	70,022
Duals	40,616	10.11%	26,562	2,929	5	11,120
LTC	1,269	0.32%	1,268			1
LTC-Dual	255	0.06%	239	7		9
Total Medi-Cal:	401,812	100%	89,148	89,461	44,055	179,148
Total: Group Care:	5,586		2,147	939	0	2,686
Total	**407,398**	**100%**	**91,295**	**90,400**	**44,055**	**181,834**
Medi-Cal %	98.63%		97.65%	98.96%	100.00%	98.52%
Group Care %	1.37%		2.35%	1.04%	0.00%	1.48%
			22.41%	*22.19%*	*10.81%*	*44.63%*
			% Direct:	**45%**	**% Delegated:**	**55%**

2024 Trended Categories of Aid, Distibution and Growth/Loss

Category of Aid Trend											
	Members				% of Total (ie. Distribution)				% Growth (Loss)		
Category of Aid	Nov-2022	Nov-2023	Oct-2024	Nov-2024	Nov-2022	Nov-2023	Oct-2024	Nov-2024	Nov 2022 to Nov 2023	Nov 2023 to Nov 2024	Oct 2024 to Nov 2024
Adults	50,124	52,215	62,638	62,582	15.37%	14.76%	15.40%	15.36%	4.2%	19.9%	-0.1%
Child	101,680	101,660	109,879	109,832	31.19%	28.74%	27.02%	26.96%	0.0%	8.0%	0.0%
SPD	28,505	31,018	35,535	35,738	8.74%	8.77%	8.74%	8.77%	8.8%	15.2%	0.6%
ACA OE	117,051	120,761	151,048	151,520	35.90%	34.14%	37.14%	37.19%	3.2%	25.5%	0.3%
Duals	22,889	41,381	40,488	40,616	7.02%	11.70%	9.96%	9.97%	80.8%	-1.8%	0.3%
LTC-Dual	0	986	1,263	1,269	0.00%	0.28%	0.31%	0.31%		28.7%	0.5%
LTC	0	139	250	255	0.00%	0.04%	0.06%	0.06%		83.5%	2.0%
Medi-Cal Total:	320,249	348,160	401,101	401,812	98.22%	98.42%	98.62%	98.63%	8.7%	15.4%	0.2%
Group Care Total:	5,791	5,586	5,607	5,586	1.78%	1.58%	1.38%	1.37%	-3.5%	0.0%	-0.4%
Total Membership:	**326,040**	**353,746**	**406,708**	**407,398**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**8.5%**	**15.2%**	**0.2%**

2024 Trend Enrollment by Age Category

	Members				% of Total (Distribution)				% Growth (Loss)		
Age Category	Nov-22	Nov-23	Oct-24	Nov-24	Nov-22	Nov-23	Oct-24	Nov-24	Nov-22 to Nov 2023	Nov-23 to Nov 2024	Oct-24 to Nov 2024
Under 19	103,974	104,107	112,347	112,273	32%	29%	28%	28%	0%	8%	0%
19 - 44	119,089	122,783	152,338	152,599	37%	35%	37%	37%	3%	24%	0%
45 - 64	68,279	72,981	84,403	84,501	21%	21%	21%	21%	7%	16%	0%
65+	34,698	53,875	57,782	58,209	11%	15%	14%	14%	55%	7%	1%
Total	**326,040**	**353,746**	**406,870**	**407,582**	**100%**	**100%**	**100%**	**100%**	8%	15%	0%

In November of 2024, the Alliance annual membership increased by 15.0 % from November 2023. The Alliance experienced membership growth in all age categories from 2023 to 2024 with 8.0% growth in the Under 19 category, 24.0% growth in the 19-44 age category, 16.0% growth for 45-64 age category and 7.0% growth for the 65+ age category.

The increase in membership was due to the transition of Anthem members into Alliance, under the single plan model arrangement. In addition, the delay in member disenrollments from health plans by the state also contributed to the growth in membership.

Provider Network

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

2024 Provider Network by Type, Enrollment and Percentage

PROVIDER NETWORK	PROVIDER TYPE	Line of Business	MEMBERS (ENROLLMENT)	% OF ENROLLMENT IN NETWORK
Direct-Contracted Network	Independent	GroupCare	2,142	0.52%
Direct-Contracted Network	Independent	Medi-Cal	93,942	22.78%
Alameda Health System (AHS)	Managed Care Organization	GroupCare	946	0.23%
Alameda Health System (AHS)	Managed Care Organization	Medi-Cal	89,539	21.71%
Children First Medical	Medical Group	Medi-Cal	44,124	10.70%

Group (CFMG)				
Community Health Clinic Network (CHCN)	Medical Group	GroupCare	2,703	0.66%
Community Health Clinic Network (CHCN)	Medical Group	Medi-Cal	179,022	43.41%
TOTAL			**412,418**	**100%**

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

- Ambulatory care
- Hospital care
- Emergency Services
- Mental Health
- Home Health Care
- Hospice
- Palliative Care
- Rehabilitation Services
- Skilled Nursing Services
- Long-Term Services and Support (LTSS)
- Community Based Adult Services
- Enhanced Care Management and Community Support
- Long Term Care (custodial, Subacute care, and Intermediate Care Facility for the Developmentally Disabled (ICF/DD) facilities)
- Transportation
- Pharmacy

Care coordination along the continuum of care includes arrangements for linked and carved out services, programs, and agencies. These services are provided through a network of contracted providers inclusive of hospitals, nursing facilities, ancillary providers, and service vendors. The providers/vendors are responsible for specifically identified services through contractual arrangements and delegation agreements.

The Alliance provider network includes:

Alliance Ancillary Network

Ancillary Type	Count
Behavioral Health Network	Individuals: 2,607
Durable Medical Equipment (DME) Vendor	1 Capitated, 12 Non-Capitated

Health Centers (FQHCs)	83
Hospitals	17
Pharmacies/Pharmacy Benefit Manager (PBM)	Over 200
Skilled Nursing and Long Term Care Facilities	106
Transportation Vendor	1 Individual Vendor with 380 Individual Transportation Providers

Alliance members may choose from a network of over 500 Primary Care Practitioners (PCPs), more than 9,000 specialists, 17 hospitals, 83 health centers, 106 skilled nursing and long term care facilities, and more than 200 pharmacies throughout Alameda County. The Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan members. Our members' optimal health is always our priority.

The Alliance QIHE Program strives to ensure that members have access to quality health care services.

Health Plan Quality Performance

HEDIS Performance

The Alliance is committed to ensuring the level of care provided to all enrollees meets professionally recognized standards of care and is not withheld or delayed for any reason. The Alliance adopts, re-adopts, and evaluates recognized standards of care for preventive, chronic and behavioral health care conditions. The Alliance also approves the guidelines used by delegated entities. Guidelines are approved through QIHEC. Adherence to practice guidelines and clinical performance is evaluated primarily using standard Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a set of national standardized performance measures used to report on health plan performance in preventive health, chronic condition care, access, and utilization measures. The California Department of Health Care Services (DHCS) requires all Medicaid plans to report a subset of the HEDIS measures. Preliminary 2024 Medicaid administrative rates are noted below. Minimum Performance Level (MPL) and High-Performance Level are determined by the Medi-Cal Managed Care Division.

Medicaid Administrative HEDIS Rates

NCQA Acronym	Measure Description	2023 Admin Rates	2023 Hybrid Rates	2024 Admin Rates	MPL	Measure Type
Behavioral Health						
FUA1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30 Day	38.90%		42.37%	36.34%	Administrative

FUM1	Follow-Up After Emergency Department Visit for Mental Illness - 30 Day	54.69%		28.52%	54.87%	Administrative
Children's Domain						
CIS10	Childhood Immunization Status - Combo 10	41.24%	45.74%	37.07%	27.94%	Administrative / Hybrid
IMA	Immunizations for Adolescents - Combo 2	49.27%	47.69%	47.86%	34.30%	Administrative / Hybrid
LSC	Lead Screening in Children	60.78%	61.31%	66.72%	63.84%	Administrative / Hybrid
DEV	Developmental Screening in the First Three Years of Life	54.39%		63.61%	35.70%	Administrative /Hybrid
TFL	Topical fluoride for Children Rate 1 – dental or oral health services	14.13%		14.68%	19.00%	Administrative / Hybrid
W30	Well-Child Visits in the First 15 Months of Life - 6 or More Visits	58.67%		64.74%	60.38%	Administrative
W30	Well-Child Visits for Age 15 Months to 30 Months - Two or More Visits	74.03%		77.65%	69.43%	Administrative
WCV	Child and Adolescent Well-Care Visits	56.30%		55.56%	51.81%	Administrative
Chronic Disease						
AMR	Asthma Medication Ratio	69.88%		68.55%	66.24%	Administrative / Hybrid
GSD 2	HbA1c Control (>9.0%)	32.06%		33.85%	33.33%	Administrative / Hybrid
CBP	Controlling High Blood Pressure	48.85%	65.21%	50.21%	64.48%	Administrative / Hybrid
Women's Health						
BCS	Breast Cancer Screening	59.59%		59.63%	52.68%	Administrative
CCS	Cervical Cancer Screening	58.33%	60.58%	49.77%	57.18%	Administrative / Hybrid
CHL	Chlamydia Screening in Women	67.14%		69.95%	55.95%	Administrative
PPC1	Timeliness of Prenatal Care	85.90%	90.87%	86.16%	84.55%	Administrative / Hybrid
PPC2	Timeliness of Postpartum Care	86.74%	89.95%	85.99%	80.23%	Administrative / Hybrid

Analysis of HEDIS Medicaid Managed Care Accountability Set (MCAS)

In Measurement Year (MY) 2024, the Alliance observed improvements in some HEDIS/MCAS rates, while a few measures declined compared to MY2023. The most significant barriers to measures falling below the Minimum Performance Level (MPL) include data discrepancies, the transition to a single-plan county, and the adult expansion in 2024.

Despite these challenges, the Alliance has achieved notable improvements in several HEDIS/MCAS measures from MY2023 to MY2024, including:

- **Follow-Up after Emergency Visit for Alcohol and Other Drug Dependencies (FUA)**
- **Lead Screening in Children (LSC)**
- **Well-Child Visits 0-15 months (W30)**
- **Well-Child Visits and 15-30 months (W30)**
- **Chlamydia Screening in Women (CHL)**

These gains result from provider education and support, member and provider incentive programs, and data mining efforts.

Preliminary MY2024 administrative rates indicate a few areas where the Alliance falls short of the MPL:

- **Follow-Up After Emergency Visit for Mental Health (FUM)**
- **Topical Fluoride for Children (TFL)**
- **HbA1c Control (>9.0) (GSD 2)**
- **Controlling High Blood Pressure (CBP)**
- **Cervical Cancer Screening (CCS)**

The primary factor affecting FUM and TFL rates is data integrity. While Alameda County provided some FUM data, system upgrades have led to missing information. The Alliance expects an increase in FUM rates once complete data is integrated. For TFL, key challenges include a shortage of dental providers in Alameda County and inconsistent coding for TFL services. Although the Alliance quality team has worked with FQHC medical providers on proper coding, many non-FQHC providers rely on the county's dental network, which the Alliance does not oversee. Additionally, providers report that members have barriers to accessing dental care in Alameda County. While the number of Primary Care Providers (PCPs) offering TFL services has increased, many are reluctant to provide the service for children over five since it is not reimbursed.

The Alliance remains committed to improving HEDIS/MCAS rates to meet or exceed the MPL. Our comprehensive quality strategy includes:

- Expanding access to care
- Strengthening provider engagement
- Enhancing member and community outreach
- Increasing educational efforts

- Focused QI projects through multidisciplinary workgroups

These initiatives will drive progress toward meeting the required 2025 milestones through internal and external collaboration.

Quality Improvement Health Equity Performance Initiatives and Projects

Overview

The Alliance's quality improvement efforts strive to impact the safety and quality of care and service provided to our members and providers. Review of the Alliance's 2024 QIHE activities as described herein demonstrates the Alliance's QI department ability (in collaboration with internal and external entities) to successfully assess, design, implement, and evaluate an effective QIHE Program including but not limited to, the following:

1. Improved focus on the importance of chronic condition management and accessing appropriate care through initiatives to educate and connect with members, direct and delegated providers, community-based organizations, state, and county entities and enhance our improvements in our internal operations.
2. Maintained a targeted focus on the analysis of key drivers, barriers, and best practices to improve access to care.
3. Expanded staff knowledge of health disparities and equity within the Alliance membership through population data collection, analysis, segmentation, and targeted quality improvement activities as part of the Population Health Management Program
4. Promoted the awareness and concepts of inter-departmental QI initiatives and activities, data-driven approaches, including Plan-Do-Study-Act (PDSA), and Inter-Rater Reliability (IRR), to:
    a. Identify, investigate, and resolve Potential Quality Issues (PQIs).
    b. Identify and address service over-and-underutilization.
    c. Promote patient safety.
    d. Remove barriers to access timely care and services.
5. Invested in quality measurement analysis expertise.
6. Monitored and demonstrated improvement in HEDIS measures.
7. Ensured timely Facility Site Review (FSR/Medical Record Review (MRR) audits and Physical Accessibility Review Surveys (PARS) in person and virtually.
8. Targeted QIHE initiatives to improve direct and delegate provider engagement in access to care efforts to improve rates of preventive care and services, screenings, and referrals for members.
9. Targeted partnerships with community-based county agencies and delegate providers to improve referral and resources triage and management through technology collaboration and support.
10. Improved engagement with interpreter services vendors and Alliance network providers to ensure quality interpreter services at all points of healthcare service contact.
11. Coordinated engagement with Behavioral Health and Care Management teams
12. Collaborated with First 5 of Alameda County and delegate provider networks to improve well-child visits (WCV) and Early Periodic Screening and Diagnostic Treatment (EPSDT)

service utilization for pediatric and adolescent members.

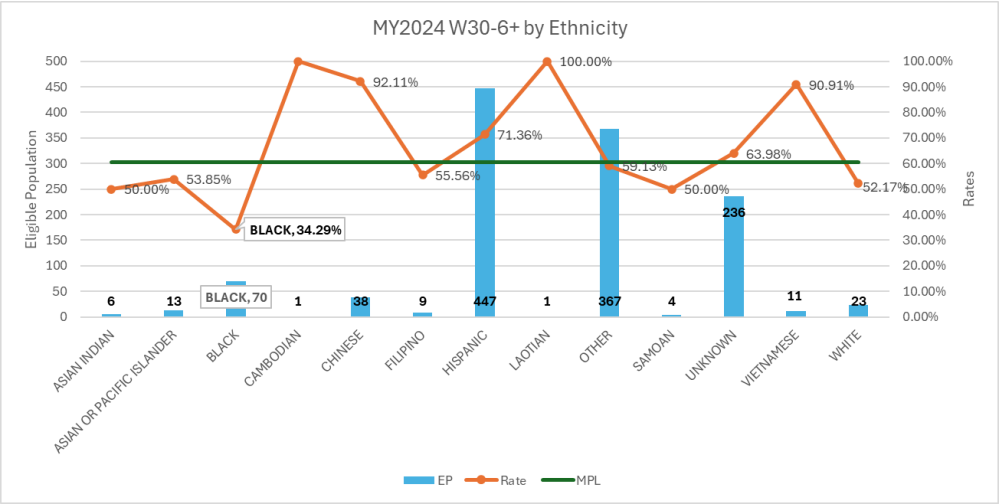
13. Provided webinars and technical assistance to providers to promote access, preventive care, chronic disease management, women's health, and behavioral health services.
14. Incorporated a health equity lens by analyzing health disparity data, member feedback on barriers and root causes, and alignment with the Population Health Strategy and Health Equity Department initiatives.

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

Equity Performance Improvement Project (PIP) (2023 – 2026) – Well Child Visit in the First 15 Months of Life - (W30 6+)

The Department of Health Care Services (DHCS) has reported a concerning trend of lower rates of well-child visits for African American children aged 0-15 months. As a result, the Equity Performance Improvement Project (PIP) topic for MY2023-MY2026 is focused on enhancing well-visit rates for African American children in this age group. In MY2023, the Alliance submitted population size and baseline data for African American children aged 0-15 months residing in Alameda County and a member of the Alliance to DHCS, and the PIP topic was accepted as an equity project through 2026.

The chart below indicates that the Well Child Visits in the First 30 Months of Life (W30-6+) score for Black/African American children ages 0-15 falls below the Minimum Performance Level (MPL). When comparing the Black population with other demographic groups in the Alliance population, the rates for Black children are significantly lower. The Alliance recognizes an opportunity to improve the current scores for Black children to reach or exceed the MPL of 55.72%. As the first step in the PIP process the Alliance is conducting barrier analysis through member surveys to help inform the Alliance and providers on barriers members encounter to completing well visits. In partnership with First 5 Alameda County, the Alliance conducted member surveys targeting African American families to help understand barriers to completing appointments. The results of the survey revealed transportation was a barrier to completing well visits.

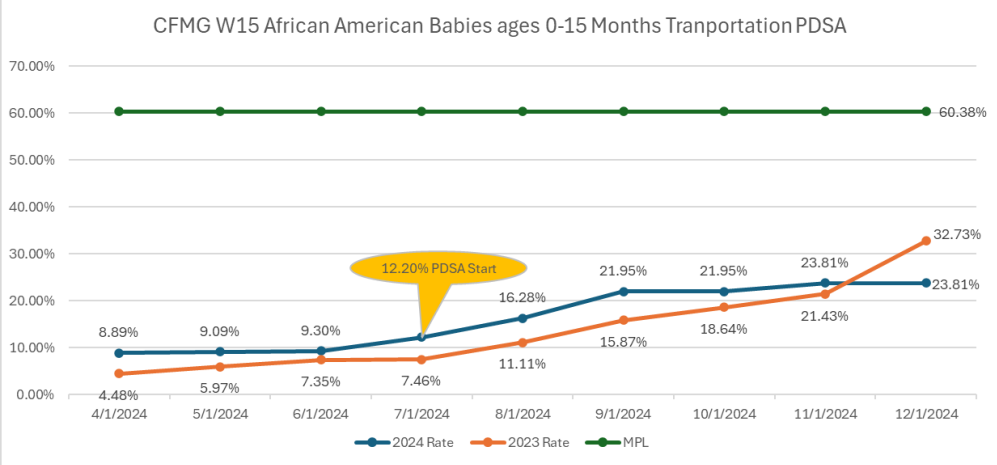


2024 Intervention

Alameda Alliance for Health, in partnership with First 5 Alameda County, implemented a Plan-Do-Study-Act (PDSA) cycle to improve well-child visit completion rates among Black/African American children aged 0-15 months. This outreach intervention specifically targeted families assigned to Children's First Medical Group (CFMG), providing information on the Alliance transportation benefit and educating them on the importance of well-child visits. The PDSA cycle was conducted from July 15, 2024, to December 31, 2024, focusing on 41 African American children within the age group.

2024 Results

- Of the 41 members identified, 5 had invalid phone numbers, reducing the outreach population to 36 members.
- 10 members completed at least one well-child visit after the outreach.
- 7 members utilized the Alliance transportation benefit between July and November 2024.
- The chart below shows CFMG's rates for African American members 0-15 months, a month-over-month improvement is display comparing MY2024 to MY2023.
- The preliminary well-child visit rate for CFMG African American children (0-15 months) is 23.81%. This data will be further analyzed once all MY2024 claims are submitted.
- The overall Alliance well-child visit rate for African American children (0-15 months) is 63.87%, reflecting a 5.2% improvement in MY2024 from MY2023.



Nonclinical Performance Improvement Project (PIP) (2023-2026) – Improve the Percentage of Provider Notifications for Members with SUD/SMH Diagnoses Following or Within 7 Days of Emergency Department (ED) Visit

When a member seeks care in the Emergency Department (ED) for either substance use disorder (SUD) or mental health conditions, it is typically because they are in crisis or in need of assistance not currently provided by their regular providers. During such crises or urgent situations, there's an opportunity for intervention if the member can relate to the appropriate services and receive timely follow-up care. Without such follow-up, members are more likely to return to the ED, and their SUD or mental health conditions often worsen when consistent treatment is not initiated. Therefore, the Department of Health Care Services (DHCS) has identified Follow-up After Emergency Department Visit for Substance Use or Mental Health as the nonclinical Performance Improvement Project (PIP) for 2023 – 2026.

For the nonclinical PIP, DHCS has allowed managed care plans to choose from three topics:

1. Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within 7 days of an emergency department (ED) visit.
2. Enhance the percentage of referrals to Community Support programs (such as Sobering Centers, Day Habilitation programs) within 7 days of visiting the ED for members with a SUD/SMH diagnosis and seen in the ED for the same diagnoses.
3. Increase the percentage of members enrolled in care management, complex care management (CCM), or enhanced care management (ECM) within 14 days of a provider visit where the member was diagnosed with SMH/SUD.

The Alliance has selected topic number one: to improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within 7 days of an ED visit. This choice was made because a notification system to ensure providers are aware that their patients had an ED visit is crucial and represents the first step in following up with patients.

In the chart below, MY2022 rates for Follow-up After ED Visit for Substance Use or Mental Health (FUA/FUM) within 7 days are low. Therefore, the Alliance believes that by increasing provider notifications, the rates for FUA/FUM within 7 days will also increase.

Measure	Number of Events	Notified Provider within 7 Days	Rate
Follow-Up After Emergency Department Visit for Substance Use (FUA)	1,700	37	2.18%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	1,591	44	2.77%

2024 Intervention

There were two interventions tested for this PIP in 2023 - 2024:

- ADT report-based provider notification
- ED claims-based provider notification

ADT report-based provider notification

Primary care providers are usually not aware when their assigned members visit the emergency department due to the hospital and the PCP provider being in different health care systems. This lack of notification creates a barrier for the provider to follow up with the member within 30 days. Thus, from 01/01/2023 – 06/30/2023, the Alliance Analytics teams created a report based on hospital admit, discharge, and transfer (ADT) data to identify members who were seen for a condition that qualified them to be included in the FUA or FUM measure. Reports were then sent to providers via Secure File Transfer Protocol (SFTP) daily. Through this intervention the Alliance notified PCP providers when their assigned member visits the ED within 7 days to facilitate a timely follow up. After evaluating this intervention, the Alliance learned that the ADT data is not an effective source for notifying providers. In June 2023, the Alliance Analytics team analyzed the ADT feed and found that it identified less than 10% of visits eligible for follow-up. The Alliance decided to modify this intervention after June 2023, by switching from using ADT data to using ED claims data to notify providers.

ED claims-based provider notification

From 07/01/2023 - 12/31/2023, this intervention utilized ED claims data instead of ADT feeds to identify members who meet the criteria for FUA and FUM measures. Under this revised process, the Alliance Analytics team extracted ED claims data daily, identifying members who had a qualifying visit and met HEDIS measurement criteria. These reports were then sent to PCPs via SFTP to facilitate timely outreach and follow-up care within the required 7-day timeframe. After evaluating this intervention, the Alliance has discovered that ED Claims data provides a more comprehensive report to providers of the eligible population. The claims data captures all the members who are eligible for follow up for both the FUA & FUM measure. The Alliance has seen

an increase in the 7-day notification rate to providers since switching to using ED claims data. When the Alliance was using ADT data to notify PCPs of ED events that required follow up, the 7-day notification rate for both the FUA and FUM measure was 0%. Since using the ED claims data, the 7-day notification rate is 13.56% for FUA and 12.46% for FUM.

2024 Results

Between January 1, 2024, to December 31, 2024, there were 1784 ED visits in the eligible populations for FUA and 1675 ED visits in the eligible populations for the FUM measure. Among the 1784 ED visits eligible for follow up for FUA, there were 104 ED visits where the member's PCP received a notification within 7 days. Among the 1675 ED visits eligible for follow up for FUM, there were 88 ED visits where the member's PCP received a notification within 7 days. Thus, the Alliance's FUA 7-day provider notification rate 5.83% and FUM 7-day provider notification rate is 5.25%.

Measure	Number of Events	Notified Provider within 7 Days	Rate
Follow-Up After Emergency Department Visit for Substance Use (FUA)	1,784	104	5.83%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	1,675	88	5.25%

Initial Health Appointment (IHA) Rates & Audits

The Alliance continues to make outreach efforts to encourage members to schedule Initial Health Appointments (IHA). These efforts include Interactive Voice Recordings (IVR), reminders through New Member Letters and member orientation. Additionally, the Alliance provides IHA reports to help providers identify members who are newly enrolled or re-enrolled and regularly educates providers on IHA guidelines through provider meetings, webinars and newsletters.

The preliminary rates for 2024 indicate a slight decrease. The decline can be attributed to the departure of Kaiser members and addition of the Anthem and Adult Expansion members. Furthermore, due to claims lag and 120-day timeframe for completion, quarters 3 and 4 data is not finalized. The Alliance will continue to strategize opportunities for improving IHA rates.

Audit of Initial Health Appointments via FSR/MRR

IHAs include History and Physical (H&P). An IHA must be completed within 120 days of member plan enrollment or PCP effective date (whichever is more recent) or documented within the 12 months prior to plan enrollment/PCP effective date.

Alliance reviewed records of IHA for members eligible for IHA criteria. IHA was also reviewed for newly enrolled members who presented for well care visits at the provider's office. In 2024, medical records at 54 sites were reviewed for the presence of an IHA. During the MRR, there were at least 30% of records reviewed or members eligible for IHA. The Table below lists the results of these reviews. There was a total of 54 IHA charts audited and 67% (36) were compliant with the required elements. The 18 total non-compliant providers received CAPs and re-

education/training on IHA compliance.

2024 MRR Results

TYPE	Q1	Q2	Q3	Q4	TOTAL
Total IHAs Audited via FSR	6	20	15	13	54
# of MRRs with Compliant* IHAs	4 (66%)	14 (70%)	9 (60%)	9 (69%)	36 (67%)
# of MRRs with Non-Compliant IHAs (CAPS)	2	6	6	4	18 (33%)

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

IHA Audit

The Alliance conducted 2 audits of the Initial Health Appointments (IHA). A random sample of member charts were selected, and medical records were requested to review the IHA elements, including:

- Comprehensive physical and mental exam
- Identification of risks
- Preventive care
- Health Education
- Diagnoses and plan of care

In 2024, 30 charts were requested, 30 received. The following were the results of the IHA audit:

- Adults – 15charts reviewed, 47% of elements completed.
- Children – 8 charts reviewed, 63% of elements completed.
- Adolescents – 5 charts reviewed, 78% of elements completed.

To improve IHA compliance rates, the Alliance worked to:

- Ensure member education – through mailings, member orientation and outreach.
- Improve provider education – through provider manual and newsletter/packets, Joint Operational Meetings (JOMS), QIHEC meeting, provider site visits to educate providers on timely access standards, and provider educational webinars.
- Improve data sharing – by sharing newly enrolled members in addition to gaps in care lists with delegates and providers.
- Developed an IHA Provider Guide with requirements, codes, and best practices which was shared with providers through various communication methods.
- Monitor medical records – through IHA audits, FSR/MRR site review, and monitoring of IHA rates.
- Provider webinars on IHA, preventive screenings, and chronic care management guidelines

- Ensure accountability – through corrective action plans and follow up.

Well Child Domain

The Well-Child Workgroup focused on improving performance on childhood domain measures held to the Minimum Performance Level (MPL) on the California DHCS Managed Care Accountability Set (MCAS) for MY24/RY25. The aim of the workgroup was as follows:

Alameda Alliance for Health (AAH) will improve on well-child measures in the Managed Care Accountability Set (MCAS) that are under the Minimum Performance Level (MPL), by conducting improvement projects to increase the rates from below the MPL to above the MPL and to maintain current rates, by December 31, 2024, as follows:

- Child and Adolescent Well-Care Visits (WCV), from 56.30% to 58.07%, by December 31, 2024.
- Lead Screening in Children (LSC), from 60.78% to 66.72%, by December 31, 2024.
- Well-Child Visits in the First 0-15 Months of Life (W30-6+), from 58.67% to 64.74%, by December 31, 2024.

To support these improvements, the Workgroup conducted various projects on member education, member outreach, provider education, provider collaboration, and addressing data gaps with the Analytics Department. Here are highlights of projects that helped drive improvements in the overall rates:

- HEDIS Sprint with Children First Medical Group (CFMG): The goal of this project was to meet or exceed CFMG's rates in W30-6+, W30-2+, and WCV measures by providing members, and their families, with a $25 Target Gift Card upon completion of their well-visits. For MY24, 14 CFMG clinics collectively distributed 1,419 gift cards from June-December of 2024. As a result, CFMG exceeded the MPL in the W30-2+ and WCV measures. W30-6+ did not meet or exceed the MPL; however, CFMG had a 0.14% improvement in this rate from MY23, which may be attributed to the HEDIS Sprint project.
- Measure Highlight Tools: In MY2023 the Alliance's QI Team developed Measure Highlight Tools to help providers reference a guide on the various MCAS measure definitions, codes, best practices, and tips to meet the measures. In MY2024 these tools continued to support provider education.
- Supplemental Data for W30-6+: The QI Team partnered with the Quality Analytics Team to bridge the gap in data for the W30-6+ visits. The Alliance identified that there was a significant gap in administrative data for the first well-child visits given to newborns due to the babies' Medi-CAL Client Index Numbers (CINs) being tied to their Mother's Medi-Cal CIN. As a result, when reviewing claims or administrative data it is difficult to delineate if the visit should be attributed to the mother or the baby. To improve this data gap, the Quality Analytics Team worked with CFMG providers, who historically performed low in this measure, to collect medical records. After reviewing the medical records, the Quality Analytics Team would abstract information from encounters that met the NCQA W30 measure specifications.
- Lead Screening Point-of-Care (POC) Incentive: To improve lead screening rates, provider network groups moved towards the use of Point of Care (POC) units. Completing the

lead screening at a provider's office eliminates the need for an extra visit for members to labs and improves adherence. In MY2023 Children's First Medical Group (CFMG) supported their providers to obtain POC units. The Alliance also provided incentive payment to Community Health Center Network (CHCN) to obtain POC units. As a result both delegated entities improved lead screening rates in MY2024.

- CFMG: 10 clinics participated. CFMG's overall Lead Screening rate increased by 8.12% from MY2023.
- CHCN: 6 CHCN clinics participated. CHCN's overall Lead Screening rate increased by 3.69% from MY2023.

- Extended Office Hours (EOH) Incentive: The EOH incentive offers an incentive to providers who offer clinic hours outside of regular business hours. Regular business hours are defined as Monday-Friday, 8 a.m. – 5 p.m. If a clinic can achieve a 70% rate of Alliance members scheduled, with a 70% overall completion rate, they can be rewarded $500 per hour. The number of hours each clinic can claim is approved by QI Leadership. This program addresses access barriers for members who cannot access care during regular business hours. Two clinics participated in the EOH Incentive, focusing on W15 and WCV, outcomes:
  - Patients scheduled: 62
  - Appointments completed: 55
  - Completion rate: 88.70%
  - **Disease Management Domain**

The Chronic Disease Workgroup focused on improving performance on measures held to the MPL on the MCAS. The aim of the workgroup was as follows:

Alameda Alliance for Health (AAH) will improve or maintain performance on chronic disease management measures in the Managed Care Accountability Set (MCAS) to meet the Minimum Performance Level (MPL), by conducting PDSA (Plan, Do, Study, Act) projects by December 31, 2024, as follows:

- Asthma Medication Ratio (AMR), maintain at least 10% performance above MPL, by December 31, 2024.
- Controlling High Blood Pressure (CBP), increase from 48.84% to 61.31%, by December 31, 2024.
- Hemoglobin A1c Control for Patients with Diabetes, decrease from 32.48% to 37.96%, by December 31, 2024.

The overall focus of projects in 2024 was on developing QI infrastructure and increasing provider knowledge of measures and best practices to meet the measure. In partnership with the Pharmacy and Analytics teams, the workgroup produced specialized gap in care reports that provided further detail on the health status of members to increase provider awareness of patient gaps. The CBP/GSD comorbidity report identified members who were diagnosed with either or both hypertension and diabetes, and included information such as the member's latest blood pressure or A1c levels, date of last primary care visit, whether the member has

received a blood pressure monitor as a covered benefit, whether the member is eligible for a Diabetes Prevention Program, and whether the member has a history of tobacco use. The AMR, GSD, and CBP medication reports respectively identified gaps in members either receiving or filling medications that help manage their conditions. These reports were sent to providers on a monthly basis to facilitate tailored interventions to improve performance rates.

One area of needed identified by network providers is staff capacity to conduct outreach. To help address this, the workgroup developed two PDSA projects and a mailing outreach campaign.

The first PDSA involved calling members who are diagnosed with hypertension, have a most recent blood pressure level above 140/90, and have not received a blood pressure monitor as a covered benefit. Contracted call center agents outreached to 105 members to inform them of their eligibility to receive a monitor and to facilitate having the monitor delivered to the member whenever possible. Of those 105 members, 21 out of the 26 members agents spoke to opted to receive a monitor, which resulted in a 24.8% successful contact rate and an 80.8% opt-in rate. Members were also offered the opportunity to receive health coaching on the use of the monitor once it was received; two members received health coaching calls. Throughout the PDSA several barriers were encountered: several members were told by their chosen pharmacy that the monitor was not covered, some never received a monitor, and some members had not been seen at the partnering provider and so were unable to have prescriptions written. In total, only 5 members received a monitor during the PDSA cycle. The workgroup will work to incorporate the lessons learned from the first round into the next PDSA cycle.

The second PDSA project involved conducting phone outreach by AAH engagement staff to members who were diagnosed with hypertension or diabetes, were missing an A1c or blood pressure reading, and were newly transitioned into the plan. A total of 2,488 members received an outreach call encouraging them to schedule an appointment with their provider and receive assistance with updating their assigned provider if needed. There were 1,868 successful contacts which included leaving a voicemail or speaking with the member to assist changing their PCP, transferring to their PCP to schedule an appointment, or receiving additional assistance from the Member Services Department. Staff members were also able to collect qualitative feedback from the members, which included learning that some members had recently seen their PCP, some members had difficulty with understanding recommendations for managing their condition or planning to see their PCP soon. Engagement staff also heard about several access issues include transportation, being on a waitlist, and not receiving a call back from their provider. These findings support the need for increased communication between the Alliance, providers, and members, as well as increased structural support and health education.

The final project related to assisting with member outreach included sending a flyer to members ages 45-49 who were due for colorectal cancer screening. Flyers were sent to 3,231 members informing them about the recommendations for screening including the recently expanded age range to begin screening and how to be connected to screening. Following the mailing campaign, 287 members received colorectal cancer screening. While our data do not

allow for determining whether a member was prompted to complete a screening due to the flyer, these results show there may be at least some benefit to multiple forms of screening reminders from multiple sources.

The other approach to supporting quality program infrastructure was through grants. The Community Health Center Network received funding to improve remote self-measured blood pressure (SMBP) programs and increase colorectal cancer screening. All eight (8) health centers participated in the SMBP grant, with the overall goal of improving the overall CBP rate by 10% above the 2023 rate (60.03% administrative), and the rate for African American members by 15% above the 2023 rate (49.0%). CHCN tracked several measures:

1. The percentage of patients with improved blood pressure readings (>=5 mmHg decrease in systolic blood pressure) in 2024: 53.6% (1810/3377).
2. CBP control stratified by race/ethnicity: African American 55%, all others 63%
3. Number of AAH patients with an SMBP cuff order: 3672
4. Number of AAH patients with an SBMP cuff order and subsequent BP reading: 3376 (92%)

Overall, CHCN has not achieved either aim of increasing the control rate for the overall population or African American patients specifically. However, there were several additional outcomes that show SMBP is a promising intervention: in addition to the number of patients whose systolic BP improved, 85% of members who responded to a satisfaction survey at one health center indicated they were satisfied with the program, and the percentage of members using the monitors increased (92% vs 83% in 2023). Health center staff members also reported increased familiarity with the devices and plan to continue targeted outreach and enrollment into SMBP programs.

CHCN also received funding to improve colorectal cancer screening rates, with the aim to increase the overall rate from 41% in 2023 to 48%. Health center efforts to increase screening included delivering provider education and access to technology, mitigating linguistic barriers, and improving patient responsiveness to outreach through member incentives. Increased access to education and technology was completed by integrating Cologuard ordering into the network's electronic health record (EHR) which allowed for easier ordering and more accessible screening results. Health center staff also received training from Exact Sciences (the manufacturer of Cologuard) covering the importance of colorectal cancer (CRC) screening, how to use Cologuard testing kits, patient engagement strategies, and CRC screening resources. Two health centers also used funds to continue contracts with text-based outreach programs allowing for easier and more frequent outreach attempts. CHCN in partnership with the American Cancer Society also provided colon cancer screening information in languages other than English and Spanish. Health centers purchased gift cards to provide to patients who successfully completed CRC, with a variable response: health centers with well-established outreach programs saw a higher response and patients were more likely to collect their gift card, whereas for those without a robust program the screening rate remained low. Some barriers to the effectiveness of a gift card incentive included patients not returning test kits, patients losing their test kits, and not scheduling a pickup within the specified time. Overall, CHCN's COL rate improved to 49.33% in MY2024, with strong evidence for the importance of electronic health record sharing and improved technological

infrastructure to increase access to colon cancer screening.

Women's Health Domain

The Women's Health Workgroup focused on improving measures that were performing below the minimum performance level in the Managed Care Accountability Set (MCAS), aiming to increase rates to meet or exceed the minimum performance level (MPL) and coordinate efforts to address population health disparities. These measures included:

- Cervical cancer screenings (CCS)
- Breast cancer screenings (BCS)
- Chlamydia screenings in women (CHL)
- Timeliness of prenatal care (PPC 1)
- Timeliness of postnatal care (PPC 2)

In 2024, the workgroup initiated several quality improvement projects to enhance measures in the women's health domain. These projects included mobile mammography, texting campaign in partnership with Alameda Health Systems, outreach efforts through birthday card reminders and outreach calls targeting newly added Anthem and Adult Expansion members.

Mobile Mammography: The Alliance aimed to improve access to BCS screenings for its members and streamline clinic workflows for breast cancer by offering mobile mammography services. In partnership with the provider network, the Alliance hosted 21 mobile mammography events, resulting in 185 completed screenings.

BCS Texting Campaign: In partnership with Alameda Health Systems and Lifelong Medical Health Center, members were eligible to receive a $50.00 gift card for completing a mammogram. Automated text messages were sent to 2,485 members at Alameda Health Systems and those who completed a screening were mailed a gift card resulting in 136 completed screenings. At Lifelong Medical Health Center, out of 1,391 members, 83 members completed a mammogram and received a gift card.

CCS Birthday Card: Birthday cards targeting women who are non-compliant for cervical cancer screenings was mailed a birthday card reminder. Two versions of the birthday card were created: one with an incentive and one without. The incentive birthday card facilitated 267 screenings out of 15,283 eligible members from July 2023 to December 2024, while the non-incentive birthday card facilitated 63 screenings from June 2023 to December 2024 among 1,816 eligible members.

CCS Outreach Calls: Outreach calls were conducted targeting Anthem and Adult Expansion members to address the decline in cervical cancer screening rates following the departure of Kaiser members and the addition of the Adult Expansion members. In collaboration with the vendor Xaqt, these calls aimed to remind members of their due screenings, facilitate real time appointment scheduling with their PCPs, and offer a $25.00 incentive to encourage participation. As a result, 15,914 members were identified as eligible, leading to 91 actual completed cervical cancer screenings.

Cervical Cancer Pap Drives: Multiple providers organized pap events to increase cervical

cancer screenings for women aged 24-64. The Alliance supported these events by conducting outreach calls to schedule appointments, reminding members of their upcoming appointments, and providing incentives and giveaways. These efforts led to 142 completed cervical cancer screenings through these events.

As a result of the improvement projects, preliminary MY2024 data indicates breast cancer screenings rates improved over MY2023 for both Medical and Group Care line of business, exceeding the 75th percentile. Additionally, breast cancer screening rates for African American women have increased significantly in MY2024 compared to MY2023. Preliminary administrative rates for Cervical Cancer Screening shows improvement in MY2024 rates for Group Care; however, Medi-Cal rates have declined over MY2023. This decline is a result of the Adult Expansion members who may have received services under other state coverage. Challenges with accessing this data have contributed to lower reported rates.

Behavioral Health

The Behavioral Health Workgroup focused on increasing performance rates of measures held to MPL on the MCAS: Follow-up after Emergency Department Visit for Mental Illness (FUM) and Follow-Up after Emergency Department Visit for Substance Use (FUA). The aim statement of the workgroup was as follows:

By December 31, 2024, Alameda Alliance for Health will improve behavioral health measures in the MCAS to meet MPL and to further increase rates to reach the 75th percentile.

To meet this goal the workgroup engaged in the following activities:

Learning Best Practices from Other Health Plans

The Behavioral Health Workgroup studied successful strategies from high-performing health plans to improve follow-up care for members after ED visits. Key learnings include:

- The importance of connecting with and following up with members before they leave the ED to improve follow-up rates.
- The role of CA Bridge Substance Use Navigators (SUN) in ensuring that members are linked to care before discharge.
- Collaborations with hospitals employing Community Health Workers (CHWs) in the ED to conduct follow-ups before discharge, which has shown positive results.

In 2024, the workgroup prioritized implementing these best practices within the Alliance. Through research, it was discovered that half of the EDs in the Alliance network were funded for SUNs via the CA Bridge program. To assess the impact, the workgroup analyzed data from Measurement Year 2023 to determine if members in the FUA and FUM categories were receiving follow-up care from SUNs. However, findings revealed that this was not the case—SUNs were not using the appropriate CPT or diagnosis codes to document these visits. To address this gap, the Alliance provided the correct coding information to Alameda Health System, which has the most frequently utilized ED in the network. There are administrative challenges that make it difficult for SUNs to use these codes and submit a claim. The Alliance is continuing to work with the hospital to come up with a way to accurately track and improve follow-up care for members in need.

Targeting High-Utilization Emergency Departments

Using data analysis, the workgroup identified the most frequently utilized EDs among members requiring follow-up care. Nearly 50% of members that fall in the FUA and FUM measures visited Highland Hospital, Sutter Alta Bates, Eden Medical Center, and Washington Hospital in measurement year 2023. This analysis allowed the team to focus intervention efforts on these high-utilization hospitals in 2024. As discussed above, the Alliance worked with Alameda Health Systems, which runs Highland Hospital, to provide data, education on the measures, and make sure follow up care by SUNs is being captured.

Member Incentives for Follow-Up Care

A PDSA cycle was conducted in partnership with Axis Community Health Center from 8/1/2024 - 12/31/2024 to test whether financial incentives could encourage members to complete follow-up visits after an ED visit for mental illness. Despite offering a $25 gift card, most members were not interested in returning for follow-up care. Additionally, the provider noted that many of these ED visits involved individuals experiencing homelessness, making post-discharge outreach particularly challenging.

Expanding Community Health Worker (CHW) Partnerships

To strengthen follow-up efforts, the workgroup has been exploring collaborations with Journey Health, a medical group and CHW provider. In partnership with the Alliance Director of Housing & Community Services and Journey Health, two efforts were put forth in 2024:

- Placing CHWs in EDs to conduct follow-ups with members before discharge
- Utilizing CHWs to make outreach calls to recently discharged members to ensure they stay connected to care

Journey Health already has CHWs deployed at Sutter Hospitals and will conduct follow-ups before members leave those EDs. However, the project to make outreach calls to members who have already been discharged from the ED is on hold, because Journey Health has decided it no longer would like to utilize CHWs for that purpose.

As a result of the improvement efforts, preliminary MY2024 data suggests that the Alliance will be above MPL and in the 75th percentile for FUA. There has been an increase in the rate from MY 2023 by 3.47%, going from 38.90% to 42.97%. The Alliance is still waiting for data from Alameda County Behavioral Health to determine FUM rates.

First 5 Alameda Partnership

The Alliance continued to partner with First 5 Alameda in MY2024. The goal of the initiative was to engage, assess, and connect Medi-Cal enrolled children, ages 0-5 and their families to appropriate clinical and community-based services and support to improve their health and well-being through an integrated community-based care management program. First 5 Alameda served as a key care management entity for Alliance pediatric members, ages 0 to 5 and worked in partnership with the Alliance to:

- Conduct outreach and engagement to increase child access to well-child preventative care for select Alliance members, ages 0-5.

- Provide pediatric health education to families in a culturally appropriate and accessible manner.
- Bolster pediatric health provider capacity to deliver DHCS/Bright Futures mandated pediatric screenings, with an emphasis developmental screening, Adverse Childhood Experiences (ACEs) Screening, and social determinants of health.
- Coordinate family-centered access to well-child visits, as well as needed developmental/behavioral services, mental health services, community-based services and supports, and social support needs, to enhance and supplement practice-based care coordination services and comply with EPSDT requirements.

Through our partnership with First 5, 2,379 distinct Alliance members received an outreach call, 693 members completed a well visit or has a scheduled visit. First 5 facilitated 10 in-person or virtual provider training on EPSDT requirements and conducted 14 provider training to improve capacity to deliver ASQ and ACEs screenings. 457 Alliance members referred by First 5 to at least one community services or support.

Non-Utilization Outreach

The Alliance Board of Governors expressed ongoing concerns about the utilization of services by Alliance members. In addition, the Alliance gained an additional population of members through accepting Anthem transition and adult expansion members. As a result, non-utilization was included as a strategic organization-wide goal. The goal was to reach out to at least 20% of non-utilizers over the age of fifty and connect 2% to primary care services, as well as to outreach to 20% of non-utilizers ages six and under and connect 2% to primary care services by June 30, 2024.

In partnership with Xaqt, a vendor for member outreach, the Alliance conducted outreach calls from March to June 2024. The outreach campaign aimed to facilitate scheduling an appointment for members who had not utilized any services during the baseline period of October 2022 to September 2023, with a specific focus on adults 50 and older and children 6 and younger. The primary goal of the outreach was to update the members' assigned PCP and facilitate scheduling an appointment with their assigned PCP. The secondary goal was to identify members with HEDIS measure completion gaps to tailor calls to complete needed preventive services. One outreach attempt was made to 10,156 adults (9,527 Medi-Cal, 629 Group Care) and 2,179 children. .

The results of the outreach campaign:

- 41.72% overall outreach success* rate – 39.90% of adults, 50.21% of children.
- 0.33% (34) adults and 4.96% (1087) children had a PCP visit following a successful contact based on claims filed.
- 36.52% of calls resulted in a voicemail.
- 18.35% of members had a terminated account at the time of the outreach attempt.

- 29.04% of members could not be reached due to incorrect/disconnected phone number, no option to leave voicemail or no phone number on file.

*Note – successful defined as, changed PCP, Left Voicemail, Shared General Information, Spoke with Member, Parent or Guardian, Transferred to PCP.

Opioid/SUD Continuation

In 2020, the Alliance partnered with the network providers and other local leaders to develop a Substance Use Disorder Program. This program has continued through 2024.

Alameda Alliance has continued to use multiple strategies involving *Member and Provider Educational Outreach and Pharmacy Safeguards*. The Alliance has accurate and comprehensive monthly reports that detail opioid overutilization, members grandfathered to high dose opioids, members excluded from the SUD Program (including those involved in hospice/palliative, cancer, and members with sickle cell disease), and monitoring the changes in Morphine Milligram Equivalence (MME).

The Alliance monitors a list of members who meet the definition of *chronic opioid users and potential chronic opioid users*. Chronic users are defined as members with prescriptions of greater than 120 MME consecutively for the last three months. Potential chronic opioid users are defined as members with prescriptions between 50 to 119 MME consecutively for the last three months.

The Alliance also has compiled a list of members who presented to the ED with opioid and benzodiazepine overdose and a separate list of members on concurrent use of opioids and benzodiazepines.

In 2024, the Alliance sent pertinent members and providers educational mailings. Mailing includes:

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

Day	Member	Provider
1	Original mailing gets sent out	Original mailing gets sent out.
45	Repeat mailing. Refer to case management	Repeat mailing.

	if a member is on greater than 300 MME.	
90	Check if member transition to buprenorphine or received appropriate pain treatment.	Receive letters from medical director. Submit a PQI.
120	N/A	Include operations and peer review committee to decide whether to keep in-network.

Note the above escalation process for members and providers with persistent chronic use of opioids. Cancer, hospice, and sickle cell anemia members are excluded from this. Pharmacy will work with QI to receive chart notes to check on this. Rising risk members will be tracked and looked at on a case-by-case basis. Handouts may include opioid safety, medication assisted therapy, non-opioid alternatives, opioid and benzodiazepines tapering tools and provider maps for non-opioid alternatives such as physical therapy, acupuncture, etc.

The table above outlines the actions to be taken after initially mailing to members and providers (day 1). Each respective row reflects a higher escalation process to be taken if members and providers continue to use opioid inappropriately or with no identified treatment plan.

Opioids Stewardship Report

June 2024 and January 2025: Mailings to 23 high-risk members with prescriptions of greater than 120MME consecutively for the last three months. These members received:

- High risk cover letter
- Health education: Safety guide for patients and caregivers
- Health education: Treating pain without opioids.
- Health education: Medicines for opioid dependence

June 2024 and January 2025: Mailings to 46 rising risk members with prescriptions between 50 to 119 MME consecutively for the last three months. These members received:

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

June 2024 and January 2025: Mailings of a total of 44 clinics in June 2024 and 39 clinics in January 2025 with members who were on any of the following lists:

- Opioid and Benzodiazepine Co-use list
- Rising risk list: 50-119 MME for 3 consecutive months
- High risk list: 120+ MME for 3 consecutive months
- Opioid and Benzodiazepine ER list
- Chronic use without Naloxone Mail list

The Alliance developed a Provider packet that included an Opioid and Benzodiazepine Tapering

Tool, Shared Data for providers / delegates / committees, Health Education materials, Local Maps that identify providers who may meet the member's needs, and member facing materials.

Goals for 2024

- Continue educating members and providers who are chronic and rising risk opioid users.
- Continue sharing data for providers/delegates/committees.
- Organize materials on Alliance website to be accessible to members and providers.

Opioid and Benzodiazepine ER Reporting

- Reports are based on claims data and reflected on each unique claim with opioids/benzodiazepine related ICD code.
- Reports are shared with assigned PCPs of members on an annual basis.
- There were several peaks between 2023 and 2024 with opioid/benzodiazepine related ER visits. After the highest peak in February 2024, there was a steady decline in opioid/benzodiazepine overdoses, ending with December 2024 having fewer overdoses .

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

Figure 1: 2023 – 2024 Benzodiazepines and Opioid ED visits

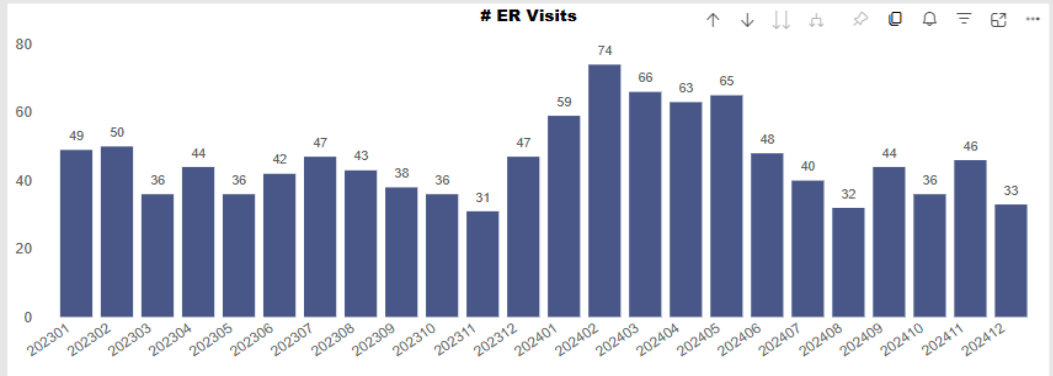
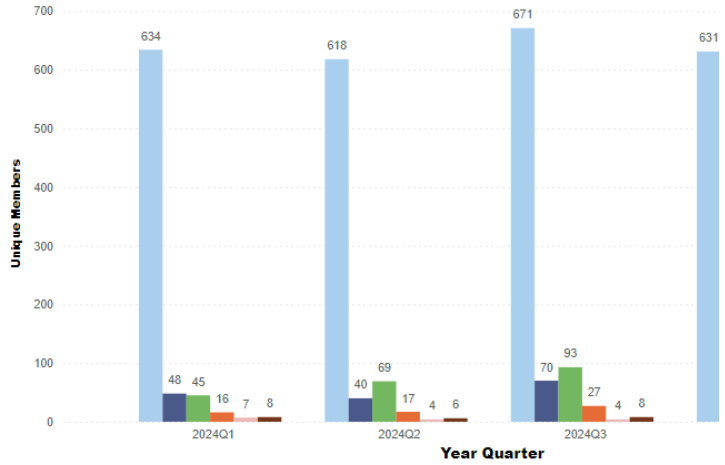


Table 2: Unique Members per Quarter on >50MME

MME (MORPHINE MILLIGRAM EQUIVALENTS)				
MME	**2024Q1**	**2024Q2**	**2024Q3**	**2024Q4**

50-89	634	618	671	631
90-119	48	40	70	68
120-199	45	69	93	86
200-299	16	17	27	31
300-399	7	4	4	10
>400	8	6	8	17

Figure 2: 2024 Active Opioid Members by Quarter



2023 Active Opioid Members by Quarter

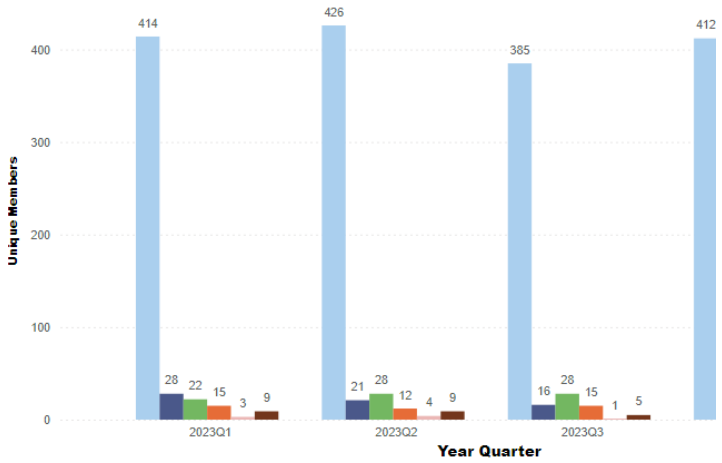
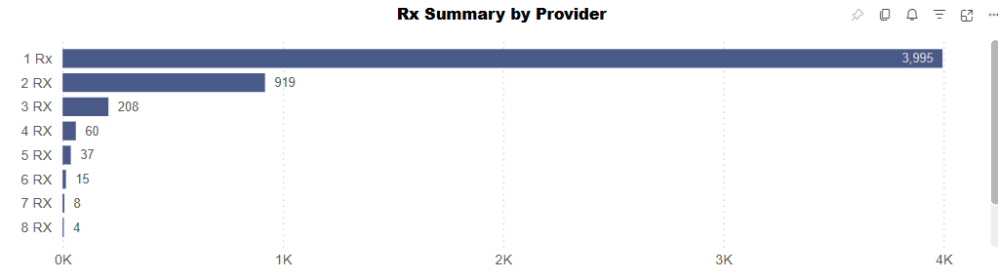


Figure 2 and Table 2 both show opioid utilization by MME. Table 2 shows a significant increase in Q1 2024 of the number of utilizers under 200 MME. We hypothesize this increase could be due to the influx of Adult Expansion and Anthem Transition members, many with chronic conditions. Utilization >300 MME remains stable until an increase in Q4 2024.

Below is a graph depicting how many unique providers prescribing opioids categorized by ascending MME. These graphs are looking at provider prescription claims. There is a general decrease in prescribing trend as the MME goes up. In 2024, 21 providers each wrote 1 prescription for 300-399 MME and 31 providers each wrote 1 prescription greater than 400 MME. In addition, 1 provider wrote at least 10 prescriptions. The top five providers who wrote more than 300 MME were oncology, internal medicine, and family practitioners. In comparison with 2023, there was an increase in utilization for all MME.

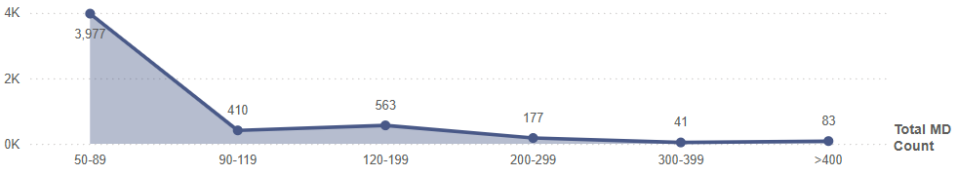
Figure 3: Frequency of Provider Opioid Prescription Count by MME for 2023 and 2024

2024

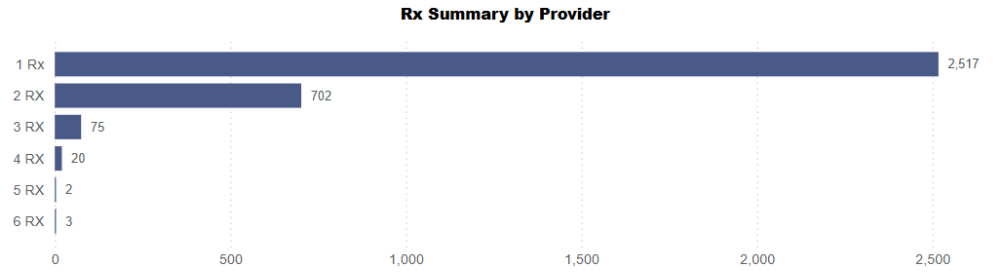


Rx by # Provider

MME	1 Rx	2 RX	3 RX	4 RX	5 RX	6 RX	7 RX	8 RX	9 RX	10+ RX	Total
50-89	3,257	570	112	18	10	6	1	3			**3,977**
90-119	229	131	28	10	10	1	1				**410**
120-199	367	136	33	13	7	2	1	1	2	1	**563**
200-299	90	59	22	2	4						**177**
300-399	21	5	6	6	2		1				**41**
>400	31	18	7	11	4	6	4		2		**83**
Total	**3,995**	**919**	**208**	**60**	**37**	**15**	**8**	**4**	**4**	**1**	**5,251**

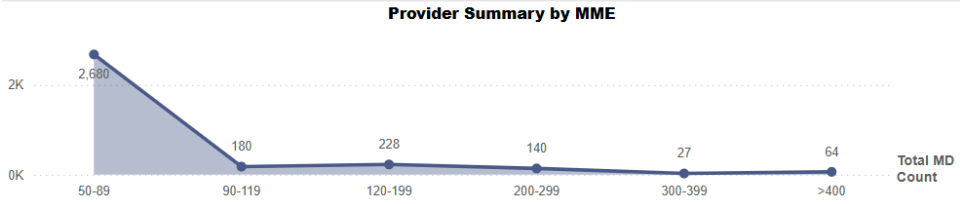


2023



Rx by # Provider

MME	1 Rx	2 RX	3 RX	4 RX	5 RX	6 RX	Total
50-89	2,170	443	49	13	2	3	**2,680**
90-119	99	77	3	1			**180**
120-199	151	67	7	3			**228**
200-299	47	78	14	1			**140**
300-399	19	8					**27**
>400	31	29	2	2			**64**
Total	**2,517**	**702**	**75**	**20**	**2**	**3**	**3,319**



Drug Recalls

The Pharmacy Department monitors all drug recalls for IHSS. In 2024, there were 102 recalls. Recalls were monitored for adversely affected members. The number of notifications where the PBM completed a claims data review was 3.

2024 Pharmacy Recalls

RECALL TYPE	QUANTITY
Total number of safety notices/recalls	**102**
Total number of withdrawals	**0**
The number of notifications where PBM completed a claims data review	**3**

Pay-for-Performance Programs

Overview

The Alliance Pay-for-Performance (P4P) program offers performance-based incentive payments for delivered services. Through this program, primary care providers (PCPs) and PCP Groups are rewarded for superior performance and yearly improvement. The P4P program focuses on preventative care, pediatrics, access, and chronic disease and includes clinical quality measures (HEDIS) and other measures. The evaluation of the P4P is for January 1, 2023, through December 31, 2023.

2023 Program Summary

The 2023 P4P program is tailored to each delegate and directly contracted PCP group category: AHS, CHCN, CFMG, and Directs. The measures for each are outlined below.

Category	Measure	AHS	CHCN	CFMG	Directs - Family Practice	Directs - Internal Medicine	Directs - Pediatrics
HEDIS	Childhood Immunizations: Combo 10 (CIS)			X			X
	Immunizations for Adolescents: Combo 2 (IMA)			X			X
	Lead Screening in Children (LSC)	X	X	X	X		X
	Well-Child Visits in the First 15 Months of Life: Six or More Visits (W30)	X	X	X			X
	Well-Child Visits 15- 30 Months of Life: Two or More Visits (W30)	X	X	X			X
	Child and Adolescent Well-Care Visits (WCV)	X	X	X	X		X
	Breast Cancer Screening (BCS)	X	X		X	X	
	Cervical Cancer Screening (CCS)	X	X		X	X	
	Hemoglobin A1c Poor Control (> 9%) For Diabetics (HBD)	X	X		X	X	
	Follow-up After ED Visit for Mental Illness (FUM) - 30 day	X	X				
Other	PCP Visits Per 1,000 Members	X	X	X	X	X	X
	ED Visits Per 1,000 Members	X	X	X	X	X	X
	Readmission Rate	X	X				
	Member Satisfaction Survey: Non-Urgent Appt Availability	X	X	X	X	X	X
	Member Satisfaction Survey: Urgent Appt Availability	X	X	X	X	X	X

Delegates and PCP groups earned points based on performance compared to the NCQA 50th

percentile and/or improvement from the prior year. This applied to all measures except for the Member Satisfaction Survey questions. For the "Member Satisfaction Survey: Urgent Appointment Availability" full points were earned if 70% of the responses indicate a member was able to get an urgent appointment within two (2) business days. To earn full points for the "Member Satisfaction Survey: Non-Urgent Appointment Availability" 80% of the survey responses for a delegate or PCP group needed to indicate that the member was able to schedule a non-urgent appointment within 10 business days. Below is a breakout of percentage of pool dollars earned by delegate and directly contracted provider category.

Delegate/Directly Contracted Provider Category	% of Pool Dollars Earned in 2023
AHS	34.00%
CHCN	46.91%
CFMG	51.33%
Directs - Family Practice Providers	58.05%
Directs - Internal Medicine Providers	43.12%
Directs - Pediatric Providers	73.35%
TOTAL	**44.67%**

Delegates and directly contracted PCP groups earned 44.67% of the available pool dollars allocated to the 2023 P4P program. QI Improvement Academy

To establish a culture of quality and enhance knowledge HEDIS/MCAS measures both with internal staff and provider network, the QI Performance Team have established a training program under the umbrella of Improvement Academy. Through the Improvement Academy, the QI Performance Team offers a range of educational webinars throughout the year. The webinars include education on the improvement methodologies, transferring knowledge on the PDSA (Plan-Do-Study-Act) methodology. The training encompassed methods for enhancing quality, creating an aim statement, utilizing data for performance enhancement, tools for devising change ideas, and testing change ideas with the PDSA methodology. In 2024, the QI Performance Team hosted two webinar series, each comprising of three one-hour sessions, attended by 188 Alliance and provider staff. Out of the 12 respondents who completed the survey, 100% gave the course an excellent/very good rating.

Annually, the Alliance conducts education sessions, to delegates and primary care direct providers, for the Pay-for-Performance (P4P) incentive program. The education session's objectives are for attendees to understand the P4P measures, goals, points, potential earnings, and review new or updated measure descriptions. Conducted in January 2024, the Alliance extended this opportunity to primary care direct providers for the first time, 22 provider staff attended.

Lastly, to support performance improvements on the DHCS Managed Care Accountability Set (MCAS), the QI Team offered a Measure Highlight Webinar Series which focused on the domain measures for cancer prevention, childhood, and chronic disease. The objectives for these webinars reviewed the measures specifications, shared tips on what counts to complete the measures successfully and allowed opportunity for high-performing providers to discuss and

share bright spots on what made them successful in achieving the measures. This series spanned through February-May of 2024, with 70 attendees from various primary care clinics. Overall, 6 providers completed the survey, indicating they found this webinar beneficial particularly as it pertains to learning bright spots from their peers.

Patient Safety and Quality Compliance

Consistency in Application of Criteria

The Alliance QI Department assesses the consistency with which clinical reviewers, physicians, pharmacists, UM nurses, Retrospective Review nurses and non-physician reviewers apply criteria to evaluate Inter- Rater Reliability (IRR). A full description of the testing methodology is available in policy QI-133. The IRR passing threshold is noted below.

IRR Thresholds (UM)

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

The IRR process for PQIs involves reviewing actual PQI cases. Results will be tallied as they complete the process and corrective actions implemented as needed. When there are opportunities for improving consistency in applying criteria, QI staff address corrective actions through global, individualized training, or completing additional IRR case reviews.

For 2024, IRR testing was performed with QI clinical staff to evaluate consistency in classification, investigation and leveling of PQIs. All QI Review Nurses and Medical Director Reviewers passed the IRR testing with scores of 100%.

Facility Site Reviews

Facility Site Review (FSR) and Medical Record Review (MRR) audits are mandated for Medi-Cal Managed Care Plans to occur every three (3) years, per DHCS All Plan Letter 22-017. FSRs are another way the Alliance ensures member quality of care and safety within the provider office environment. Interim monitoring and focused reviews occur between each regularly scheduled full scope review. Corrective Action Plans (CAPs) for non-compliance are required depending on the site FSR and MRR scores and critical element failures.

The bi-annual DHCS report was submitted in August 2024 for FSRs conducted in January to June 2024) and FSRs conducted in July to December 2024 was submitted in February 2025

through DHCS Web Portal. The DHCS' Managed Care Quality and Monitoring Division (MCQMD) Site Review Portal (MSRP) is still in the process of bulk upload testing and production file submission. Alliance will continue to submit the report via Web Portal until further notice.

In 2024, there were 178 site reviews including PCP sites and urgent care centers. The total number and types of audits are detailed in the table below.

2024 Facility Site Reviews

TYPE	Q1	Q2	Q3	Q4	TOTAL
FSR					
Initial FSR	0	1	1	2	**4**
Periodic FSR	7	7	15	21	**50**
Annual FSR	2	1	0	0	**3**
Urgent Care FSR	1	0	0	0	**1**
MRR					
Initial MRR	0	3	1	0	**4**
Periodic MRR	3	8	14	13	**38**
Annual MRR	1	2	0	0	**3**
Focused MRR	1	5	3	0	**9**
Interim Monitoring	9	0	1	4	**14**
PARS	2	5	29	16	**52**
Total Reviews	**26**	**32**	**64**	**56**	**178**

DHCS regulation requires that Critical Element (CE) CAPs be received by the Alliance within 10 business days and FSR/MRR CAPs within 30-days of the FSR and/or MRR Report. A CE CAP is issued for deficiencies in any of the 14 critical elements in the FSR that identify the potential for adverse effects on patient health or safety. In 2024, there were 74 CAPs issued and all CAPs are closed.

Per DHCS regulation, failed periodic reviews are reported bi-annually. In 2024, the Alliance had two providers with non-passing scores of 79% and below for the full scope MRR. This is the first time these two providers were audited on the new DHCS tool effective July 2022. Alliance will continue to educate the providers on the new standards and conduct focused reviews. An annual full scope review will be conducted in 2025.

In July 2022, DHCS implemented the use of the revised FSR/MRR tools. Many providers are continuing to adjust to the new standards. Alliance anticipated the drop in scores on their subsequent periodic reviews. We conducted provider education and training leading to the changes. A corrective action plan was provided to DHCS. Failed reviews are escalated to the

Medical Director to follow up with the provider. In addition, a new process implemented to facilitate CAP closure was placing new member assignments on hold for PCP sites that receive failing scores on FSR/MRR and/or providers who do not correct FSR/MRR deficiencies within established CAP timelines until the CAP is closed. In 2024, there were 6 providers with new member assignment holds.

PCP FSR/MRR CAPs Issued in 2024

TYPE	Q1	Q2	Q3	Q4	TOTAL
Total CAPs Issued	**11**	**18**	**22**	**27**	**74**
Open	0	0	0	1	1
Open >120 days	*0*	*0*	*0*	*0*	*0*
Closed	11	18	22	10	73

2024 Audits with Non-Passing Scores

QUARTER	Audit Date	FSR Score	MRR Score
Q1	N/A	N/A	N/A
Q2	Provider 1: 6/28/24	95.04%	79.19%
Q3	N/A	N/A	N/A
Q4	Provider 2: 11/14/24	88.72%	77.39%

On August 13, 2024, DHCS notified the Alliance of a DHCS random full-scope FSR and MRR from September 17 to 19, 2024. The DHCS' Site Review Unit's team of Nurse Evaluators (NE) conducted the FSRs and MRRs in 10 provider sites. DHCS conducts separate site reviews to validate the Alliance's FSR and MRR processes. The two Alliance site review nurses accompanied the NEs during the audits. DHCS notified the Alliance of the report findings on Critical Elements (CE) on September 24, 2004. Eight out of ten provider sites had CE CAPs. The Alliance nurses worked with the providers to be in compliance. On October 4, all CE CAPs were submitted to DHCS. On October 22, 2024, DHCS notified the Alliance of the complete FSR and MRR report findings with CAP due within 30 calendar days of the report date. The Alliance issued the CAP to the providers and assisted them to be in compliance. On December 6, the Compliance Department submitted the CAP to DHCS. DCHS confirmed receipt on December 18, 2024. Additional documents were uploaded to the DHCS Web Portal on January 6, 2025. On February 10, 2025, DHCS notified the Alliance that the CAP addressed all findings in the report. All items of the CAP have been corrected, and the review is considered closed.

Long Term Care Quality Monitoring

With the transition of the Long Term Care (LTC) benefit and members to Medi-Cal Managed Care Plans, the Alliance is in the process of building out the LTC quality monitoring program. For Skilled Nursing Facilities (SNF), to comply with APL 23-004, a tracker was developed to

collect quality assurance and improvement findings from California Department of Public Health (CDPH) survey deficiency findings, Medicare Stars, and PQIs. An attestation was developed for SNF providers to attest to compliance with the five key elements identified by the Centers for Medicare and Medicaid (CMS) Quality Assurance Performance Improvement (QAPI) program. In addition, Analytics programmed a report for the LTC measures within the MCAS of performance measures for each SNF, including emergency room visits, healthcare associated infections requiring hospitalization, and potentially preventable readmissions. For Subacute facilities, these facilities will emulate the SNF quality monitoring process. For Intermediate care facilities for individuals with developmental disabilities (ICF/DD), in addition to monitoring CDPH findings, quality monitoring includes service delivery findings from the Regional Centers. In 2024, efforts included adding a QI Review Nurse to conduct site visits as needed, interdisciplinary meetings the Regional Center, and performance measures monitoring and reporting. The clinical QI nursing team have on-going meetings bi-weekly LTC teams at the Alliance to ensure appropriate coordination, quality, and oversight of these facilities.

Peer Review Committee and Credentialing Committee

In 2024, 70 practitioners were reviewed for lack of board certification. If there were complaints about a practitioner's office, facility site reviews were conducted, and the outcome was reviewed by the CC. There were no site reviews conducted based on complaints in 2024. All grievances, complaints, and PQIs that required investigation were forwarded to this committee for review. In 2024, 148 practitioner grievances, complaints, or PQIs were investigated by the committee. There were no practitioners that required reporting to the National Practitioner Data Bank (NPDB) by the Alliance.

In 2024, the CC granted a one-year reappointment for three (3) practitioner for grievances filed regarding quality of care and accessibility and one-year reappointment for one (1) practitioner for grievances filed regarding quality of care and accessibility. The table below shows evidence of practitioners reviewed by the CC for credentialing and re-credentialing decisions.

Count of Practitioners Reviewed for Quality Issues at PRC and CC in 2024

Count of Practitioners Reviewed for Quality Issues At Credentialing Committee in 2024												
PRCC Date	PRC	NPDB	Attestation	Malpractice	Felony/Misdemeanor/Fraud	Facility Site Review	Grievance, Complaints, PQI	License Action	Board Certification	CAP	GAP	Total
January		4	2	1			14		2	4	6	33
February		4	1				16		4	1	2	28
March		11	1	1			11		3		8	35
April		4	2	1			17		5	3	14	46
May		9	7	2			13	1		2	24	58
June		2	4	3			7		2	1	11	30
July		3					11					14
August	No Credentialing Commiittee Meeting											
September		7	5				12		21	3	13	61
October	1		2				15		11	3	7	39
November		6	2	1			18		12	4	7	50
December		2	1				14		10	3	9	39
Total	**1**	**52**	**27**	**9**			**148**	**1**	**70**	**24**	**101**	433

Potential Quality Issues

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

Quality Review Nurses investigate PQIs and summarize their findings. QOA cases are referred to the A&A Team for review and tracking while QOS cases that do not contain a clinical component are investigated and closed by the review nurse. QOL cases are reviewed and investigated by the Cultural and Linguistic Team. The Senior Director and/or the QI RN Supervisor oversees and audits a random sample of QOS cases. The QI Medical Director reviews all QOC cases, in addition to any QOA, QOL, or QOS cases where the Quality Review Nurse and/or RN manager/director requests Medical Director case review. The QI Medical Director will refer cases to the Peer Review Committee (RPC) and/or the Credentialing Committee (CC) for resolution, per clinical discretion

Quality of Care (QOC) Issue Severity Level

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

C4	Serious QOC With significant adverse effect or outcome (life or limb threatening) Examples: Life or limb threatening

The Alliance's QI Department received 10424 PQIs during MY2024, which is a 12% increase from 2023. The total volume of PQIs increased by 1148 which is largely reflected in the number of QOS and QOA issues identified during the measurement year. Of the 10424PQIs received in 2024, 6%, or 596of the PQIs were classified as a QOC. PQI monthly and quarterly totals are listed below:

2024 All PQI Type Monthly Totals

PQI Type	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	TOTAL	%
All Types of PQIs	991	1198	1027	1412	720	444	587	808	669	1051	607	912	**10424**	
QOA	301	430	316	451	210	153	197	248	182	293	163	262	**3206**	**30%**
QOC	54	64	50	47	49	38	60	47	36	56	57	38	**596**	**6%**
QOS	608	659	612	869	438	242	318	479	403	659	359	579	**6225**	**60%**
QOL*	28	45	49	45	23	11	12	34	48	43	28	33	**399**	**4%**

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

Prior to 2024, there was a PQI designation of "Other" that pertained to referrals related to Beacon or Kaiser. Since they are no longer delegated entities as of January 2024, this PQI designation is no longer being used.

As of February 2025, there are still 106 QOC cases open due to turnaround time of 120 days which may extend closure date to end of April for cases that were received at the end of December 2024.

2024QOC PQI Quarterly Totals

INDICATOR	Q1	Q2	Q3	Q4
Indicator 1: QOC PQIs	Denominator: **3216** Numerator: **168** Rate: **5%**	Denominator: **2576** Numerator: **134** Rate: **5%**	Denominator: **2064** Numerator: **143** Rate: **7%**	Denominator: **2570** Numerator: **151** Rate: **6%**

Indicator 2: QOC PQIs leveled at severity C2-4	Denominator: **168** Numerator: **14** Rate **8%**	Denominator: **134** Numerator: **9** Rate: **7%**	Denominator: **143** Numerator: **19**Rate: **13%** **1 case still open**	Denominator: **150** Numerator: **6** Rate: **4%** **105 cases still open**

Exempt Grievance Audit

QI RN management continued to conduct Exempt Grievances case audits via random sampling, to ensure that clinical PQIs are not missed and forwarded to the Quality Department. QI Department clinical management provides oversight of exempt grievances via review of randomly selected exempt grievances. In 2024, 100 exempt grievance cases per quarter were reviewed by QI clinical management, with an overall performance rate of 100% which exceeds the established performance metric of 90%.

	Q42023	Q1 2024	Q22024	Q3 2024
Numerator	100	100	100	100
Denominator	100	100	100	100
Performance Rate	100%	100%	100%	100%
Gap to Goal	N/A	N/A	N/A	N/A
Universe	4448	7162	5383	5444

*

The Alliance IT department continues to provide support with workflow enhancements to the PQI application. An enhancement was made in Quality Suite with the ability to identify long term care (LTC) facilities when PQIs are opened. This will allow the QI clinical safety team to track and trend PQI cases in LTC facilities. The PQI application remains a robust and responsive system allowing for timely and accurate reporting, documentation, tracking, and adjudication of PQIs.

Quality in Member Experience

Overview

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

- Member Experience Survey
- Member Complaints (Grievances)

- Member Appeals

Standards and Provider Education

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

Appointments Wait Times

APPOINTMENTS WAIT TIMES	
Appointment Type:	**Appointment Within:**
Urgent Appointment that *does not* requires Prior Authorization	48 Hours of Request
Urgent Appointment that *requires* Prior Authorization	96 Hours of Request
Non-Urgent **Primary Care** Appointments	10 Business Days of the Request
First Prenatal Visit	2 Weeks of the Request
Non-Urgent Appointment with a **Specialist** Physician	15 Business Days of the Request
Non-Urgent Appointment with a **Behavioral Health** Provider	10 Business Days of the Request
Non-Urgent Appointment for **Ancillary Services** for the diagnosis or treatment of injury, illness, or other health conditions	15 Business Days of the Request

All Provider Wait Time/Telephone/Language Practices

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

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

**The DMHC Timely Access Standard is 15 Business days for Psychiatrist; however, to comply with NCQA accreditation standards of 10 business days, Alliance uses the more stringent standards.*

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

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

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

Shortening or Extending Appointment Timeframes: The applicable waiting time to obtain a particular appointment may be extended if the referring or treating licensed health care Practitioner, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the member's medical record that a longer waiting time will not have a detrimental impact on the health of the member.

Each of these standards are monitored as described in the table below. In 2023, the Alliance

made changes to the CG-CAHPS instrument to ensure that the collected data was consistent with the Alliance standards which remained in place since MY2020.

Access Monitoring Surveys

Primary Care Physician (PCP) Appointment

PRIMARY CARE PHYSICIAN (PCP) APPOINTMENT	
Appointment Type:	**Measured By:**
Urgent Appointment that *requires* Prior Authorization	PAAS, CG-CAHPS, Confirmatory Survey
Urgent Appointment that *does not* require Prior Authorization	PAAS, CG-CAHPS, Confirmatory Survey
Non-Urgent **Primary Care** Appointment	PAAS, CG-CAHPS, Confirmatory Survey
First Prenatal Appointment	Non-PAAS, Confirmatory Survey
Non-Urgent Appointment with a **Specialis**t Physician	PAAS, Confirmatory Survey
Non-Urgent Appointment with a **Behavioral Health** Provider	PAAS, CG- CAHPS, Confirmatory Survey
Non-Urgent Appointment for **Ancillary Services** for the diagnosis or treatment of injury, illness, or other health conditions	PAAS, Confirmatory Survey

All Provider Wait Time/Telephone/Language Practices

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES	
Standard:	**Measured By:**

In-Office Wait Time	CG-CAHPS, Confirmatory Survey
Call Return Time	CG-CAHPS, Confirmatory Survey
Time to Answer Call	CG-CAHPS, Confirmatory
Telephone Access – Provide coverage 24 hours a day, 7 days a week	After Hours: Emergency Instruction Survey, Confirmatory Survey
Telephone Triage and Screening – Wait time not to exceed 30 minutes	After Hours: Emergency Instruction Survey, Confirmatory Survey
Emergency Instructions – Ensure proper emergency instructions	After Hours: Emergency Instructions Survey, Confirmatory Survey
Language Services-Provide interpreter services 24 hours a day, 7 days a week	CG-CAHPS

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

Plan: The standards were discussed and adopted, and surveys have been aligned with our adopted standards.

Do: The surveys were administered, per our policies and procedures (P&Ps); survey methodologies, vendors, and processes are outlined in P&Ps.

Study: Survey results along with QI recommendations were brought forward to the A&A Committee; the Committee formalizes recommendations which are forwarded to the QIHEC and Board of Governors

Act: Dependent on non-compliant providers and study / decision of the A&A Committee, actions may include, but are not limited to, provider education/re- education and outreach, focused discussions with providers and delegates, re-surveying providers to assess/reassess provider compliance with timely access standard(s), issuing of corrective action plans (CAPs), and referral to the Peer Review Committee and/or the Credentialing Committee.

Provider Capacity

The Alliance reviews network capacity reports monthly to determine whether primary care providers are reaching network capacity standards of 1:2000. The Alliance Provider Services Department continues to monitor the threshold at 80% and above to ensure member assignment does not reach the 2,000-capacity standard. If a provider is close to the threshold, the plan will outreach to the provider to make them aware and see if they intend to recruit other providers. If not, the panel is closed to new assignment if they reach 2,000 capacity standards. During this time, the plan and the provider were in communication of such changes. In 2024, there were

providers who reached 80% of the threshold and received outreach and were monitored throughout the year. No providers exceeded the 2,000-capacity standard.

Geo Access

The geographic access reports were reviewed quarterly to ensure that the plan meets the geographic access standards for provided services in Alameda County. For PCPs, the Alliance has adopted standards of one provider within 30 minutes / 10 miles. For specialists, the Alliance has adopted standards of one provider within 30 minutes / 15 miles. During 2024, the Alliance continued its cross functional quarterly meetings to review access issues and concerns.

In 2024, the Alliance continued to face geographic access issues for certain pediatric specialists in various parts of Alameda County, specifically in zip code 94550 in Livermore, CA.

In 2024, there were 32 alternative access standards (AAS) requested and approved by the Department of Health Care Services (DHCS) for pediatric specialties. The zip code of 94550 had the largest area of deficiency with 15 AAS requested and approved. The remaining 17 AAS were in zip codes spread throughout Alameda County and had less than 5 specialties per zip code that were outside of time and distance standards. For adults, there were 12 AAS requests that were submitted and approved and all for zip code 94550 in Livermore, CA. There were no deficiencies in time or distance for PCP services. For hospitals, there was one hospital AAS that was requested and approved by DHCS for zip code 94550.

In those instances, the Plan requested approval of alternative access standards from DHCS. When reviewing the geographic access maps and data, Livermore has unincorporated parts of Alameda County or where Adult and Pediatric Specialties may not be available, resulting in deficiencies. Even though the provider and member were in the same zip code, the time and distance standards were still compromised. The Plan requested alternative access standards in these instances.

Member Satisfaction Survey (CAHPS 5.1H)

The Medi-Cal and Commercial Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is administered by the National Committee for Quality Assurance (NCQA), a certified Health Effectives Data and Information Set (HEDIS) survey vendor. Press Ganey Analytics was selected by the Alliance to conduct the 2024 CAHPS 5.1H survey. The HEDIS CAHPS survey included minor changes to some of the instructions and survey items to indicate the different ways in which patients may be receiving care: in person or via telehealth.

The survey method includes mail and phone responses. Members in each Alliance line of business (LOB) was surveyed separately. The table below shows the survey response rates. As of April 2024, the Alliance had a total of 405,340 members.

The breakdown of member enrollment by network are as follows:

- AHS: 22.41%
- Directs: 22.08%
- CHCN: 44.7%
- CFMG: 10.80%

- **Survey Response Rates by Line of Business**

	Medi-Cal Adult	Medi-Cal Child	Commercial Adult
2024	13.6%	15.8%	17.6%
2023	11.7%	12.3%	20.0%
2022	12.4%	12.3%	21.5%

The Medi-Cal Child, Adult Medi-Cal, and Adult Commercial Trended Survey Results in the tables below, contains trended survey results for the Medi-Cal Child, Medi-Cal Adult, and Commercial Adult populations across composites. Quality Compass All Plans (QCAP) benchmark noted within the tables is a collection of CAHPS 5.1H mean summary ratings for the Medicaid and Commercial samples that were submitted to NCQA in 2023.

In respect to benchmark scores, Red signifies that the current year 2024 score is significantly lower than the 2023 score. Green indicates that the current year 2024 score is significantly higher than the 2023 score.

Medi-Cal Child Trended Survey Results

Summary Rate Scores: Medi-Cal Child				
Composite	**2024**	**Previous Year Comparison**	**2023**	**2022**
Getting Needed Care	76.3%	↓	79.2%	78.4%
Getting Care Quickly	78.3%	↑	73.0%	77.8%
How Well Doctors Communicate	92.6%	↓	92.8%	91.3%
Customer Service	91.0%	↓	92.1%	85.5%
Rating of Health Care (8-10)	89.9%	↑	81.7%	89.5%
Rating of Personal Doctor (8-10)	93.4%	↑	90.7%	90.6%
Rating of Specialist (8-10)	87.7%	↓	95.2%	85.3%
Rating of Health Plan (8-10)	90.9%	↑	86.6%	86.0%
Coordination of Care	84.3%	↑	83.0%	89.1%

Medi-Cal Adult Trended Survey Results

Summary Rate Scores: Medi-Cal Adult

Composite	2024	Previous Year Comparison	2023	2022
Getting Needed Care	73.6%	↓	75.2%	75.9%
Getting Care Quickly	74.9%	↑	72.9%	75.9%
How Well Doctors Communicate	93.9%	↑	87.5%	92.3%
Customer Service	87.3%	↓	88.7%	89.4%
Rating of Health Care (8-10)	81.6%	↑	61.1%	66.3%
Rating of Personal Doctor (8-10)	83.5%	↑	80.0%	82.9%
Rating of Specialist (8-10)	73.8%	↓	80.3%	78.6%
Rating of Health Plan (8-10)	76.4%	↑	70.9%	74.4%
Coordination of Care	78.3%	↓	91.7%	79.0%

Commercial Adult Trended Survey Results

Summary Rate Scores: Commercial Adult				
Composite	2024	Previous Year Comparison	2023	2022
Getting Needed Care	71.1%	↓	72.0%	65.8%
Getting Care Quickly	65.0%	↑	56.0%	62.0%
How Well Doctors Communicate	89.7%	↑	87.5%	83.2%
Customer Service	82.7%	↓	82.9%	78.5%
Rating of Health Care (8-10)	75.0%	↓	76.7%	61.0%
Rating of Personal Doctor (8-10)	83.4%	↑	82.4%	74.9%
Rating of Specialist (8-10)	76.3%	↓	80.6%	72.6%
Rating of Health Plan (8-10)	73.7%	↑	67.1%	65.9%
Coordination of Care	78.2%	↓	80.0%	74.4%

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

Medi-Cal Child Trended Survey Results – Delegates

MY2023 CAHPS 5.1H Child MediCal	2024 Plan Total	CHCN			CFMG			AHS			Alliance		
		2024	2023	YoYT	2024	2023	YoYT	2024	2023	YoYT	2024	2023	YoYT
Total Respondents	323	160	115		107	65		38	21		18	7	
Rating of Health Care (8-10)	89.9%	90.5%	78.6%	↑	94.7%	82.9%	↑	80.0%	92.9%	↓	71.4%	66.7%	↑
Rating of Personal Doctor (8-10)	93.4%	92.1%	87.5%	↑	93.5%	96.3%	↓	97.0%	87.5%	↑	93.8%	100.0%	↓
Rating of Specialist (8-10)	87.7%	83.9%	100.0%	↓	100.0%	91.7%	↑	66.7%	100.0%	↓	100.0%	100.0%	<->
Rating of Health Plan (8-10)	90.9%	90.7%	84.8%	↑	93.3%	90.2%	↑	89.2%	90.0%	↓	82.4%	80.0%	↑
Getting Needed Care	76.3%	71.5%	71.9%	↓	82.9%	87.1%	↓	77.9%	76.2%	↑	92.9%	83.3%	↑
Getting Care Quickly	78.3%	70.6%	70.9%	↓	87.1%	81.2%	↑	71.8%	77.8%	↓	90.0%	55.0%	↑
How Well Doctors Communicate	92.6%	89.6%	90.5%	↓	96.1%	98.5%	↓	92.4%	90.7%	↑	95.0%	93.8%	↑
Customer Service	91.0%	90.4%	88.8%	↑	91.7%	97.2%	↓	95.5%	100.0%	↓	83.3%	100.0%	↓
Coordination of Care	84.3%	77.5%	92.0%	↓	93.3%	90.0%	↑	90.9%	60.0%	↑	50.0%	100.0%	↓

YoYT = Year-Over-Year Trend

Medi-Cal Adult Trended Survey Results - Delegates

MY2023 CAHPS 5.1H Adult MediCal	2024 Plan Total	CHCN			AHS			Alliance		
		2024	2023	YoYT	2024	2023	YoYT	2024	2023	YoYT
Total Respondents	181	80	70		46	32		54	28	
Rating of Health Care (8-10)	81.6%	75.0%	58.5%	↑	95.7%	70.6%	↑	80.0%	57.1%	↑
Rating of Personal Doctor (8-10)	83.5%	80.4%	71.4%	↑	92.3%	92.0%	↑	81.4%	83.3%	↓
Rating of Specialist (8-10)	73.8%	64.3%	70.8%	↓	88.2%	81.8%	↑	73.7%	94.1%	↓
Rating of Health Plan (8-10)	76.4%	76.6%	67.1%	↑	81.0%	80.6%	↑	72.2%	69.2%	↑
Getting Needed Care	73.6%	73.1%	71.8%	↑	81.6%	78.7%	↑	67.9%	90.6%	↓
Getting Care Quickly	74.9%	67.8%	62.4%	↑	82.0%	80.3%	↑	79.2%	80.0%	↓
How Well Doctors Communicate	93.9%	91.4%	81.8%	↑	100.0%	90.9%	↑	93.0%	92.1%	↑
Customer Service	87.3%	86.7%	82.3%	↑	94.1%	95.5%	↓	82.6%	93.3%	↓
Coordination of Care	78.3%	70.8%	93.3%	↓	100.0%	90.9%	↑	76.9%	85.7%	↓

YoYT = Year-Over-Year Trend

Commercial Adult Trended Survey Results – Delegated Network

MY2023 CAHPS 5.1H Adult Commerical	2024 Plan Total	CHCN			Alliance			AHS		
		2024	2023	YoYT	2024	2023	YoYT	2024	2023	YoYT
Total Respondents	185	91	91		71	90		23	34	
Rating of Health Care (8-10)	75.0%	74.6%	73.7%	↑	85.0%	78.8%	↑	52.9%	80.0%	↓
Rating of Personal Doctor (8-10)	83.4%	82.1%	82.9%	↓	83.3%	79.2%	↑	88.9%	89.3%	↓
Rating of Specialist (8-10)	76.3%	77.8%	80.6%	↓	80.6%	78.0%	↑	50.0%	87.5%	↓
Rating of Health Plan (8-10)	73.7%	72.4%	68.2%	↑	79.7%	64.0%	↑	60.9%	72.7%	↓
Getting Needed Care	71.1%	70.6%	67.4%	↑	67.5%	72.0%	↓	82.7%	83.7%	↓
Getting Care Quickly	65.0%	64.2%	47.7%	↑	68.3%	60.6%	↑	58.3%	67.0%	↓
How Well Doctors Communicate	89.7%	91.8%	86.4%	↑	86.1%	87.6%	↓	94.6%	90.0%	↑
Customer Service	82.7%	81.4%	79.4%	↑	80.4%	83.9%	↓	94.4%	88.9%	↑
Coordination of Care	78.2%	83.3%	82.1%	↑	71.8%	75.8%	↓	83.3%	84.6%	↓

YoYT = Year-Over-Year Trend

The 2024 CAHPS survey results year-over-year trends show variation within the **Alliance** business lines. Across LOBs, the Medi-Cal Child population had the highest measure summary

rate scores in 2024.

2023 – 2024 Alliance and Delegate Comparative Findings

Medi-Cal Child

- AHS: Four (4) of nine (9) scores increased based on the above table. A significant increase in percentage scores were seen for 'Rating of Personal Doctor' and 'Coordination of Care.' Significant decreases in percentage scores were seen for 'Rating of Specialist.'
- Direct: Five (5) of nine (9) scores increased based on the above table. With significant increase in percentage scores for 'Getting Care Quickly.' Significant decreases in percentage scores were seen for 'Customer Services' and 'Coordination of Care'.
- CFMG: Five (5) of the nine (9) scores increased based on the above table. Overall, there is no significant increase or decrease in scores for CFMG in 2024.
- CHCN: Four (4) of nine (9) scores increased based on the above table. A significant increase in percentage scores was seen for 'Rating of Healthcare.' Significant decreases in percentage scores were seen for 'Rating of Specialist' and 'Coordination of Care'.

Quantitative Trends:

- Overall, a consistent increase in percentage scores was seen throughout all delegate groups. 'Rating of Specialist' and 'Coordination of Care' are the largest decreased compared to previous year.

Medi-Cal Adult

- AHS: Eight (8) of nine (9) scores increase based on the above table. A significant increase was seen for 'Rating of Health Care,' 'How Well Doctors Communicate,' and 'Coordination of Care.'
- Direct: Three (3) of nine (9) scores increase based on the above table. With significant increase in percentage scores for 'Rating of Health Care.' Significant decrease in percentage scores were seen for 'Rating of Specialist' and 'Getting Needed Care.'
- CHCN: Seven (7) of nine (9) scores increased based on the above table. With a significant increase for 'Rating of Health Care,' and 'How well Doctors Communicate.' Significant decrease in percentage score was seen for 'Coordination of Care.'

Quantitative Trends:

- All delegates showed significant increased percentage scores in 'Rating of Health Care.'

Commercial Adult

- AHS: Seven (7) of nine (9) scores decreased based on the above table. A significant decrease in percentage scores were seen for 'Rating of Health Care,' 'Rating of Specialist,' and 'Rating of Health Plan.'
- Direct: Five (5) of nine (9) scores increased based on the above table. A significant

increase was seen for 'Rating of Health Plan.'

- CHCN: Seven (7) of nine (9) scores increase based on the above table. A significant increase was seen for 'Getting Care Quickly.'

Quantitative Trends:

- Small fluctuation of percentage scores was seen overall for most of the measures but 'How Well Doctors Communicate' received the accumulative highest rating compared to other measures.

Top and Bottom 3 Measures

Population	Top 3 Measures	Bottom 3 Measures
Medi-Cal Child	Rating of Health Plan (9or10)	How Well Doctors Communicate
	Customer Service	Getting Needed Care
	Rating of Personal Doctor (9 or10)	Getting Care Quickly
Medi-Cal Adult	Rating of Healthcare (9-10)	Getting Care Quickly
	How well Doctors Communicate	Getting Needed Care
	Rating of Health Plan (9 or 10)	Coordination of Care
Commercial Adult	Rating of Health Plan (9or10)	Rating of Specialist (9or10)
	Rating of Health Care (9or10)	How Well Doctors Communicate
	Rating of Personal Doctor (9 or 10)	Getting Care Quickly

'Getting Care Quickly' is identified in 2024 as the common bottom measure for all three Lines of Business. The low scoring measures provide opportunities for improvement via root cause analysis as part of the QIHE Work Plan for 2025.

Key Drivers of Rating of Health Plan

Population	Key Drivers
Medi-Cal Child	Rating of Health Care
	Rating of Personal Doctor
	Dr. Listened carefully
Medi-Cal Adult	Rating of Health Care
	Rating of Personal Doctor
	Getting Care, Test, or Treatment
Commercial Adult	Getting Routine Care
	Rating of Personal Doctor
	Dr. Spent enough time

The above table shows 'Rating of Personal Doctor' was found to be the common Key Driver in all three Lines of Business. With 'Rating of Health Care' being the second most common Key

Drivers in at least two Lines of Business.

Next Steps

The Alliance will continue to collaborate interdepartmentally, focusing on maintaining power in top rated measures and improving member perception of care and services ranked at the bottom of composite scores. Additionally, the Alliance will continue to partner with providers on initiatives designed to improve the member experience and survey scores in 2024 using PDSA cycles to improve or maintain Member Satisfaction scores.

Review improvement strategies recommendations by Press Ganey (PG) for targeted improvement focus that include:

- Assess CAHPS data by direct and delegate provider/networks. Beginning Q2 2024 share results at Joint Operations Meetings (JOM) and Quality Improvement meetings with providers. Correlate with grievance data and access PQI complaint data to share with providers.
- Continue best practices for LOBs with increasing survey results.
- Educate providers and staff about Plan and regulatory appointment wait time requirements or standards (i.e., CAHPS, CMS, States, etc.). Identify opportunities for improvement.
- Virtual/onsite visits to providers not meeting Timely Access year over year.
- Encourage/support provider in approaches toward open access scheduling. Allow portion of each day to open the schedules urgent care and/or follow-up care.
- Support members and collaborate with providers to enhance routine and urgent access to care through proactive approaches with Member Services, Provider Relations, Utilization Management, Behavioral Health, and Case and Care Management.
- Ensure Member Services representatives are able to accurately advise members of available alternatives for care, such as Nurse advise line, Telehealth, Urgent Care, etc.

Provider Satisfaction Survey Overview

The Alliance contracted with its NCQA certified vendor, Press Ganey (PG), to conduct a Provider Satisfaction Survey for MY2024. Information obtained from these surveys allows plans to measure how well they are meeting their providers' expectations and needs. The Alliance provided PG with a database of Primary Care Physicians (PCPs), Specialists (SPCs) and Behavioral Health (BH) providers who were part of the Alliance network. Duplicate provider names or NPIs were removed from the database prior to submitting to survey vendor. From the database of unique providers, a sample of 915 records was sampled. A total of 137 surveys were completed between September - November 2024 (83 mail, 39 internet, 15 phone).

The table below contains the survey response rates, survey respondents, and role of survey respondents for 2024 compared to 2023.

Survey Response Rates for Mail/Internet and Phone: 2024 vs. 2023

	Mail/Internet	Phone
2024	13.3%	1.6%
2023	12.6%	1.7%

Survey Respondents for PCPs, BH Providers, SPCs: 2024 vs. 2023

	PCPs	BH Providers	SPCs
2024	10.4%	25.1%	15.5%
2023	9.7%	24.0%	14.6%

Year to Year Trend Comparisons

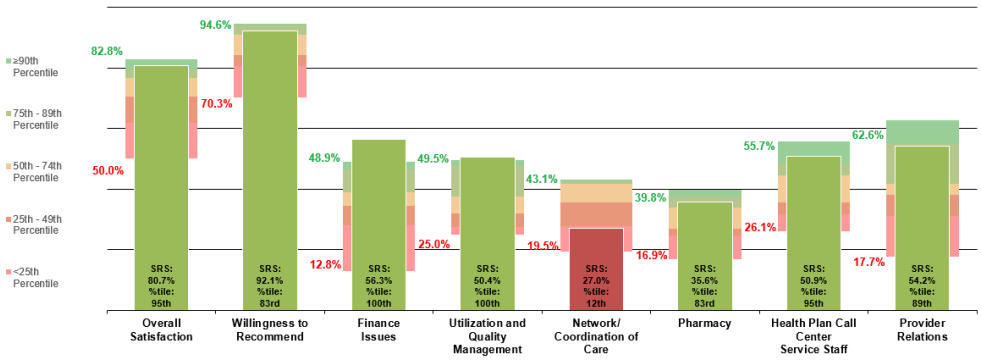
The table below contains the trended survey results across composites.

Trended Survey Results Across Composites

Summary Rate Scores				
Composite / Attribute	**2024**	**Variance Compared to Previous Year**	**Variance Compared to PG Commercial Benchmark BoB**	**2023**
Overall Satisfaction with the Alliance	**80.7%**	Higher	Significantly Higher	**78.4%**
All Other Plans (Comparative Rating)	**64.1%**	Higher	Significantly Higher	55.3%
Finance Issues	**56.3%**	Higher	Significantly Higher	49.0%
Utilization and Quality Management	**50.4%**	Higher	Significantly Higher	47.5%
Network Coordination of Care	**27.0%**	Lower	N/A	41.7%
Pharmacy	**35.6%**	Lower	N/A	38.1%
Health Plan Call Center Service Staff	**50.9%**	Higher	Significantly Higher	49.2%
Provider Relations	**54.2%**	Lower	Significantly Higher	62.7%

The Alliance identified higher composite scores in 5 of 8 measures compared to 2023 scores. One (1) of the 8 composites scored significantly lower compared to 2023. All six (6) composites

scores significantly higher than the vendor commercial BoB benchmark.



Green bar = AA performing at or above the 75th percentile

Red bar = AA performing below the 25th percentile

Survey results indicated that the Alameda Alliance is performing above the 75th percentile in 7 of 8 measures compared to the distribution of scores in the 2023 PG Commercial Book of Business and performing below the median measure 'Network/Coordination of Care. PG Alliance POWER List:

Promote and Leverage Strengths (Top 5 Listed):

1. Timeliness of plan decisions on urgent prior authorization requests.
2. Timeliness of plan decisions on routine prior authorization requests.
3. Procedures for obtaining pre-certification/referral/authorization information.
4. Health Plan call center staff helpfulness in assisting with the referral process or referral network
5. Timeliness of obtaining pre-certification/referral/authorization information.

Best Practice

Below are the performance results for the past three years, for Overall Satisfaction with the Alliance, which has exceeded the PG Aggregate BoB value in all three years.

Overall Satisfaction with Alameda Alliance for Health	Numerator: % Completely of Somewhat Satisfied	Denominator: No. of question respondents	Rate	PG Aggregate Book of Business	Met PG Aggregate BoB? (Y/N)
2022	88	102	86.3%	70.2%	Y
2023	98	125	78.4%	70.1%	Y

2024	108	135	80.7%	69.8%	Y

Next Steps

- Survey results will be shared at the Access and Availability Sub-Committee and Quality Improvement Health Equity Committee.

CG-CAHPS Survey

The Alliance contracted with Press Ganey (PG) Analytics to conduct its quarterly Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey within 2024, which measures member perception of and experience with three timely access standards: In-Office Wait Time; Call Return Time; and Time to Answer Call. The CG-CAHPS survey was fielded in Q1, Q2, Q3, Q4 of 2024. PG followed a mixed methodology of mail and phone to administer the survey to a randomized selection of eligible members who had accessed care with their PCP and BH providers within the previous six months.

*BH providers were added to the survey starting Q2 2024.

The table below presents the compliance rates across the three metrics for the CG-CAHPS surveys conducted in 2024 within each quarter.

CG-CAHPS Survey Results 2024 - PCP

Metric	Compliance Goal	Q1 2024	Q2 2024	Q3 2024	Q4 2024
In-Office Wait Time (Within 60 minutes)	80%	91.8%	91.7%	93.9%	TBD
Call Return Time (Within 1 Business Day)	70%	74.1%	72.0%	73.5%	TBD
Time To Answer Call (Within 10 minutes)	70%	71.5%	76.1%	76.6%	TBD

CG-CAHPS Survey Results 2024 - BH

Metric	Compliance Goal	Q1 2024	Q2 2024	Q3 2024	Q4 2024
In-Office Wait Time (Within 60 minutes)	80%	n/a	94.4%	90.5%	TBD
Call Return Time (Within 1 Business Day)	70%	n/a	72.0%	61.9%	TBD
Time To Answer Call (Within 10 minutes)	70%	n/a	80.0%	80.0%	TBD

Providers and delegates have continued to face staffing and provider shortages in their offices.

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

After Hours Care

The Alliance contracted with Press Ganey (PG) Analytics to conduct the annual Provider After-Hours Survey for MY2024, which measures providers' compliance with the after-hours emergency instructions standard. The MY2024 After-Hours Survey was conducted in September of 2024. PG followed a phone-only protocol to administer the survey to the eligible provider population during closed office hours. A total of 480 Alliance providers and/or their staff were surveyed, which consisted of 96 primary care physicians (PCPs), 261 specialists, and 123 behavioral health (BH) providers. Of the 480 providers 314 providers were eligible with 166 providers ineligible and have been excluded from the survey results. The survey assesses the presence of instructions for a caller in an emergency, either via a recording or auto-attendant, or a live person.

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

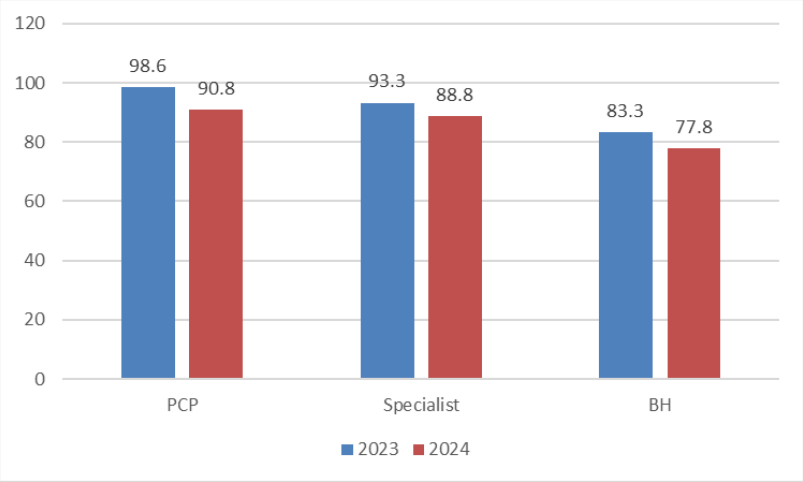
Compliance Rates for After Hours Survey

	Emergency Instructions		
Provider Type	**Total Compliant**	**Total non-compliant**	**Compliance Rate**
PCP	57	6	90.8%
Specialist	151	19	88.8%
BH	63	18	77.8%

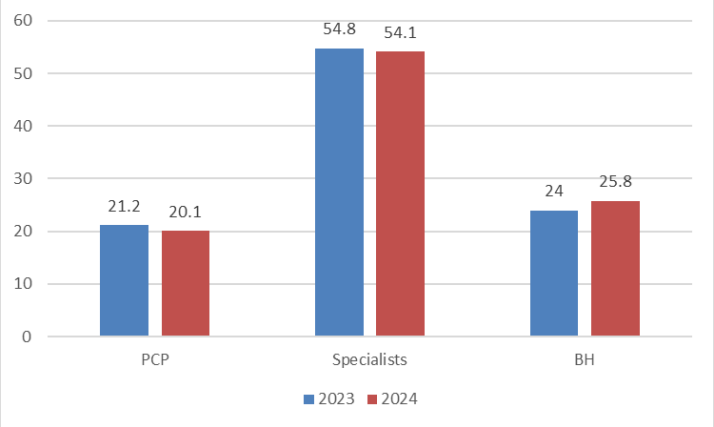
Total	**261**	**43**	

A total of 43 providers (6 PCPs, 19 Specialists, 18 BH) were found to be non-compliant with the emergency instructions standard for the After-Hours Survey. Behavioral Health providers had the highest non-compliance rate in 2024.

After Hours Emergency Instruction and Access to Physician Compliance Rate Comparison (2023 v 2024)



After Hours Emergency Instruction and Access to Provider Survey Response Rate Comparison (2023 v 2024)



- Number of survey respondents in 2023 = 325
- Number of survey respondents in 2024 = 314
- Year-over-year Specialist providers have had the highest response rate to the survey.
- BH providers showed a slight increase in response rate in 2024 from 2023
- Both PCP and Specialists providers had a slight decrease in response rate in 2024 from 2023

In 2024, PCPs and Specialists continue to perform above the 80% compliance rate goal. While BH providers decreased in compliance rate by 2.2% bringing them below the threshold goal in 2024. Results of survey were presented at Q1 2025 Access and Availability Committee with the following next steps for improvement:

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

Initial Pre-Natal Visits

The Alliance conducted the annual First Prenatal Visit Survey for 2024, which measures providers' compliance with the first prenatal visit standard. The survey was conducted in November – December of 2024 and was administered to a random sample of eligible Alliance Obstetrics and Gynecology (OB/GYN) providers. The table below shows the results of the survey.

First Prenatal Visit Survey

Appointment within 2 weeks of request	75% Target Goal Met	Percent of Ineligibles	Precent of Non- Responsive
49.2%	No	44%%	10%

Measurement Year 2024, the Alliance did not meet the threshold goal of 75% for First Prenatal Visit Survey. Corrective Action Plans (CAPs) will be issued to all non-responding and non-compliant providers within Q1 2025.

The Alliance's QI Department will continue:

1. Survey monitoring of First Prenatal Visit compliance via Quality of Access PQIs
2. Ongoing provider education and discussions at delegate JOMs and QI meetings regarding timely access standards.
3. CAPs for non-compliant and non-responsive providers.
4. Virtual/Onsite office visits to providers not meeting Timely Access year over year.
5. Collaboration with Analytics, Provider Services, and delegate networks to improve the accuracy of provider data, thus decreasing the number of ineligible providers.
6. Provider recruitment incentive focusing on improving access to care.

Provider Appointment Availability Survey

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The Alliance's annual Provider Appointment Availability Survey (PAAS) for MY2024 was used to review appointment wait times for the following provider types:

- Primary Care Physicians (PCPs)
- Specialist Physicians (SPCs):
  - Cardiovascular Disease
  - Endocrinology
  - Gastroenterology
  - Dermatology
  - Neurology
  - Ophthalmology
  - ENT
  - Pulmonology
  - Urology
  - Oncology

- Non-Physician Mental Health (NPMH) Providers (PhD-level and Masters-level)
- Ancillary Services Providers offering Mammogram and/or Physical Therapy
- Psychiatrists

The Alliance reviewed the results of its annual PAAS for MY2024 to identify areas of deficiency and areas for potential improvement. The Alliance defines deficiency as a provider group scoring less than a seventy-five percent (75%) compliance rate on any survey question related to appointment wait times.

The Alliance analyzed results for Alameda County, as most members live and receive care in Alameda County, the Alliance's service area. Additionally, per the MY2024 Department of Managed Health Care (DMHC) PAAS Methodology, the Alliance reported compliance rates for all counties in which its contracted providers were located, regardless of whether the providers were located outside the Alliance's service area. This included provider groups in the following counties – Contra Costa, San Joaquin, Sacramento, San Francisco, Santa Clara, San Jose, Solano, Marin, Madera, Monterey, San Mateo, Santa Cruz, San Luis Obispo, Santa Barbara, and Sonoma.

MY2024 Compliance Rates by Appointment/Type across All Provider Types

LOB	**Urgent Appt**	**Routine Appt**	
IHSS	Not applicable	72.7%	
MCL	Not applicable	72.7%	
PCPs			
LOB	**Urgent Appt**	**Routine Appt**	
IHSS	47.5%	71.9%	
MCL	60.7%	73.3%	
NPMH			
LOB	**Urgent Appt**	**Routine Appt**	**Follow-up Appt**
IHSS	81.9%	93.2%	91.4%
MCL	81.4%	90.8%	91.1%
Psychiatrists			
LOB	**Urgent Appt**	**Routine Appt**	
IHSS	80.4%	96.2%	
MCL	80.4%	96.2%	
Specialists			
LOB	**Urgent Appt**	**Routine Appt**	
IHSS	34.7%	51.2%	
MCL	48.4%	51.8%	

Across all provider types, there was greater compliance with the routine appointment standards than with the urgent appointment standard, and this was evidenced for both LOBs – MCL and IHSS. The Alliance will continue engaging in provider/delegate re-education around the timely

access standards, to increase its efforts around compliance for urgent and non-urgent appointment standard, AAH performed through the following:

- Onsite/Virtual office visits to providers not meeting Timely Access year over year
- Ongoing provider education and delegate JOM discussions regarding Timely Access Standards
- Closed provider panel to prevent longer waiting time
- Encourage/support provider in approach toward open access scheduling. Allow a portion of each day open for urgent care and/or follow care
- Access and Availability collaborate with Analytics and Provider Services to reconsolidate provider data, and thus to decrease the number of ineligible providers
- QI initiatives to improve access such as pay for performance (P4P), extended office hours incentives, practice coaching, and provider recruitment/retention incentive
- CAP and Timely Access Standard sent out to non-compliant and non-responsive providers

Percentage of Ineligible Provider Types

MY	Psychiatrists	PCPs	Specialists	Ancillary	NPMH
2024	8.2%	13.8%	9.7%	25.0%	8.1%
2023	14.0%	23.0%	21.3%	10.0%	7.6%

In MY2024, across all provider types, Ancillary providers had the highest percentage of ineligible providers followed by PCP, Specialists, Psychiatrist, and NPMH. PCPs, Psychiatrists, and Specialist providers all showed improvement for MY2024. NPMH had a slight increase in ineligible providers compared to MY2023. Ancillary showed the highest increase in ineligible providers compared to MY2023. However, Ancillary providers have the smallest sample size compared to all other provider types. Due to the smaller sample size, a few ineligible providers can alter the percentage score in a more drastic way compared to other provider types. The Alliance will ensure continued collaboration with its Analytics and Provider Services Teams, as well as with its delegate networks to enhance accuracy of provider contact information, provider specialty, provider network status, and/or provider appointment availability, with the goal of decreasing the overall percentage of ineligible providers.

Percentage of Non-Responsive Provider Types

MY	Psychiatrists	PCPs	Specialists	Ancillary	NPMH
2024	20.5%	22.8%	62.5%	20.0%	38.1%
2023	17.5%	19.9%	51.9%	10.0%	36.2%

Across all provider types, Specialists had the highest percentage of non-responsive providers,

followed by NPMH, PCPs and Psychiatrists, and with Ancillary having the lowest percentage of non-responsive providers in MY2024 (see table above). The Alliance will increase its level of provider/delegate education around survey completion and purpose, including a focus on the development of provider/delegate improvement plans, with the overall goal of lessening and/or removing barriers for non-responsiveness. These efforts will include a focus on Specialists, given they had the highest level of survey non-responsiveness across provider types year-on-year.

Year-Over-Year Analysis

For eligible providers who completed the survey in MY2024, most of the provider categories showed a decrease in percentage score. Psychiatrists were the only providers who show percentage increase in both appointment standards. NPMH providers also had a percentage increase for non-urgent and follow-up appointment standard for both LOBs. Both Psychiatrist and NPMH continue to meet the 75% compliance goal. Ancillary providers were the only provider category that received a 100% in MY2023. However, in MY2024 they dropped below the threshold goal. PCP providers continue to stay around the same scores as the previous year. Lastly, Specialist providers continue to score the lowest compared to other provider types.

Alameda Health Systems (AHS)

For the PCP provider type, AHS met the compliance goal of 75% for non-urgent appointment standard but did not meet the compliance rate threshold for urgent appointment standard for both LOBs. For the Specialists provider type, AHS scored 100% for non-urgent appointment standard for both LOBs for Cardiology and ENT. AHS did not meet the compliance rate threshold for both appointment standards for Endocrinology, Gastroenterology, Neurology, and Pulmonology.

Children's First Medical Group (CFMG)

For the PCP provider type, CFMG providers maintained a stable rate of compliance and met the compliance rate threshold of 75% for urgent and non-urgent appointments. For the Specialist provider type, CFMG providers met the compliance rate for both appointment standards for Cardiology, Hematology/Oncology, and Ophthalmology. The threshold goal was not met for both appointment standards for Endocrinology, Gastroenterology, ENT, Pulmonology and NPMH.

Community Health Center Network (CHCN)

For the PCP providers, CHCN met the compliance goal of 75% for non-urgent appointment standard for both LOBs but failed to meet the compliance rate threshold for urgent appointment. For Ancillary providers, CHCN scored 100% compliance rate for Mammography, but did not meet the compliance rate threshold for Physical Therapy. For the NPMH providers, CHCN met the compliance rate threshold for both appointment standards for both LOBs. As for Hematology/Oncology and Ophthalmology, CHCN met the compliance rate threshold for both appointment standard for both LOBs. For Cardiology, CHCN met the compliance rate threshold for the Commerical LOB for non-urgent appointment but failed to meet the threshold goal for Medi-Cal. As for Endocrinology, Gastroenterology, Dermatology, Neurology, ENT, and Urology, CHCN did not meet the threshold goal for these provider type.

Individual Contracted Providers (ICP)

ICPs meet the threshold goal of 75% for both appointment standards and LOBs for PCP, Psychiatrists, and NPMH. For the Specialty providers, ICPs met the compliance threshold goal for Cardiology, Pulmonology, and Urology for both appointment standards and LOBs. Gastroenterology and ENT both met the non-urgent appointment standard but did not meet the urgent appointment standard. Endocrinology, Dermatology, Neurology, and Ophthalmology did not meet the appointment standard threshold goal for MY2024.

Provider-Focused Improvement Activities

As part of the QI strategy for 2025, the Alliance will continue its ongoing re-education of providers/delegates regarding timely access standards via various methods (e.g., quarterly provider packets, fax blasts, postings on the Alliance website, targeted outreach to providers/delegates, and in-office provider visits as appropriate), with the goal of increasing individual response and compliance rates to 5 Additionally the Alliance A A unit ill conduct focused scheduled and confirmatory surveys/audits that assess provider compliance with timely access standards. Time-sensitive corrective action plans (CAPs) will be issued to all non-responsive and non-compliant providers. Results and corrective actions needed for improvement will be discussed with delegate leadership staff during Joint Operations Meetings between the Alliance and its delegate. The Alliance will review other survey result indicators of access and availability to identify both best practice and opportunities for improvement throughout the year for performance improvement activities. In addition, AAH provides incentives for extending office hours, funding for provider retention and recruitment, focusing on improving access to care.

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For PAAS MY2024 all non-compliant PCPs, Specialists, NPMH providers, Ancillary providers, and Psychiatrists receive notification of their survey results and the timely access standards in which they were deficient, along with time-sensitive CAPs. All non-responsive PCPs, Specialists, NPMH providers, Ancillary providers, and Psychiatrists receive notification of their non-responsiveness reminding them of the requirement to respond to timely access surveys, along with the timely access standards and time-sensitive CAPs.

The Alliance will share findings from the MY2024 PAAS at the Q2 2025 Access and Availability Sub-Committee for feedback and recommendations, as well as, in the August 2025 QIHEC, which is comprised of Chief Medical Officer leadership from delegated networks, offering additional opportunities for discussion of best practice and improvement opportunities.

Provider Outreach and Engagement

During 2024, the Provider Services department continued outreach to all PCP, Specialists and Ancillary provider offices. Outreach and engagement with providers were done in various ways including virtual meetings, email, telephone, fax blasts, and mail.

Topics covered in the outreach, engagement, and fax blasts included but, were not limited to: Provider Satisfaction updates, Provider Appointment Availability Survey (PAAS) updates, utilization management updates and reminders, Immunizations, provider network updates, Annual Healthcare Effectiveness Data and Information Set® (HEDIS) medical record data retrieval notice, Fraud, Waste and Abuse information, Timely Access Standards Reminders, coverage reminders for Tobacco Cessation Medications, Health Education information,

information about how members may receive access to Doula services, Case and Disease Management program information, Pay-for-Performance program, Long-Term Care updates, behavioral health updates, Provider webinars, and Member Rights.

In addition to ongoing outreach, every newly credentialed provider received a new provider orientation within 30 business days of becoming effective with the Alliance. This orientation includes a very detailed summary which includes but not limited to:

- Plan review and summary of Alliance programs,
- Review of network and contract information,
- How to verify eligibility,
- Referrals and how to submit prior authorizations,
- Timely Access Standards,
- Member benefits and services that require PCP referral,
- Filing of complaints and the appeal process,
- Interpreter Services process,
- Transportation benefit information,
- Initial Health Appointment,
- Coordination of Care, California Children's Services, Regional Center, WIC program,
- Claims and billing information,
- Child Health and Disability Program,
- Members' Rights and Responsibilities,
- Member Grievances,
- PQIs,
- Provider Portal, and
- Health Education.

Overall, there were over 500 quarterly packets mailed to providers with updates as mentioned above. Additionally, over 3,500 outreach occurrences were conducted during the 2024 calendar year. The Provider Services department plans to continue our robust provider outreach and engagement strategies in 2025.

Member Outreach and Member Services

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

The Alliance monitors access to its Member Services Department quarterly. The following internal standards and goals are used to evaluate access to the Member Services Department

by telephone.

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

The Alliance also offers an orientation to help members better understand their benefits, the importance of the initial health assessment and who to call when they need help. The member orientation is available to all Alliance members.

Member Engagement and Feedback

Community Advisory Committee (CAC)

The purpose of the CAC is to provide a link between the Alliance and the community. The CAC reflects the Alliance's member population and diversity. The CAC meets quarterly and advises the Alliance on the development and implementation of policies and procedures that affect cultural and linguistic access, quality, and health equity.

In 2024, the CAC provided input and feedback on various topics. A summary of the input and feedback provided by the CAC across various domains is outlined in the table below.

2024 CAC Input and Feedback

Topic	CAC Input and Feedback
Health Education	1. Promote Member Materials and Use of Alliance Benefits • Use clinics, staff, community partners (i.e., IHSS, Regional Center) and Alliance newsletters to promote materials, care books, and Alliance benefits. • Promote preventive care with member stories ▪ Promote benefit Awareness in newsletter and reduce benefit silos for members
Population Health	1. Promote screenings and well visits through focus on inequities, taking trust in doctors, disability access, and possible provider shortages into consideration. Conduct culturally concordant surveys to understand reasons for low visit rates. 2. Consider using telehealth for follow-ups or for those unable to visit in-person. 3. Importance of having trusted, compassionate relationships with doctors for new symptoms, medications or serious matters.
Alameda County Public Health Needs Assessment	1. Concern about multiple poor health outcomes for African Americans 2. Recommend assessing the needs of young adults, elders, children, and understand mental health needs. 3. Recommend easier access to public health services and to inform members about available services.

	4. Concern about food quality and access to healthy food, housing and rent burden.
Non-Specialty Mental Health Services (NSMHS) Outreach and Education Plan	1. Interest in ease of access to talk to someone about mental health problems and having support with follow-up and understanding pre-authorizations. 2. A community organization's social media may be a good way to promote NSMHS 3. Suggested partnering with sports teams to reduce mental health condition stigma.
Alliance Services	1. Promote doula program with OB/GYN, PCP, and La Leche League. 2. ABA service concerns about high turnover of staff, minimal qualifications, and low pay. 3. Increase awareness off the transportation benefit by featuring why members like ModivCare, how to preschedule regular dialysis appointments, and share how easy it is to make a complaint to help with program improvement.
Communication	Diversify outreach strategies, such as using radio or television campaigns may work best for certain communities (i.e., newcomers or older Latinx population); members use email and text more than other modes of communication.

CAC input and feedback was shared at the Cultural and Linguistic Services Subcommittee, Quality Improvement Health Equity Committee, and Utilization Management Committee. This ensured that the feedback was reviewed and utilized to help address Alliance member needs and improve Alliance services.

QI Engagement Coordinator Data

In September of 2024, the Quality Improvement (QI) Performance Team launched a program to conduct outreach to Alliance Medi-Cal members to engage them in their care. Members were identified based on gaps in their services through measures on the Managed Care Accountability Set (MCAS). Outreach campaigns were conducted on Cervical Cancer Screening, Controlling Blood Pressures, and Glycemic Status Assessments for Patients with Diabetes (>9.0%). Profoundly, members from all outcall campaigns shared their appreciation for these phone calls, as they have not received a call like this from their Health Plan before. Additionally:

- Cervical Cancer Screening: During December 2024, 254 calls were made to members needing a pap smear, resulting in 173 successful contacts, or 68.11%. The QI Performance Team learned:
    - Pap Smears have been completed for members who previously resided in other counties. However, their medical records were not transferred from their prior provider(s).

  - Most members agreed to schedule a pap smear, acknowledging the importance due to knowing someone close to them who previously had cervical cancer.
- Controlling High Blood Pressure and Glycemic Status Assessments for Patients with Diabetes (>9.0%): Over the course of four months, September-December 2024, 2,972 calls were made to patients identified not having received care in the last year, who had qualified diagnosis for each of these measures. The Outreach Coordinators successfully contacted 1,868 of these members, or 62.85%. From these calls, the QI Performance Team learned:
  - Many members are unfamiliar with what it means to have their blood pressure or diabetes controlled. However, many of these members also reported they felt like they were under control because they do not feel sick or unwell.
  - Home testing devices are readily available, but the data is not being shared with their Primary Care Physicians (PCPs). These devices do not have Wifi to help transfer this data easily.

Population Health and Equity

Population Health Management (PHM) Overview

In accordance with NCQA 2024 Population Health Program Standards and Guidelines and in alignment with the California Department of Health Care Services (DHCS) *CalAIM: Population Health Management Policy Guide*, the Alliance has developed a PHM Strategy for identifying and addressing member needs across the continuum of care with the aim of improving the health outcomes of the Alliance membership and supporting enhanced quality of life. This continuum includes members with the highest levels of needs, those with emerging risks, and wellness and prevention activities for all members. The Alliance conducts an annual analysis of the impact of its PHM strategy that includes quantitative and qualitative analysis for evidence of program effectiveness and opportunities for improvement.

PHM Strategy

Goal

Develop the Alliance 2024 PHM Strategy to address priority gaps in care and disparities in compliance with DHCS and NCQA requirements.

Results

This goal was achieved. The Alliance created the *2024 Alliance Population Health Management Strategy* and approved the strategy at the May 17, 2024, Quality Improvement and Health Equity Committee (QIHEC) meeting and submitted the strategy to DHCS in October 2024. The 2024 PHM Strategy is described in a separate document. The following table highlights objectives in key focus areas included in the 2024 Alliance PHM Strategy.

The 2024 Population Assessment included a disparity analysis by race/ethnicity of the Department of Managed Health Care (DMHC) Health Equity Quality Measures Set (DMHC

HEQMS) and NCQA health equity HEDIS measures. The 2024 Alliance PHM Strategy includes goals and programs to address disparities identified for the following measures: W30 (Well-Child Visits in the First 30 Months), CIS-10 (Childhood Immunization Status), and BCS (Breast Cancer Screening).

Note: Line of Business (LOB) is noted by Medi-Cal (MC) or Group Care (GC).

Alameda Alliance for Health 2024 NCQA PHM Strategy Goals

2024 PHM Strategy Goals			
Domain	**LOB**	**Program Name**	**Goal**
Managing Multiple Chronic Illnesses			
Connect members in need to whole person care	MC & GC	Complex Case Management	At least 80% of members with at least 2 or more comorbidities that are enrolled in CCM between April 2024 and March 2025 will report a confidence level of at least 6 out of 10 in being able to better manage their health condition since receiving care management services on the case management satisfaction survey.
Support members managing health conditions	MC & GC	Multiple Chronic Disease Management	At least 80% of members with 2 or more chronic conditions who enrolled in Disease Management between April 2024 and March 2025 will have a confidence score in disease self-management knowledge and behaviors of at least 24 out of 30 after receiving 2 to 3 health coaching sessions as measured by post health coaching assessment.
Managing Members with Emerging Risk			
Support members managing health conditions	MC	Diabetes Prevention Program	20% of participants who have continued tracking their weight through 26 weeks between April 2024 and March 2025 will have reached and maintained at least 5% weight loss.
Connect members in need to whole person care	MC	BirthWise Wellbeing	By March 2025, at least 3% of (or approximately 75) Black (African American), Hispanic (Latino), or American Indian or Alaskan Native members who are or were pregnant in the last year will receive doula services.
Address primary care gaps and inequities	MC & GC	Black (African American) Breast Cancer	Increase Breast Cancer Screening (BCS) rates for Black (African American) women ages 50-74 by 3% from MY2023 (as of April 2024) to

		Screening QI Project	MY2024.
Keeping Members Healthy			
Address primary care gaps and inequities	MC	Black (African American) Well-Child Visit QI Project	HEDIS well-child visit (W30) and immunization (CIS-10) rates will increase for Black (African American) members by 5% from MY2023 (as of April 2024) to MY2024.
Address primary care gaps and inequities	MC & GC	Non-Utilizer Outreach QI Project	Outreach to at least 20% of members ages 50 years and above who did not utilize services from October 2022 to September 2023 by June 2024 and connect 2% to primary care services.
Address primary care gaps and inequities	MC	Non-Utilizer Outreach QI Project	Outreach to at least 20% of members ages 6 years and under who did not utilize services from October 2022 to September 2023 by June 2024 and connect 2% to primary care services.
Patient Safety of Outcomes Across Settings			
Support members managing health conditions	MC	Follow-up after ED Visit for Mental Illness QI Project	Follow-up After ED Visits for Mental Illness (FUM) - 30 days HEDIS rate for Medi-Cal members will increase from 51.10% in MY2023 (as of April 2024) to 54.87% in MY2024.
Connect members in need to whole person care	MC & GC	Transitional Care Services	Increase the percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7 days post-discharge from 20.7% for Medi-Cal and 21.3% for Group Care in August 2024 by 1 percentage point in March 2025.

Population Needs Assessment

Goal

Define meaningful participation in Alameda County and City of Berkeley Community Health Assessment (CHA) and Community Health Improvement Program (CHIP) processes in coordination with Kaiser by August 1, 2024.

Establish project plans with Alameda County and City of Berkeley by September 30, 2024.

Results

This goal was achieved. Alameda Alliance and Kaiser Permanente participated in monthly meetings with both the Alameda County Public Health Department (ACPHD) and City of

Berkeley to align CHA/CHIP efforts, identify resource contributions, and support data sharing. The MCPs, Alameda County, and the City of Berkeley worked together on a worksheet provided by DHCS to define meaningful participation. Collaboration progress was reported to DHCS in October 2024 through the PHM deliverable. It continues to be a challenge to align DHCS deadlines for the collaboration with LHJ timelines.

PHM Monitoring

Goal

Expand PHM monitoring and evaluation processes to include further analysis for understanding PHM Key Performance Indicators (KPIs), Quality Measures, PHM Strategy goals, and identifying barriers and opportunities for action by the end of 2024.

Results

This goal was achieved. The Alliance conducted the 2024 comprehensive analysis of the impact of its 2023 Population Health Management (PHM) Strategy. The PHM Evaluation includes quantitative results for relevant clinical, utilization, and experience measures. Quantitative and qualitative analysis are conducted on the results for evidence of program effectiveness and continuous improvement. This analysis is conducted by the Health Care Services Department to support Alliance members and promote an effective PHM Strategy. The complete 2023 PHM Strategy is a separate document.

Although the submission of the DHCS PHM KPIs was put on hold in 2024, the PHM Workgroup continued to monitor the KPIs monthly and discuss semiannually. The PHM quality measures and NCQA health equity measures were also reviewed. The Alliance onboarded a consultant group in November 2024 to create a monitoring framework for KPIs, Quality Measures, and PHM Strategy goals.

Health Education Overview

Alliance promotes the appropriate use of plan health care services, risk reduction, healthy lifestyles, and self-management of health conditions through a Health Education Program available to all members. The Alliance Health Education Program is updated annually as needed with input from the PHM Population Needs Assessment. The Program develops culturally appropriate materials and programs that meet the diverse needs of the Alliance membership and participates in community collaborations to promote health and wellness in Alameda County. The 2024 Health Education objectives and results are as follows:

Member Wellness Handouts and Programs

Health Education continues to offer educational handouts and programs to members covering a wide variety of prevention, healthy lifestyle, and condition self-management topics.

From January 2024 to December 2024, a total of 2,685 health education and community referral mailings were distributed. These mailings covered important health topics such as nutrition and exercise, heart health, tobacco cessation, and fall prevention. Additionally, they included healthcare tools like Advance Directives, medication lists, and healthcare visit checks.

Below is a breakdown of the distribution of health education materials and community referrals

through member mailings:

- Health Education
  - 385 Mailings
  - 381 Unique Members
- Case Management
  - 2,300 mailings
  - 2,243 Unique Members

In addition to health materials, Health Education also conducted targeted outreach and referrals for members living with asthma, diabetes, and our birthing members in 2024. Below is a summary of this effort:

Health Topics	Effort
Asthma	• There were 799 Asthma Start pediatric asthma post emergency department visit and member referrals. • Asthma Start provided asthma education and remediation services to 62 members.
Diabetes	• Alliance providers offered Diabetes Self-Management Education and Support to 769 unique members at hospital and clinic locations.
Pregnancy, Baby Care, and Lactation	• Continued prenatal (5,227) and postpartum (3,395) mailing campaigns. • Referrals to Alameda County and Black Infant Health (637) for culturally responsive care.

Objective 1

Maintain a 95% fulfillment rate for health education material requests and referrals within 10 business days for threshold languages and within 15 business days for translated materials through the end of 2024.

Results 1

The fulfillment goal for health education requests was met in quarters two, three and four (98.3%, 100% and 100%, respectively), but it was not met in quarter one (89.7%). A challenge in quarter one was back filling a vacant staff position for the Health Education Coordinator whose responsibility is to fulfill member health education requests. The position was filled in April 2024.

Members request health education materials and program information through the Wellness Request Form, referrals from Alliance staff, and provider referrals. The Wellness Request form is included in the Alliance biannual member newsletter (mailed out to all Alliance households) and Health Risk Assessment, Case Management and Health Education mailings.

Top 6 Requested Health Topics 2024

Topic	Member Requests
Diabetes	185

Hypertension	181
Nutrition	172
Back Care	134
Asthma	126
Safety	99

Objective 2.1

Implement the Health Education Intake form and enable reporting on Health Education activities by Q2 of 2024.

Results 2.1

This goal was met, but the timeline was extended to the end of December 2024. Additional time was needed for health education to have the form tested by multiple departments before finalizing a go-live date. The Health Education Request Form was finalized by December 2024 and is now fully operational. The form has been uploaded to our internal website and integrated with a Smartsheet for tracking and reporting.

Objective 2.2

Develop one new health education initiative by the end of 2024.

Result 2.2

This goal was met. The Alliance contracted with Our Roots. Our Roots virtually connects perinatal communities of color impacted by poverty with peer support coaches. The organization's goal is to prevent anxiety and depression and promote intergenerational healing. The Health Education team developed rationale and designed how it could connect members to perinatal peer supports. A community health worker (CHW) provider contract has been executed and onboarded. The organization is currently finalizing a Scope of Work (SOW) and referral workflows.

Disease Management (DM) Overview

Alliance Health Education and Case Management teams collaborate to launch programs and interventions that support members in disease self-management. From 2023 to 2024, the Alliance launched its full suite of disease management interventions in Asthma, Cardiovascular Disease, Diabetes, and Perinatal Depression.

Objective 1

Collaboratively develop a strategy to support DM populations with closing care gaps and addressing inequities by the end of 2024.

Results 1

This goal was met. The DM team reviewed disease management disparities data and built a health equity data index. A target population of members with gaps in care was identified. The DM team developed a diabetes and cardiovascular disease disparities analysis and developed

a plan for tailored outreach to address disparities. The outreach intervention included health-related social needs screening, health coaching, a health coaching member incentive, and referrals to Alliance and community-based resources. The pilot ran for six months. Five members participated in health coaching, 7 members were connected to resources associated to their health-related social need, 10 members were provided care coordination, and 13 members were referred to Case Management, Health Education or Pharmacy services.

Objective 2

Develop a comprehensive DM dashboard that can track all applicable measures. Each DM program will utilize the dashboard to find and analyze 75% of the data they will require for reporting by the end of 2024.

Results 2

This goal was met. The DM team developed and refined the DM PowerBI Dashboard, which was launched in June 2024. Subsequent program goals like eligibility, outreach, and engagement measures were tracked and monitored in the dashboard. The DM team used 100% of the data in the dashboard to complete annual program evaluations.

Summary

The Alliance continues to achieve its goals and make strides across Population Health and Equity programs. The Alliance launched new collaborations with local health jurisdictions, Alameda County Public Health and the City of Berkeley, to define and begin meaningfully participating in community health assessment and improvement programs. Although the deliverables this year for the CHA/CHIP collaboration were met, it continues to be a challenge to align DHCS deadlines for the collaboration with LHJ timelines. A challenge for the PHM team was to continue to add to its capability to analyze and address disparities. The evolution of collaborative efforts internally and externally will lead to increased understanding of its member populations, strengthen capacities to identify inequities and help inform its overall population health strategy.

Health Education continued to fulfill wellness requests from members at 100% of the service level target after a brief ramp up period. It also launched and implemented a successful Diabetes Prevention Program with strong interest and engagement from members. It will continue to work toward the launch of new CHW efforts to connect members to health education and navigation. The DM team also saw various successes with the design and launch of additional analytical capabilities via the DM dashboard that will help inform future program improvements and additional tailored interventions for subpopulations experiencing disparities.

Cultural and Linguistic Services Program

Alameda Alliance for Health (Alliance) regularly evaluates its performance on planned culturally and linguistically appropriate services described in the Cultural and Linguistic Services (CLS) Program description and work plan. This includes:

- Analysis of results of activities, including barrier analysis.
- Trending of measures to assess performance.
- Review and evaluation of the results by community representatives.

- Evaluation of the overall effectiveness of the program.

Completed and Ongoing Activities:

a. **Member Cultural and Linguistic Assessment**.
Workplan goal: Assess the cultural and linguistic needs of plan enrollees.
Description: The Alliance conducts a quarterly assessment of trending data at multidisciplinary Cultural and Linguistic Services Subcommittee (CLSS Committee) meeting. The Alliance CLSS Committee reviews trends in the linguistic, racial and ethnic make of our member population each quarter comparing current trends to the previous year.
Results: This goal was met. The Alliance reviewed the Member Cultural and Linguistic Assessment at the quarterly Cultural and Linguistic Services Subcommittee meetings held on: January 24, 2024, April 24, 2024, August 8, 2024, and December 3, 2024. Overall, there was an increase in membership and significant increase in Spanish-speaking and Latinx members. This increase can be attributed to the transition of Anthem members and the Adult Expansion for Medi-Cal.
Completion dates: January 24, 2024, April 24, 2024, August 8, 2024, and December 3, 2024

b. **Language Assistance Services Fulfillment**
Workplan goal: Reach or exceed an average fulfillment rate of ninety-five percent (95%) or more for in-person, video, and telephonic interpreter services.
Description: The Alliance CLS team presents trending data for interpreter services provision and a 4-quarter comparison of interpreter services rates quarterly, and by vendor.
Results: This goal was met. The Alliance exceeded an average fulfillment rate of 95% or more for in-person, video, and telephonic interpreter services:
    - Q1 2024: 97%
    - Q2 2024: 98%
    - Q3 2024: 98%
    - Q4 2024: 98%

Completion date: December 31, 2024

c. Language Assistance Services for Behavioral Health
Workplan goal: Ensure tracking of interpreter services utilization for Behavioral Health (BH) services.
Description: The Alliance will work with our interpreter services vendors to develop systems needed to track the provision of interpreter services for behavioral health visits and develop tracking systems that will assist in comparing interpreter services offered for BH and other types of services
Results: This goal was not met. The Alliance worked with our interpreter services vendor to develop a process to identify behavioral health (BH) calls. However, the vendor is unable to identify a BH call without hange to the telephone prompt to indicate that it is a BH call. We will continue to work with the vendor to explore solutions for BH interpreter services tracking.

Completion date: In-progress

d. Provider Language Capacity (Member Satisfaction)
Workplan goal: Based on the Member CG-CAHPS Survey 81% of adult members and 92% of child members who need interpreter services will report receiving a non-family qualified interpreter through their doctor's office or health plan.
Description: The Alliance distributes the CG-CAHPS post-visit survey quarterly to measure the members' experience with health care providers and staff, including language access for interpreter services.
Results: This goal was met or unmet in the following quarters:

- Q1 2024-Adult: 84% (Met); Child: 91.4% (Unmet)
- Q2 2024-Adult: 86.6% (Met); Child: 94% (Met)
- Q3 2024-Adult: 90% (Met); Child: 93% (Met)
- Q4 2024-Data not available

For the Adult and Child surveys, satisfaction results improved in both 2024 Q2 and Q3. Q4 2024 data will be available in Q1 2025. Overall, we will continue to monitor satisfaction results.
Completion date: In-progress

e. Language Assistance Services (Member Satisfaction)
Workplan goal: Based on the Timely Access Requirement (TAR) Survey results, develop and implement action steps, as needed, to address member's satisfaction with: a) scheduling appointments with an interpreter; b) availability of interpreters who speak member's preferred spoken language; c) knowledge, skill, and quality of interpreters
Description: The Alliance distributes an annual Timely Access Requirement (TAR) Survey in 15 foreign languages and English to evaluate the experience of limited English proficient (LEP) Alliance members in obtaining interpreter services for health care services from their doctor or health care providers.
Results: This goal was met. This was the first year of fielding the TAR Survey and the 2024 TAR Survey results were reviewed at the Cultural and Linguistic Services Subcommittee and Quality Improvement and Health Education Committee meetings with no concerns identified. Based on 2024 results, there were no actions needed.
Completion date: May 1, 2024

f. Provider Language Capacity and Race and/or Ethnicity (Provider Network).
Workplan Goal: Complete Analysis of Capacity of Alliance Provider Network to meet Cultural and Linguistic needs of members.
Description: The Alliance monitors the capacity of our Network providers, including primary care providers, specialists and behavioral health providers, to meet the cultural and linguistic needs of our members. This includes the language preferences, cultural attributes, and race/ethnicity of our providers as compared to our members.

Results: This goal was met. The Alliance wrote the 2024 Availability of Practitioners to Meet the Cultural Needs and Preferences of Members Report (also referred to as the Net 1A Report). The report includes enhancements to the "Meeting Member Cultural Needs" section to include information on the cultural traits for ethnic groups within Alameda County and the religious beliefs of adults.

The Net1A Report was presented and reviewed at the Cultural and Linguistic Services Subcommittee and Quality Improvement Health Equity Committee meetings with no concerns identified. However, feedback was provided to include additional information regarding the discrimination cases, distinguishing between substantial vs. non-substantial cases in the 2025 report.

Overall, this report has met all standards, and the Alliance provider network capacity was achieved a ratio of 1 provider per 2000 members by language.
Completion date: May 1, 2024

g. **Community Engagement: Community Advisory Committee (CAC)**
Workplan goal: Ensure implementation of DHCS 2024 Contract updates to CAC and community engagement.
Description: The Alliance convenes a Community Advisory Committee (CAC) made up of 51% members. The CAC meets four (4) times a year to provide feedback and input into the member-facing programs and policies of the Alliance, including the Alliance Cultural and Linguistic Services Program and CLAS activities.
Results: The Alliance continues to ensure the implementation of 2024 contractual requirements for the CAC. Under the 2024 contractual updates, the Alliance was able to:
    - Establish a CAC Selection Committee that will now review/vote on CAC candidates.
    - Hold two (2) CAC Selection Committee meetings.
    - Present and receive approval by the CAC Selection committee to bring onboard a new CAC member.
    - Complete the CAC Demographic Survey to assess and ensure the CAC representation is reflective of the Alliance membership.
    - Identify gaps in the CAC representation based on the CAC Demographic Survey.
    - Start CAC member recruitment to fill identified gaps and present information about the CAC to the following organizations: Father-Friendly Provider Network (FFPN), Healthy Relationships Learning Community (HRLC), Health and Human Resource Education Center (HHREC), and Alameda County Public Health Fatherhood Initiative.

    The Alliance will continue to work on ongoing CAC member recruitment to fill identified gaps with guidance from the CAC Selection Committee.
    Completion date: Ongoing

h. Address Quality of Language Potential Quality Issues (QOL PQIs)

Workplan goal: Monitor, evaluate, and conduct appropriate interventions for PQI-QOLs with a closure rate of 95% or more within 60 (updated in Q3 of 2024) business days.
Description: QOL PQIs are assigned to the CLS Manager and Cultural and Linguistic Services team for review, action as needed to ensure appropriate language services, and tracking and trending. Patterns of concern are addressed with the plan departments, providers or vendors and when needed Corrective Action Plans are put into place.
Results: This goal was met or unmet in the following quarters:

- Q1 2024: 96% closure rate (Met)
- Q2 2024: 86% closure rate (Unmet)
- Q3 2024: 95% closure rate (Met)
- Q4 2024: 93% closure rate (Unmet)

An increase in volume of scheduling interpreter services requests and difficulty reaching provider offices to provide education regarding availability of the Alliance interpreter services presented as challenges to meeting the goal. The Alliance plans to hire an additional staff person to support interpreter services provision, PQI interventions, and make workflow enhancements to address situations when staff are unable to reach a provider office.
Although our internal goal of 95% or more within 60 days was not met, all QOL PQIs were closed within the required closing threshold within 120 days with no trends of concern identified that led to issuing of a provider corrective action plan (CAP).
Completion date: December 31, 2024

Successes: Under the Cultural and Linguistic Services Program, the Alliance:

- Maintained a 95% or above fulfillment rate for all interpreter services modalities despite an increase in membership.
- Received favorable responses related to accessing interpreter services through member satisfaction surveys.
- Met all standards for the Net 1A report and identified an enhancement opportunity to improve reporting regarding discrimination cases.
- Met contractual requirements for the CAC regarding the CAC Selection Committee, member recruitment, and the annual CAC Demographic Survey.

Challenges: While the Alliance identified several successes, the Cultural and Linguistic Services Program faced the following challenges:

- Increased volumes in scheduling interpreter services request and QOL-PQIs.
- Limitations with the interpreter service vendor regarding tracking and reporting systems for BH calls.
- Difficulty with outreach to provider offices to address QOL-PQIs due to lack of contact.

Action Steps: The Alliance plans to address the identified challenges and leverage opportunities for better outcomes through:

- Implementation of a bulk interpreter services scheduling system with one of our interpreter services vendor to assist with the increased scheduling volume.

- Hiring additional staff.
- Reviewing and streamlining workflows for QOL-PQIs.
- Continuing to explore solutions for BH interpreter services tracking.
- Including granular information and outcomes for discrimination cases in the Net 1A report.

Delegation Oversight

As a part of its compliance program and strategy, the Alliance deploys an array of auditing and monitoring exercises throughout the year. Annually, First-tier subcontracted entities, called delegates, undergo an annual delegation oversight audit. The audits are conducted in accordance with DHCS, DMHC, and the NCQA regulations.

Audit results are reported to the Subcontractor & Delegation Oversight Committee, which is a committee that reports to the Compliance Committee.

In 2024, the Alliance conducted annual delegation oversight audits for the functions and entities included in the Alameda Alliance Delegated Entities - 2024 noted in the table below. For Quality Improvement, the Alliance does not delegate this function to any entity.

To supplement its approach to Compliance, the Alliance holds monthly meetings and quarterly JOMs with delegates, as necessary. The monthly meetings allow a collaborative partnership with the delegates to discuss reporting, audits, CAPs, APLs and operational changes, In addition to JOMs, the Alliance holds regular Executive Team meetings with its strategic partners CHCN and AHS.

ALAMEDA ALLIANCE DELEGATED ENTITIES - 2024

	Delegate's Name	Quality Improvement		Utilization Management X = NCQA Accredited		Credentialing X = NCQA Accredited		Grievances & Appeals		Claims		Call Center		Case Management		Cultural & Linguistic Services		Provider Training	
		Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care
1	Community Health Center Network (CHCN)			X	X					X	X			X	X			X	X
2	March Vision Care Group, Inc.					X				X									
3	Children's First Medical Group (CFMG)			X		X				X									
4	PerformRx (PBM)				X		X				X						X		
5	UCSF (Credentialing)					X	X												
6	Physical Therapy PN (Credentialing)					X	X												
7	Lucille Packard (Credentialing)					X	X												
8	Teladoc (Credentialing)					X	X												

Analysis of 2024 Quality Program Evaluation and Effectiveness

The Alliance has identified successes, challenges/barriers, and improvements throughout the 2024 QIHE Evaluation. Many of the QIHE Program goals were met or exceeded. The evaluation included recommended activities and interventions to inform the 2025 QIHE Work Plan

Major accomplishments in which objectives were met for 2024 include but are not limited to:

- Adequate QI program resources to carry out roles, functions, and responsibilities.
- Health Equity activities in collaboration with the Chief Health Equity Officer and team members
- Provided QI investments to improve HEDIS/MCAS performance through the following strategies: provider engagement, member engagement, data collection/sharing,

innovative funding/projects, and organizational alignment.

- Enhanced Pay-for-Performance program with a focus on quality measures below the minimum performance level and promotion of primary care visits
- Implemented the Population Health Management Program, including publication of a Population Health Strategy with on-going goals/objectives, and in collaboration with multiple departments and community partners, utilized a health equity lens to address health disparities.
- Successful administration of all timely access surveys within the expected timeframes, allowing for timely analysis and implementation of next steps with providers and within the Alliance.
- Maintenance of favorable Provider Satisfaction Survey scores.
- Consistent Senior Level Physician involvement despite Medical Director transitions
- Improved HEDIS performance rates for measures; above the MPL for most reported HEDIS metrics.
- Ongoing Pediatric Care Management Program to promote access to care and EPSDT service utilization in partnerships with direct, delegate, and CBOs.
- Improved turn-around times and root cause analysis of PQIs.
- Robust Health Education and Cultural and Linguistic Programs adding Quality of Language (QOL) PQIs segmentation for tracking and trending.
- Ongoing Community Advisory Committee and member input to ensure continued member input into programs and services.
- Launched the QI member engagement outreach program to address HEDIS opportunities
- Offered webinars, in-person trainings and site visits, and technical assistance for providers
- Coordinated efforts established to improve SNF/LTC quality monitoring through internal and external meetings and follow up
- Comprehensive monitoring of all practitioners during credentialing / re-credentialing to ensure high quality network.

Challenges and barriers to achieving objectives encountered within the 2024 program year included but are not limited to:

- Timely access to care continues to be strained as there are provider workforce shortages compounded by pent up demand for preventive care services.
- Transition of senior leadership, including a new Chief Medical Officer hired and QI Medical Director vacancy
- Increase in membership volume for members from Anthem Blue Cross and Adult Expansion resulted in increases in PQIs and interpreter services.
- Transition to a single plan model with Kaiser no longer a delegate (and increased

membership) resulted in initial decreases in HEDIS results in the beginning of 2024

- Financial impacts were imposed for quality sanctions and withholds based on HEDIS/MCAS performance.

Conclusion

Overall, the Alliance's QIHE Program was effective in reviewing data, assessing trends, identifying issues, and developing improvement activities within the Health Plan related to access to care, member and provider experience, health equity, and quality of care.

During 2024, Alameda Alliance focused on meeting the QIHE Program goals and completing all initiatives as outlined in the 2024 QIHE Work Plan. Health equity was integrated into the quality program and continues to be a main driver for the work. Throughout 2024, multiple PDSA activities and innovative projects resulted in improvements in the Alliance's quality performance. These PDSA activities have created a culture focused on the Alliance's mission, member-centric care, and provider satisfaction. In addition, there continues to be extensive collaboration as part of the Population Health Management program, including alignment with the DHCS Bold Goals and with both internal and external partners. In 2024, the Alliance committed to QI investments and supported strategies in member engagement, provider engagement, data collection/sharing, project funding, and organizational alignment; all of which resulted in demonstrated HEDIS/MCAS improvements. The Alliance is dedicated to improving the quality of healthcare delivered to its members through proactive analysis of shared processes and integration of health initiatives that align with the industry and government quality standards; including a preventive health model of whole person care and preemptive interventions related to health outcomes.

ALAMEDA ALLIANCE FOR HEALTH

QUALITY IMPROVEMENT HEALTH EQUITY PROGRAM DESCRIPTION 2025

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

2025 Quality Improvement Health Equity Program Description Signature Page

_____ _____

Michelle N. Stott, R.N., M.S.N. **Date**
Senior Director of Quality

_____ _____

Vice Chair, Quality Improvement Health Equity Committee (Vacant) **Date**

_____ _____

Lao Paul Vang **Date**
Chief Health Equity Officer

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Donna Carey, MD **Date**
Chief Medical Officer
Chair, Quality Improvement Health Equity Committee

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Matthew Woodruff **Date**
Chief Executive Officer
Chair, Quality Improvement Health Equity Committee

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Rebecca Gebhart **Date**
Board Chair

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OVERVIEW

Alameda Alliance for Health is a public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to lower-income people of Alameda County.

Established in January 1996, the Alliance was created by and for Alameda County residents. The Alliance currently provides health care coverage to approximately 412,732 children and adults through its programs.

Alameda Alliance for Health is licensed by the State of California and product lines include Medi-Cal managed care and Group Care commercial insurance. Medi-Cal managed care beneficiaries, eligible through one of several Medi-Cal programs, e.g. SPD, Medi-Cal Expansion. For dually eligible Medi-Cal and Medicare beneficiaries, Medicare remains the primary insurance and Medi-Cal benefits are coordinated with the Medicare provider.

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

Alameda Alliance for Health's (Alliance) Quality Improvement Health Equity (QIHE) Program applies to all product lines and strives to ensure that members have access to quality health care services that are safe, effective, equitable, and meet their needs. The QIHE program includes systematic and continuous activities to monitor, evaluate, and improve upon the health equity and health care delivered to Members in accordance with the standards set forth in applicable State and Federal regulations.

The QIHE Program Description is a comprehensive document with a set of interconnected documents that describes our quality program governance, structure and responsibilities, operations, scope, goals, and measurable objectives. Participation of all Alliance departments and staff in quality improvement activities is essential to the organization in achieving our QIHE goals and objectives.

The Alliance complies with applicable State and Federal civil rights laws and does not discriminate based on race, color, religion, ancestry, national origin, ethnic group, age, mental or physical disability, sex, gender, gender identity, or sexual orientation, medical condition, genetic condition, or marital status. The Alliance QIHE Program is committed to serving the healthcare needs of our culturally and linguistically diverse membership. The Alliance staff and provider network reflect the county’s cultural and linguistic diversity.

MISSION AND VISION

Mission

Improving the health and well-being of our members by collaborating with our provider and community partners to deliver high quality and accessible services.

Vision

All residents of Alameda County will achieve optimal health and well-being at every stage of their life.

QIHE PROGRAM SCOPE AND GOALS

The purpose of the Alliance QIHE Program is to objectively monitor and evaluate the quality, safety, appropriateness, health equity, and outcome of care and services delivered to members of the Alliance. The overall goal of the QIHE Program is to ensure that members have access to quality health care services that are safe, effective, equitable, and meet their needs. The QIHE Program is structured to continuously pursue opportunities for improvement and problem resolution. The QIHE Program is organized to meet overall program objectives as described below and as directed each year by the QIHE and UM Work Plans. Improvement priorities are selected based on volume, opportunities for improvement, risk, and evidence of disparities.

Although not limited to, the goals of the QIHE Program are to:

1. Maintain the delivery of high quality, safe, and appropriate medical and behavioral health care that meets professionally recognized standards of practice that is delivered to all enrollees.
2. Utilize objective and systematic measurement, monitoring, and evaluation through qualitative and quantitative analysis of health care services and to implement QIHE activities based on the findings.
3. Conduct performance improvement activities that are designed, implemented, evaluated, and reassessed using industry recognized quality improvement models such as Plan-Do-Study-Act (PDSA).
4. Ensure physicians and other appropriate licensed professionals, including behavioral health, are an integral and consistent part of the QIHE Program.
5. Ensure medical and behavioral health care delivery is consistent with professionally recognized standards of practice.
6. Track and trend the delivery of healthcare services to ensure care and services are not withheld or delayed for any reason, such as potential financial gain or incentive to plan providers.
7. Design and maintain an ongoing organizational culture of quality to ensure continual HEDIS improvement and accreditation readiness.

The scope of the QIHE Program is comprehensive and encompasses the following:

1. Timely access and availability to quality and safe medical, behavioral, and specialty health care and services.
2. Care and Disease management services.
3. Cultural and linguistic services
4. Patient safety.
5. Member and provider experience
6. Continuity and coordination of care across settings, with the goal of establishing consistent provider-patient relationships.
7. Tracking of service utilization trends, including over-and under-utilization
8. Clinical practice guideline development, adoption, distribution, and monitoring.
9. Targeted focus on acute, chronic, and preventive care services for children and adults for

Member and provider education.

10. Prenatal, primary, specialty, emergency, inpatient, and ancillary care.
11. Case review, investigation, and corrective actions of potential quality issues
12. Credentialing and re-credentialing activities.
13. Delegation oversight and monitoring.
14. Delegate and direct providers performance improvement project collaborations.
15. Targeted support of special needs populations including Seniors and Persons with Disabilities and persons with chronic conditions.
16. Population Health Management Integration.
17. Health care diversity and equity.

ORGANIZATIONAL STRUCTURE AND SUPPORT COMMITTEES' RESPONSIBILITY

Overview

The Alliance Board of Governors (BOG) appoints and oversees the Quality Improvement Health Equity Committee (QIHEC), Pharmacy & Therapeutics (P&T) Committee, Peer Review Committee, Credentialing Committee, Community Advisory Committee, and Compliance Committee which in turn, provide the authority, direction, guidance, and resources to enable Alliance staff to carry out the QIHE Program.

The organizational chart in **Appendix A** displays the reporting relationships for key staff responsible for QIHE activities at the Alliance. **Appendix B** displays the committee reporting relationship and organizational bodies.

Board of Governors

The Alliance BOG is appointed by the Alameda County Board of Supervisors and consists of up to 15 members who represent members, provider, and community partner stakeholders. The BOG is the final decision-making authority for the Alliance QIHE Program. Its duties include:

- Reviewing annually, updating, and approving the QIHE Program description, defining the scope, objectives, activities, and structure of the program.
- Reviewing and approval of the annual QIHE report and evaluation of QIHE workplan, studies, activities, and data on utilization and quality of services.
- Assessing QIHE Program's effectiveness and direct modification of operations as indicated.
- Defining the roles and responsibilities of QIHEC.
- Designating a physician member of senior management with the authority and responsibility for the overall operation of the QIHE program, who serves on QIHEC.
- Appointing and approving the roles of the Chief Medical Officer (CMO), including the support of the Chief Health Equity Officer, and other management staff in the QIHE Program.
- Receiving a report from the CMO as Chair on the agenda and actions of QIHEC.

Quality Improvement Health Equity Committee (QIHEC)

The QIHEC is a standing committee of the BOG and meets a minimum of four times per year, and as often as needed, to follow-up on findings and required actions. The QIHEC is responsible for the implementation, oversight, and monitoring of the QIHE Program and Utilization Management (UM) Programs. The QIHEC recommends policy decisions, analyzes and evaluates the QIHE work plan activities, and assesses the overall effectiveness of the QIHE Program. The QIHEC reviews results and outcomes for all QIHE activities to ensure performance meets standards and makes recommendations to resolve barriers to quality improvement activities. Any quality issues related to the health plan that are identified through the CAHPS and Provider Satisfaction surveys and health plan service reports are also discussed and addressed at QIHEC meetings. The QIHEC oversees and reviews all QI delegation summary reports and evaluates delegate quality program descriptions, program evaluations, and work plan activities. The QIHEC presents to the Board the annual QIHE Program description, work plan and prior year evaluation. Signed and dated minutes that summarize committee activities and decisions are maintained. The Annual QIHE Program, Work Plan, and Evaluation from the QIHEC (or other related documents as requested) are submitted to the California Department of Health Care Services (DHCS).

Responsibilities include but are not limited to:

- Analyze and evaluate the results of QIHE activities including annual review of the results of performance measures, utilization data, satisfaction surveys (i.e. CAHPS), and findings and activities of the quality committees, such as the Community Advisory Committee.
- Approve, select, design, and schedule studies and improvement activities.
- Review other member and provider survey results and related improvement initiatives.
- On-going reporting to the BOG.
- Meeting at least quarterly and maintaining approved minutes of all committee meetings.
- Approve definitions of outliers and develop corrective action plans.
- Recommend and approve Medical Necessity Criteria, Clinical Practice Guidelines, as well as pediatric and adult Preventive Care Guidelines and review compliance monitoring.
- Review member grievance and appeals data.
- Oversee the Plan's process for monitoring delegated providers.
- Oversee the Plan's UM Program.
- Review advances in health care technology and recommend incorporation of new technology into delivery of services as appropriate.
- Institute actions to address performance deficiencies, including policy recommendations, and ensure follow-up of identified findings.
- Provide guidance to staff on quality improvement activities.
- Monitor progress in meeting QIHE goals.
- Evaluate annually the effectiveness of the QIHE and Population Health Management program.
- Oversee the Plan's complex case management and disease management programs.
- Ensure that its fully delegated subcontractors and downstream fully delegated subcontractors

maintain a QIHEC that meets the QIHE program requirements.

- Review and approve annual QIHE and UM Program Descriptions, Work Plans, and Evaluations.
- Recommends and approves resource allocation for the QI Department Program. The QIHEC is chaired by the CMO and vice-chaired by the Medical Director of QI. The members are representatives of the Alliance contracted provider network including those who provide health care services to members affected by health disparities, Limited English Proficiency (LEP) members, Children with Special Health Care Needs (CSHCN), Seniors and Persons with Disabilities (SPD) and persons with chronic conditions. The QIHEC Members are appointed for two-year terms. The voting membership includes:
    - Alliance CMO (Chair)
    - Medical Director of Quality (Vice-Chair)
    - Chief Executive Officer (ex officio)
    - Chief Health Equity Officer
    - Medical Director or designee from each delegated medical group (i.e., Community Health Center Network, Children First Medical Group)
    - Physician representative of Alameda County Medical Center
    - Physician representative of Alameda County Ambulatory Clinics
    - Alliance contracted physicians (3 positions)
    - Representative of County Public Health Department
    - A Behavioral Health practitioner
    - Alliance Medical Directors
    - Alliance Senior Director, Quality

A quorum is established when the majority of voting membership is present at the meeting. The Chief Executive Officer does not count in the determination of a quorum.

Pharmacy and Therapeutics Committee (P&T)

The P&T Committee assists the QIHEC in oversight and assurance of ensuring the promotion of clinically appropriate, safe, and cost-effective drug therapy by managing and approving the Alliance's drug formulary, monitoring drug utilization, and developing provider education programs on drug appropriateness. P&T Committee meeting summaries and changes in Pharmacy related policies are presented directly to the Board of Governors.

The voting membership consists of:

- Alliance Chief Medical Officer (Chair) or designee
- Alliance Senior Director of Pharmacy Services (Co-Chair)
- Practicing physician(s) representing Internal Medicine
- Practicing physician(s) representing Family Practice
- Practicing physician(s) representing Pediatrics
- Practicing physician(s) representing common medical specialties

- Practicing Behavioral Health specialist (e.g., psychologist, psychiatrist)
- Practicing community pharmacists contracted with Alliance (not to exceed three pharmacists~~,~~

Peer Review and Credentialing Committee (PRCC)

The PRCC is a standing committee of the BOG that meets a minimum of ten times per year. The Alliance separates ~~d~~ the functions of PRCC into two distinct committees – the Peer Review Committee (PRC) and the Credentialing Committee (CC). The chair of both committees is the CMO.

CREDENTIALING COMMITTEE

Primary responsibilities include:

- Ensuring that all applicants are reviewed against minimum standards or criteria and are treated fairly.
- Determining whether there is adequate/sufficient information to evaluate and make a determination/recommendation.
- Implementation and ongoing review of Credentialing Policies and Procedures.
- Assuring that the credentialing process conforms to applicable accreditation standards and other regulatory requirements.
- Making recommendations or decisions related to participation, appointment, and privileges.

PEER REVIEW COMMITTEE

Primary responsibilities include:

- Investigating complaints regarding the quality of clinical care provided by the Alliance's contracted providers and making recommendations for corrective action.
- Reviewing conditions identified as having quality concerns.

The following Committee members have voting rights:

- Committee Chairperson
- Committee Vice Chairperson

Committee Member: Positions held by practitioners

Internal Quality Improvement Committee (IQIC)

The IQIC assists the QIHEC in oversight and assurance of the quality of clinical care, patient safety, and customer service provided throughout the AAH organization. Its primary roles are to maintain and improve clinical operational quality, review organization-wide performance against the Alliance quality goals, and report results to the QIHEC.

Committee Responsibilities include but are not limited to:

- Develop, approve, and monitor a dashboard of key performance and QIHE indicators compared to organizational goals and industry benchmarks.
- Oversee and evaluate the effectiveness of AAH's performance improvement and quality activities.
- Review reports from workgroups and, if acceptable, forward them for review at the next

scheduled QIHEC.

- Review plan and delegate corrective plans regarding negative variances and serious errors.
- Oversee compliance with NCQA accreditation standards.
- Make recommendations to the QIHEC on all matters related to:
    - Quality of Care, Patient Safety, and Member/Provider Experience.
    - Performance Measurement.
    - Preventive services including:
        - Seniors and Persons with Disability (SPD)
        - Members with chronic conditions
        - Medi-Cal Expansion (MCE) members.

The Committee shall be comprised of the following members:

- Alliance Chief Medical Officer (CMO)
- Alliance Medical Director(s)
- Sr. Director, Quality
- Quality Improvement Manager
- Access to Care Manager
- Population Health and Equity Director
- Members from Provider Relations, Member Services, Business Analytics, Compliance, and Grievance and Appeals.

Utilization Management Committee (UMC)

The UMC is a forum for facilitating clinical oversight and direction. Its responsibilities are to:

- Maintain the annual review and approval of the:
    - UM and CM Program Descriptions, UM and CM Policies/Procedures, and UM Criteria
    - Other pertinent UM documents such as the UM and CM Program Evaluations, UM and CM Workplan, and any trends or updates pertaining to the workplans.
    - Enhanced Care Management (ECM) and Community Supports Policies/Procedures
- Health Risk Assessment (HRA) and Health Information Form/Member Evaluation Tool (HIF/MET) Policies and Procedures
- Participate in the utilization management/continuing care programs aligned with the Program's quality agenda.
- Assist in monitoring for potential areas of over and under-utilization and recommend appropriate actions when indicated.
- Review and analyze utilization data for the identification of trends, including trends related to health disparities, social determinants of health, and behavioral health.
- Recommend actions to the QIHEC when opportunities for improvement are identified from

review of utilization data including, but not limited to Ambulatory Visits, Emergency Visits, Hospital Utilization Rates, Hospital Admission Rates, Average Length of Stay Rates, and Discharge Rates.

- Review information about New Medical Technologies from the Pharmacy & Therapeutics Committee including new applications of existing technologies for potential addition as a new medical benefit for Members.

Access and Availability Subcommittee (AASC)

The AASC reviews the Alliance's access and availability data to evaluate whether the Alliance is meeting regulatory standards and provides corrective actions and recommendations for improvement when needed. The committee identifies opportunities for improvement and provides recommendations to maintain compliance with access and availability regulatory requirements.

Membership is comprised of Alliance staff within departments that are involved with access and availability which include the following representation:

- Chief Medical Officer
- Medical Directors
- Senior Director, Quality
- Access to Care Manager
- Quality Improvement Manager
- Population Health & Equity
- Quality Assurance
- Grievance and Appeals Management
- Compliance
- Healthcare Analytics
- Utilization Management
- Member Services
- Provider Services

The following are the monitoring activities the subcommittee reviews to ensure compliance with access and availability and network adequacy requirements including but not limited to:

- Provider network capacity levels
- Facility Site Reviews
- Geographic accessibility
- Appointment availability surveys
- High volume and high impact specialists
- Access-related grievances and appeals. Access-related potential quality issues. Provider language capacity. Wait time and telephone practices related to access. Member and provider satisfaction survey

- After-hours care

Cultural and Linguistic Services Subcommittee (CLSS)

The Cultural and Linguistic Services Subcommittee's role is to ensure members receive culturally and linguistically appropriate health care services and to monitor the Alliance's Cultural and Linguistic Services Program. The CLSS reviews demographic changes in the Alliance membership, language services, grievances and potential quality issues related to language access and discrimination, alternative formats and translation services, and overall execution of the Alliance's Cultural and Linguistic Services Program. The CLSS makes recommendations for program improvements and corrective actions as needed. The CLSS reports results to the QIHEC.

Responsibilities include but are not limited to:

- Monitor the cultural and linguistic needs of members.
- Review reports related to provision of cultural and linguistic services.
- Ensure that language assistance services are provided at all points of contact.
- Maintain and update cultural and linguistic services policies and procedures to be compliant with ongoing regulatory and contractual requirements.
- Annually review and update Cultural and Linguistic Services (CLS)'s program description and workplan. Quarterly monitor the CLS Workplan.
- Review input from the Community Advisory Committee (CAC) on cultural and linguistic services and consider how it may inform Alliance's CLS programs, policies, and procedures.
- Identify issues related to access and provision of culturally and linguistically appropriate services and develop corrective actions to correct deficiencies found.
- Review plan and delegate corrective action plans related to CLS.

The CLSS is composed of the following members:

- Chief Medical Officer
- Chief Health Equity Officer
- Senior Director of Quality
- Director, Population Health, and Equity
- Manager, Cultural and Linguistic Services
- Manager, Population Health, and Equity
- 1 Representative from Compliance
- 1 Representative from Communications and Outreach
- 1 Representative from Grievance and Appeals
- 1 Representative from Population Health and Equity
- 1 Representative from Health Care Services
- 1 Representative from Member Services

- 1 Representative from Provider Services
- 1 Representative from Quality Improvement
- 1 Representative from Behavioral Health

Community Advisory Committee (CAC)

The CAC provides a link between Alameda Alliance for Health and the community. The CAC reflects the Alliance's member population, and advise the Alliance on the development and implementation of policies and procedures that affect cultural and linguistic access, quality, and health equity. All CAC findings and/or activities are reported to the QIHEC.

The CAC carries out, but is not limited to, the following duties:

- Identify and advocate for preventive care practices to be used by the Alliance.
- Develop and update cultural and linguistic policy and procedures related to cultural competency issues, educational and operational issues affecting seniors, people who speak a primary language other than English, and people who have a disability.
- Advise on Alliance member and provider-targeted services, programs, and trainings.
- Provide and make recommendations about the cultural appropriateness of communications, partnerships, and services.
- Advise on how to use findings from the CHAs/CHIPs to influence Alliance strategies and workstreams related to the Department of Healthcare Services Bold Goals, wellness and prevention, health equity, health education, and cultural and linguistic needs.
- Provide input and advice, including, but not limited to, the following:
    - Culturally appropriate service or program design
    - The Alliance's diversity, equity, and inclusion strategy
    - Priorities for health education and outreach program
    - Member satisfaction survey results
    - PNA findings
    - Plan marketing materials and campaigns
    - Communication of needs for network development and assessment
    - Community resources and information
    - Population Health Management
    - Quality
    - Health delivery systems to improve health outcomes.
    - Carved out services
    - Coordination of care
    - Health Equity
    - Accessibility of services
    - Development of the provider manual and clarification of new and revised policies and

procedures in the manual

- Development of covered, Non-Specialty Mental Health Services (NSMHS) outreach and education plan.

The CAC membership and representation reflects the Medi-Cal and Group Care populations in Alameda County, and representation includes the following:

- General population of the Alliance members (including adolescents and/or parents and/or caregivers of children, including foster youth)
- Diverse and hard-to-reach populations (including populations that experience health disparities, such as those with diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities)
- At least 51% of the committee shall be Alliance members (and/or the parents/guardians of Alliance members who are minors or dependents).

Joint Operations Committee/Delegation

The contractual agreements between the Alliance and delegated entities specify:

- The responsibilities of both parties.
- The functions or activities that are delegated.
- The frequency of reporting on those functions and responsibilities to the Alliance and how performance is evaluated.
- Corrective action plan expectations, if applicable.

The Alliance may delegate QI, Credentialing, UM, Case Management, Disease Management, Claims, Grievance and Appeals activities to Health Plans, County entities, and/or vendors that meet the requirements as defined in a written delegation agreement, delegation policies, accreditation standards, and regulatory standards.

To ensure delegated entities meet required performance standards, the Alliance:

- Provides oversight to ensure compliance with federal and state regulatory standards, and accreditation standards.
- Reviews and approves program documents, evaluations, and policies and procedures relevant to the delegated activities.
- Conducts required pre-delegation activities.
- Conducts annual oversight audits.
- Reviews reports from delegated entities.
- Collaborates with delegated entities to continuously improve health service quality.

As part of delegation responsibilities, delegated entities must:

- Develop, enact, and monitor quality plans that meet contractual requirements and Alliance standards.
- Provide encounter information and access to medical records pertaining to Alliance members as

required for HEDIS and regulatory agencies.

- Provide a representative to the Joint Operations Committee.
- Submit at least semi-annual reports or more frequently if required on delegated functions.
- Cooperate with state/federal regulatory audits as well as annual oversight audits.
- Complete any corrective action deemed necessary by the Alliance.

The Alliance collaborates with delegated entities to formulate and coordinate QIHE activities and includes these activities in the QIHE work plan and program evaluation. Delegated activities are a shared function. Delegate program descriptions, work plans, reports, policies and procedures, evaluations and audit results are reviewed by the Subcontractor & Delegation Oversight Committee and Joint Operations Committee and findings are summarized at QIHEC meetings, as appropriate. The Alliance does not delegate QI functions as noted in Table 1 below.

The Alliance currently delegates the following functions:

Table 1: Alameda Alliance Delegated Entities

ALAMEDA ALLIANCE DELEGATED ENTITIES - 2025																				
	Delegate's Name	Quality Improvement		Utilization Management X = NCQA Accredited		Credentialing X = NCQA Accredited		Grievances & Appeals		Claims		Call Center		Case Management		Cultural & Linguistic Services		Provider Training	
		Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care
1	Community Health Center Network (CHCN)			X	X					X	X			X	X			X	X
2	March Vision Care Group, Inc.					X				X									
3	Children's First Medical Group (CFMG)			X		X				X									
4	PerformRx (PBM)				X		X				X						X		
5	UCSF (Credentialing)					X	X												
6	Physical Therapy PN (Credentialing)					X	X												
7	Lucille Packard (Credentialing)					X	X												
8	Teladoc (Credentialing)					X	X												

QUALITY IMPROVEMENT HEALTH EQUITY PROGRAM RESOURCES

Responsibilities for QIHE Program activities are an integral part of all Alliance departments. Each department is responsible for setting and monitoring quality goals and activities.

The Alliance QI Department is part of the Health Care Services Department, and responsible for implementing QIHE activities and monitoring the QIHE Program. The QI Department participates in the accreditation process, manages the HEDIS and CAHPS data collection and improvement process, conducts facility site reviews (FSRs), processes Potential Quality Issues (PQIs), and oversees the quality activities in other departments and those performed by delegated groups.

Resource allocation for the QI Department is determined by recommendations from the QIHEC, CMO, CEO and BOG. The Alliance recruits, hires, and trains staff, and provides resources to support activities required to meet the goals and objectives of the QIHE Program.

The Alliance's commitment to the QIHE Program extends throughout the organization and focuses on QIHE activities linked to service, access, continuity and coordination of care, and member and provider experience. The Senior Director of Quality, with direction from the Medical Director of Quality and CMO, coordinates the QIHE Program. Titles, education and/or training for key positions within the Quality Department include:

Chief Medical Officer

The Alliance Chief Medical Officer (CMO) is responsible for and oversees the QIHE Program. The CMO has relevant experience and current knowledge in clinical program administration, including utilization and quality improvement management. The CMO provides leadership to the QIHE Program through oversight of QI study design, development, and implementation, and chairs the QIHEC, PR & CC, and P&T committees. The CMO makes periodic reports of committee activities, QI study and activity results, and the annual program evaluation to the BOG. The CMO reports to the Alliance CEO.

Chief Health Equity Officer

The Chief Health Equity Officer (CHEO) reports directly to the Chief Executive Officer (CEO) and is matrixed to the Chief of Human Resources (CHR). The position partners with leaders across the organization to develop and drive forward the key strategies of the organization as they relate to Diversity, Equity, and Inclusion (DEI) for members, providers, and employees. The executive position implements policies that ensure health equity is prioritized and addressed and is responsible for setting and implementing an overarching vision of DEI for the organization, including programmatic and administrative outcomes. The position is responsible for the promotion of internal and external DEI for members, providers, and employees. With supervision by the Chief Medical Officer (or designee) of the QIHE program, the CHEO participates in QIHEC and collaborates on QIHE program activities.

Medical Director, QI

The Medical Director has relevant experience and current knowledge in clinical program administration, including utilization and quality improvement management. The Medical Director is part of the medical team and is responsible for strategic direction of the Quality Improvement Health Equity programs. The Medical Director also forms a dyad partner with the Sr. Director of Quality and serves as an internal expert, consultant, and resource in QI. They are responsible for clinical appropriateness, quality of care, pay for performance, access and availability, provider experience, member experience and cost-effective utilization of services delivered to Alliance members. The Medical Director has oversight over the Behavioral Health Program responsibilities including participating in the grievance and external

medical review procedure process, resolving medically related and potential quality related grievances, and issuing authorizations, appeals, decisions, and denials. The -Medical Director reports to the CMO.

Senior Director of Quality

The Senior (Sr.) Director of Quality is responsible for the strategic direction of the Quality Improvement Health Equity Program. This position has direct oversight for the development, implementation, and evaluation of the QIHE Program. This position is responsible for all performance improvement activities, including improving access and availability of network services, developing and managing quality programs as identified by DHCS, DMHC, and NCQA. This includes PIPs, Improvement Programs i.e., HEDIS/MCAS measures, QI Standards as well as managing, tracking, analyzing, and reporting member experience/satisfaction (i.e. Consumer Assessment Health Plan Surveys (CAHPS) as requested. The Sr. Director is also responsible for the oversight of FSR and potential quality issues (PQIs) and will direct performance improvement and access and availability activities. The Sr. Director is also the senior nurse to the organization to augment clinical oversight. This position, along with the Director of Population Health & Equity, assists with setting the priorities of the Population Health Management program, and ensures Health Education and Cultural and Linguistic Services are incorporated into the QIHE program. The Sr. Director of Quality is a dyad partner with the QI Medical Director and reports to the CMO.

Senior Director of Behavioral Health

The Senior Director of Behavioral Health has relevant experience and current knowledge in clinical program administration, including behavioral health and autism spectrum disorder management. The Sr. BH Director is responsible for and oversees the BH program. Responsibilities include participating in the QI, UM, and CM processes as they pertain to behavioral health and autism spectrum disorder programs. The Senior Director of BH reports to the Chief Medical Officer.

Director of Population Health and Equity

The Director of Population Health and Equity (PHE) provides operational oversight and leadership for the Alliance's population health assessments, strategy and evaluation. The PHE Director is also responsible for state and federal regulatory and accreditation requirements concerning Population Health, Cultural and Linguistic Services and member Health Education. This position reports to the Senior Director of Quality Improvement and works closely with the Chief of Health Equity.

Manager of Population Health and Equity

The Population Health and Equity (PHE) Manager is responsible for the implementation of the Alliance's population health assessments, strategy and evaluation. In addition, the PHE Manager oversees the execution of the Alliance's population health and health education programs and related equity initiatives, supervises PHE staff, and ensures compliance with state and federal regulatory and accreditation requirements concerning population health management and health education.

Manager of Cultural and Linguistic Services

The Cultural and Linguistic Services (CLS) Manager is responsible for direct oversight of the Alliance Cultural and Linguistic Services Program. This includes activities such as ensuring members have access to language assistance services for interpreting services, review of provider capacity to meet the cultural and linguistic needs of members, and overall assessment of the cultural and linguistic needs of members. The CLS Manager is also responsible for compliance with state and federal

regulatory and accreditation requirements related to CLS. Furthermore, the CLS Manager leads the planning and implementation of internal and external committees, such as the Cultural and Linguistics Services Subcommittee and the Community Advisory Committee. The CLS manager reports directly to the Population Health and Equity Director.

Quality Improvement Manager

The Quality Improvement (QI) Manager, is responsible in advancing the goals of the Quality Improvement and Health Equity (QIHE) program. The QI Manager is responsible for the day-to-day management of the Performance Improvement Team, including but not limited to HEDIS/MCAS project improvement oversight, physician practice activities, and Quality and Performance Improvement Project oversight. The QI Manager also acts as liaison between the Alliance's physician leadership and community practitioners/providers of care across all specialties and delegates. The QI Manager works collaboratively throughout the organization to lead and establish appropriate performance management/quality improvement systems including PDSA (Plan-Do-Study-Act).

Access to Care Manager

The Access to Care Manager is responsible for day-to-day management of access to care activities throughout the organization and includes leading and establishing appropriate access to care systems. The Access to Care Manager ensures the access program complies with timely access standards as regulated by the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA). The Access to Care Manager ensures planning and oversight of access to care surveys, ensures appropriate follow up when compliance monitoring identifies deficiencies The Access to Care Manager reports to the Sr. Director of Quality.

Accreditation Manager

The Accreditation Manager is responsible for management of NCQA Health Plan Accreditation and Health Equity Accreditation. Role is responsible for internal monitoring of regulatory requirements and standards.

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Quality Improvement Nurse Supervisor

The Quality Improvement Nurse Supervisor works collaboratively throughout the organization to ensure appropriate oversight of performance management and clinical quality improvement assignments. The Quality Improvement Supervisor is responsible for day-to-day supervision of the work assigned to the clinical staff in the Quality Department. The Supervisor also acts as liaison between the health plan's physician leadership and community practitioners/providers of care across all specialties and delegates. The Quality Improvement Supervisor is responsible for oversight of timely and accurate investigation and completion of Potential Quality Issues (PQI), Provider Preventable Conditions (PPC), and quality of care corrective action plans, and participation in HEDIS activities. The QI Nurse Supervisor reports to the Sr. Director of Quality.

Quality -Review Nurse (3)

The Quality Review Nurse is a registered nurse responsible for timely and accurate investigation and completion of Potential Quality of Care Issues (PQIs), collecting quality related data and reviewing medical records for HEDIS abstraction and over reads as able, chart audits, regulatory compliance, quality improvement (QI) activities development, data tracking and trending, and outcomes reporting. The Quality Review Nurse keeps accurate records, manages, and analyzes data, as well as responds

appropriately and timely, both verbally and in writing to internal and external clinical issues of staff and regulatory agencies. The Quality Review Nurse identifies, investigates, and reports on Potential Quality Issues (PQIs) and Provider Preventable Conditions (PPCs) as appropriate. Cases involving quality-of-care issues are presented to the Medical for review and determination.

Clinical Review Nurse (2)

The Clinical Review Nurse is responsible for investigating and processing comprehensive and complex grievances and appeals requests from members and providers, coding justifications, and provider disputes. This role has oversight by the Medical Director and CMO, and matrixed to the Grievance and Appeals team within the Operational Division.

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Senior Quality Improvement Nurse Specialist (1)

The Senior Quality Improvement Nurse Specialist is responsible for the training, certification and recertification of DHCS facility site reviews (FSR) and medical record reviews (MRR) for all Alliance Provider Network and Delegated Provider Oversight. The Sr. QI Nurse Specialist is also responsible for the oversight and monitoring of the qualitative and quantitative content of the medical record process and maintaining compliance with state and regulatory quality of care standards. The Sr, QI Nurse Specialist develops provider training and education materials to assist providers with meeting quality standards.

Quality Improvement Review Nurse (1)

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The Quality Improvement Review Nurse conducts facility site reviews, chart audits, regulatory compliance, quality improvement (QI) activities, and provider training. The QI Review Nurse partners with the Sr. QI Nurse Specialist to certify and recertify the Alliance Provider Network and Delegated Provider Oversight.

Quality Performance Supervisor

The Supervisor, Quality Performance, plays a critical operational role in advancing the goals of the Quality Improvement and Health Equity (QIHE) program. Under the oversight of Quality Improvement Manager, this position is responsible for implementing high-impact quality initiatives, managing complex, cross-functional projects, and supervising a team to ensure the achievement of key performance indicators (KPIs) related to health outcomes, member engagement, and regulatory compliance.

Quality Improvement Project Specialist II (4)

The Quality Improvement Project Specialist II (QIPS II) is responsible for developing and implementing quality assessment and performance improvement activities that include quality monitoring, evaluation and facilitation of performance improvement projects. The QI Project Specialist II conducts assessment activities and facilitates compliance with Medicare/Medicaid regulations, state licensure laws, and applicable regulatory/accrediting body.

Quality Improvement Project Specialist I (5)

The Quality Improvement Project Specialist I (QIPS I) is responsible for developing and implementing quality assessment and performance improvement activities that include quality monitoring, evaluation, and facilitation of performance improvement projects. The QI Project Specialist I conducts assessment activities and facilitates compliance with Medicare/Medicaid regulations, state licensure laws, and applicable regulatory/accrediting body.

Accreditation and Regulatory Compliance Specialist (2)

The Accreditation and Regulatory Compliance Specialist is responsible for the preparation of NCQA Health Plan and Health Equity accreditation through coordination and follow-up of deliverables and requirements.

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Facility Site Review QI Coordinator (1)

The Facility Site Review Coordinator (FSRC) is responsible for performing facility site review audits and quality improvement activities in conjunction with the Sr. QI Nurse Specialists. The position assists with access and availability reports, provider training, HEDIS data collection, disease specific outreach, and preparation for accreditation and compliance surveys by external agencies such as DHCS, DMHC and NCQA.

Quality Program Coordinator (2)

The Quality Program Coordinator (QPC) is responsible for helping to plan, organize, and implement Alliance quality programs as assigned. Responsibilities include coordination of quality projects including case tracking (i.e. PQI, corrective action plans), assistance in audits or surveys (i.e. CAHPS), data collection and follow-up, and coordination of internal and external meetings. Supports the successful implementation of projects within timelines for associated department assignments.

Quality Improvement Engagement Coordinator (2)

The Quality Improvement Engagement Coordinator (QIEC) responsibilities include coordinating quality improvement projects, member outreach by phone and mail, provider and community collaboration, and data tracking and reporting. The goal of this role is to increase care for Alliance members by helping to connect them to services available directly related to QI measures.

ANCILLARY SUPPORT SERVICES FOR THE QIHE PROGRAM

Population Health and Equity

The Population Health and Equity team consists of a Population Health and Equity Director, a Population and Health Equity Manager, a Cultural and Linguistics Services Manager and supporting staff. The Population Health and Equity team is a component of the QI Department. The Population Health and Equity staff ensure integration of QIHE initiatives into the Alliance Population Health Strategy and support the QI team in the development and implementation of member and provider educational interventions and community collaborations to address health care quality, health equity and access to care. The Population Health and Equity team also manages and monitors the Population Health Management, Health Education, and Cultural and Linguistic programs for the Alliance. The Health Education and Cultural and Linguistic Programs and the Population Health Management Strategy are outlined in separate documents.

Analytics

The Analytics Department is comprised of two departments: 1) Healthcare Analytics and 2) Quality Analytics. The department works in collaboration with the Quality Improvement Department on improvement activities and initiatives.

The Healthcare Analytics Department performs reporting and analyses across the organization on clinical, claims, provider, and member data. Quality activities include management of and production

of the HEDIS NCQA certified software, HEDIS data validation/collection and HEDIS rate reporting and trending. In addition, the department collaborates on Population Health Management (PHM) strategies and initiatives, such as Risk Stratification and Segmentation (RSS), and supporting access and availability regulatory requirements.

The Quality Analytics Department is responsible for management of HEDIS operational activities, the Pay-for-Performance program, and oversight of access and availability survey vendor. HEDIS operational activities include Roadmap and rate submissions, oversight of the annual HEDIS audits, medical record retrieval and training, monitoring, and performing overreads, and oversight of the abstraction vendor.

Quality Assurance

The Director, Quality Assurance is responsible for the operations management of the Grievance and Appeals Department~~, NCQA Standard Accreditation, and internal monitoring of regulatory requirements for Health Care Services~~ under the direction of the Chief Medical Officer. The Director is responsible for ensuring the Health Care Service's overall regulatory compliance with the Department of Managed Health Care and the Department of Health Care Services (DHCS) contractual responsibilities for Health Care Service Departments. The role is also responsible for overseeing ongoing audit readiness activities for DHCS, DMHC and NCQA. The Director is also responsible in coordinating processes, activities, and regulatory compliance involving grievances and appeals for all lines of business. The position identifies, analyzes, and coordinates resolution of grievances and appeals.

Utilization Management (UM) Services

The UM and QI Departments are part of the Alliance Health Care Services Department. These departments work collaboratively to ensure that appropriate quality and safe health care is delivered to members in a timely and organized manner. QI ensures that QIHEC can identify improvement opportunities regarding concurrent reviews, tracking key utilization data, and the annual evaluation of UM activities.

The Alliance's Utilization Management (UM) activities are outlined in the UM Program Description which describes the UM program structure, and how UM decisions are made based on evidence-based guidelines, applied in a consistent manner. The Alliance's Case Management (CM) Program works in an integrated manner with the UM Program, in which care coordination and complex case management programs are designed to address the needs of members with complex physical, mental, or social determinant of health needs. Some high-risk populations include seniors and persons with disabilities (SPDs), members with multiple chronic conditions, or members with unmet social determinant of health needs (i.e.: housing or food insecurity). Core Case Management program interventions include outreach, assessment, and care coordination with members and their trusted supports, to ensure the improvement of member outcomes and overall member satisfaction. Care management staff also partner with the QI department in QIHE activities including conducting member outreach calls and mailings, as appropriate.

There are identified staff persons dedicated to working with "linked and carved out services" such as East Bay Regional Center, California Children Services (children with complex health care needs), and the Alameda County Behavioral Health Care Department. The UM and CM Program Descriptions are approved by the UMC and QIHEC. For additional information, refer to the UM and CM Program Descriptions.

Pharmacy Services

The Pharmacy Department and QI Department work collaboratively on various QIHE projects. The Pharmacy Department supports patient safety initiatives including working with the Pharmacy Benefit Manager (PerformRx) to inform members, providers, and network pharmacies of medication safety alerts. Responsibilities also include review and update of the formulary through P&T, oversight of the Pharmacy Benefit Manager, and collaboration with QIHEC.

Provider Services

The Provider Services Department is the primary point of contact for network providers. They assist the QI Department on various QIHE activities with network providers as appropriate as well as disseminating QI information to practitioners. The Department collaborates with the Access and Availability team to monitor provider capacity and assess provider satisfaction. In addition, they assist with sharing information to providers about Alliance processes and provide educational material on monitoring availability and accessibility standards at physician offices, including after-hours coverage. Provider Services staff also assist the QI Department with practitioners who do not comply with requests from QI.

Credentialing Services

The Credentialing staff support the credentialing and re-credentialing processes for practitioners and network providers. The Credentialing staff conducts ongoing monitoring and evaluation of network practitioners to ensure the safety and quality of services to members. The QI Department provides the Credentialing Department with Potential Quality Issue trends and Facility Site Review and Medical Record audit scores. The Credentialing staff is responsible for coordinating the PR and CC meetings.

Member Services and Member Outreach

The Member Services staff fields all member inquiries regarding eligibility, benefits, claims, programs, and access to care. The Communication and Outreach conducts New Member orientations to educate new members about the health plan benefits. Member Services staff also works with the QI Department on member complaints via the PQI referral process and appeals in accordance with established policies and procedures. To assist in improving HEDIS scores, the QI Department may conduct member outreach activities to get HEDIS services completed. Hold messages are used to remind members of plan benefits and services offered while waiting to speak to an agent.

Grievance and Appeals

Alameda Alliance for Health reviews and investigates all grievance and appeal information submitted to the plan to identify quality issues that affect member experience. The grievance and appeals intake process are broken down into two processes, complaints, and appeals. In both instances, the details of the member's complaints are collected, processed, and reviewed and actions are taken to resolve the issue and Potential Quality Issues are forwarded to QI for review and investigation as needed. QI will collaborates with G&A for assurance of accurate reporting exempt grievance data.

Methods and Processes for Quality Improvement

The QIHE Program employs a systematic approach to identify opportunities for improvement and evaluating the results of interventions. All program activities are documented in writing and all quality studies are performed on any product line for which it seems relevant. The program aligns with the performance improvement framework recommended by the Department of Health Care Services

(DHCS). This framework, adopted by the Alliance Quality Department, is based on the Institute for Healthcare Improvement (IHI) Model of Improvement Key concepts for DHCS performance improvement projects (PIP) utilize the following framework:

PIP Initiation

SMART Aim Data Collection

Intervention Determination

Plan-Do-Study-Act

PIP Conclusion

Identification of Important Aspects of Care

The Alliance uses several methods to identify aspects of care that are the focus of QIHE activities. Some studies are initiated based on performance measured as part of contractual requirements (e.g., HEDIS). Other studies are initiated based on analyses of the demographic and epidemiologic characteristics of Alliance members, health disparities, or identified through surveys and dialogue with member and provider communities (e.g., CAC, CAHPS, provider satisfaction survey, Joint Operating Meetings (JOM), Quality/Provider QI meetings, site visits, etc.). Particular attention is paid to those areas in which members are high risk, high volume, high cost, or problem prone.

Data Sources and Systems

The Alliance utilizes various resources to develop clinical and quality reporting and analyses that provide meaningful and actionable insights. Resources to support the QIHE Program include, but are not limited to the following:

- ODS (Operational Data Store) and Datawarehouse: These are the main databases and the primary sources for all data including member, eligibility, encounter, provider, pharmacy data, lab data, vision, encounters, etc. and claims. The databases are used for storing data required for quality reporting.
- HealthSuite: Claims and eligibility processing system
- CareAnalyzer (DST): used to inform Population Health Management and Population Needs Assessment initiatives and provide QI/UM/CM access to risk-stratified, segmented data that can be effectively applied to target high-risk members for early intervention and improve the overall coordination of care.
- Cotiviti: AAH's NCQA-certified HEDIS software that produces HEDIS/MCAS measure data and outcomes. Data integrity is audited annually through the HEDIS reporting audit process.
- CAHPS 5.1H and CG-CAHPS: Member experience survey via SPH vendor support
- California Immunization Registry (CAIR): Immunization registry information.
- Laboratory results: Data files from Quest, Foundation, and AHS
- Cactus: credentialing database.
- Provider satisfaction and coordination of care surveys via Press Ganey vendor support
- Pre-service, concurrent, post-service and utilization review data (TruCare).
- Case management data (TruCare)
- Member and provider grievance and appeal data.

- Potential Quality of Care Issue Application database (Quality Suite) used for tracking/trending data.
- Internally developed reports (e.g., asthma and diabetes).
- Provider Appointment Availability Survey (PAAS), after-hours access and emergency instructions. Other clinical or administrative data.

Evaluation

The Analytics Department compiles various data sources to produce reporting and analyses. Quality performance staff analyzes the data to determine variances from established criteria, performance goals, and for clinical issues. Data is analyzed to determine priorities or achievement of a desired outcome. Data is also analyzed to identify disparities based on ethnicity and language. Subsets of our membership may be examined when they are deemed to be particularly vulnerable or at risk.

HEDIS related analyses include investigating trends in provider and member profiling, data preparation (developing business rules for file creation, file creation for HEDIS vendors, mapping proprietary data to vendor and NCQA specifications, data quality review and data clean-up). These activities involve data sets maintained by the Alliance and supplemental files submitted by various trading partners, such as delegated provider organizations and various external health registries and programs (e.g., Quest Diagnostics, and the California Immunization Registry).

Aggregated reports are forwarded to the QIHEC. Status and final reports are submitted to regulatory agencies as contractually required. Evaluation is documented in committee minutes, workplans, and attachments.

ACTIONS TAKEN AS A RESULT OF QIHE ACTIVITIES

Action plans are developed and implemented when opportunities for improvement are identified. Each performance improvement plan specifies who or what is expected to change, the person responsible for implementing the change, the appropriate action, and when the action is to take place. Actions will be prioritized according to possible impact on the member or provider in terms of urgency and severity.

Actions taken are documented in reports, minutes, attachments to minutes, workplans, and other similar documents.

An evaluation of the effectiveness of each QIHE activity is performed. A re-evaluation will take place after an appropriate interval between implementation of an intervention and remeasurement. The evaluation of effectiveness is described qualitatively and quantitatively, in most cases, compared to previous measurements, with an analysis of statistical significance when indicated.

Based on the HEDIS data presented, areas of focus for 2025 include but are not limited to the following:

- Childhood Immunizations: Combo 10
- Well-Child Visits in the First 15 months of Life
- Well-Child Visits in members 3-15 months of Life
- Well Child Visit 3-21 Years of Age
- Lead Screening
- Topical Fluoride for Children
- Breast Cancer Screening

- Cervical Cancer Screening
- HbA1c Testing for Diabetics
- Controlling Blood Pressure
- Follow-up after Emergency Department visit for Mental Health illness (FUM) or Substance Use (FUA)

Other non-HEDIS related measures of focus will include but not be limited to:

- Initial Health Appointment
- Emergency Department Visits
- Readmission Rate
- Timely Access and Member Satisfaction Survey: Non-Urgent Appointment Availability
- Screening for Depression
- EPSDT Service Utilization
- Under and Over Service Utilization
- Behavioral Health Care Coordination

TYPES OF QI MEASURES AND ACTIVITIES

Healthcare Effectiveness Data Information Set (HEDIS)

The Managed Care Accountability Set (MCAS) Performance Measures, a subset of HEDIS (Health Effectiveness Data Information Set) are calculated, audited, and reported annually as required by DHCS. Additional measures from HEDIS are also reviewed. A root cause analysis may be performed, and improvement activities initiated for measures not meeting benchmarks.

Consumer Assessment of Health Plan Survey (CAHPS 5.1H and CG-CAHPS)

The Alliance evaluates member experience periodically. Third party vendors conduct the Consumer Assessment of Health Plan Survey (CAHPS). The Alliance assists in the administration of these surveys, receives, and analyzes the results, and follows up with prioritized improvement initiatives. Survey results are distributed to the A&A Subcommittee, followed by QIHEC, and made available to members and providers upon request. The CAHPS survey is conducted annually for the entire Medi-Cal population and the results from the CAHPS are reported in the annual QIHEC evaluation and used to identify opportunities to improve health care and service for our members.

State Quality Improvement Activities

DHCS requires Medi-Cal Managed Care plans to conduct at least two QI projects each year. Forms provided by DHCS are used for QI project milestones.

Annually, the Alliance submits its QIHE Program Description, along with an evaluation of the prior year's QIHE Work Plan. A current year Work Plan is developed and updated throughout the year as QIHE activities are designed, implemented, and reassessed.

The Alliance complies with the requirements described in the regulatory All Plan Letters.

Monitoring Satisfaction

The QIHE Program measures member and provider satisfaction using several sources of satisfaction, including the results of the CAHPS survey, the Population Needs Assessment (PNA), the annual DMHC Timely Access survey, plan member and provider satisfaction surveys, complaint and grievance data, disenrollment and retention data, ad hoc member feedback surveys, Community Advisory Committee (CAC), and other data as available. These data sets are presented to the QIHEC at quarterly and annual intervals. The plan may administer topic specific satisfaction surveys depending on findings of other QIHE studies and activities.

Health Education Activities

The Health Education Program at the Alliance operates as part of the Population and Health Equity Unit of the Quality Improvement Department. The primary goal of Health Education is to improve members' health and well-being through the lifespan through promotion of appropriate use of health care services, preventive health care guidelines: Bright Futures/American Academy of Pediatrics, U.S. Preventive Services Task Force, and clinical guidelines from professional associations, healthy lifestyles and condition self-care and management. The primary goal of Health Education is to provide the knowledge needed for Alameda Alliance members to maintain and support their health.

Health education programs are developed in alignment with needs identified by the population assessments and include individual, provider, and community-focused health education and disease management activities which address health concerns such as nutrition, injury prevention, maternal health, diabetes, pre-diabetes, asthma, hypertension, and mental health. The Alliance also collaborates on community projects to develop and distribute important health education messages for at risk populations.

Cultural and Linguistic Activities

The Alliance Cultural and Linguistic Services Program operates as a part of the Population and Health Equity Unit of the Quality Improvement Department. . It reflects the Alliance's adherence and commitment to the U.S. Department of Health & Human Services *National Standards for Culturally and Linguistically Appropriate Services* (CLAS). The program offers services and conducts activities designed to ensure that all members have access to quality health care services that are culturally and linguistically appropriate. These activities encompass efforts within the organization, as well as with Alliance members, providers, and our community partners.

Objectives include:

- Comply with state and federal guidelines related to assessment of enrollees to offer our members culturally and linguistically appropriate services.
- Provide no-cost language assistance services at all points of contact for covered benefits.
- Identify, inform, and assist limited English proficient (LEP) members in accessing quality interpretation services and written information materials in threshold languages.
- Ensure that all staff, providers, and subcontractors are compliant with the cultural and linguistic services program through cultural sensitivity training.
- Integrate community and Alliance member input into the development and implementation of Alliance cultural and linguistic accessibility standards and procedures.
- Monitor and continuously improve Alliance activities and services aimed at achieving cultural

competence and reducing health care disparities.

The objectives for cultural and linguistic activities are addressed and monitored in the Cultural and Linguistic Services work plan, updated annually, and reviewed quarterly.

Disease Surveillance

The Alliance maintains procedures to ensure accurate, timely, and complete reporting of any disease or condition to public health authorities as required by State law. The Provider Manual describes requirements and lists the Public Health Department contact phone and fax numbers.

Patient Safety and Quality of Care

The Alliance QI process incorporates several mechanisms to review incidents that pose potential risk or safety concerns for members. The following activities are performed to demonstrate the Alliance's commitment to improve quality of care and safety of its members via monitoring, investigation, track, and trending of:

- Complaints and grievances and determining quality of care impact.
- Iatrogenic events such as hospital-acquired infections reported on claims and reviewing encounter submissions.
- Inpatient admissions to evaluate and monitor the medical necessity and appropriateness of ongoing care and services. Safety issues may be identified during this review.
- Identified potential quality of care issues.
- Auditing Alliance internal processes/systems and delegated providers.
- Credentialing and re-credentialing of malpractice, license suspension registries, loss of hospital privileges for providers.
- Site review of provider offices for compliance with safety, infection control, emergency, and access standards.
- Operations compliance with local regulatory practices.
- Reviewing hospital readmission reports.
- Improve continuity and coordination of care between practitioners.
- Quality of care issues related to Long Term Care

Quality issues are referred to the QI Department to evaluate the issue, develop an intervention and involve the CMO when necessary.

Facility Site Reviews

The Alliance conducts site reviews, including Facility Site Review (FSR), Medical Record Review (MRR), and Physical Accessibility Review (PARS), including assigning scores, monitors, and reports site reviews in accordance with all applicable state and federal guidelines. If findings are identified, corrective action plans (CAP) are issued and followed upon until appropriate documentation are addressed for all deficiencies to close the CAP. A summary of the site reviews conducted are reported to A&A Committee or IQIC (i.e. workplan summary) followed by QIHEC to monitor the clinical safety activities of the Alliance Provider Network.

Long-Term Care Quality Monitoring

The Alliance maintains a comprehensive Quality Assurance Performance Improvement (QAPI) monitoring program for Long Term Care (LTC) services which includes on-going review of the following:

- A table-top review of quality assurance and improvement findings from California Department of Public Health (CDPH) to include, but not be limited to, survey deficiency results, site visit findings, and complaint findings.
- Review of QAPI programs in LTC (i.e. SNFs and Subacute) based on an attestation of compliance by the facilities of the five key elements identified by CMS:
  - Element 1: Design and Scope
  - Element 2: Governance and Leadership
  - Element 3: Feedback, Data Systems and Monitoring
  - Element 4: Performance Improvement Projects (PIPs)
  - Element 5: Systematic Analysis and Systemic Action
- Review of CMS Quality Star ratings
- Monitoring of quality measures for LTC within the Managed Care Accountability Set (MCAS) of performance measures, such as emergency room visits, healthcare associated infections requiring hospitalization, and potentially preventable readmissions.
- Review and investigation of Potential Quality Issues (PQIs)
- In collaboration with the LTC team, the Alliance monitors the quality and appropriateness of care furnished to members using LTSS, including:
  - Assessment of care between care settings and a comparison of services and supports received with those set forth, and
  - Efforts supporting member community integration.
    When significant trends or non-compliance related to the QAPI program are noted, medical chart reviews or on-site visits will be conducted for LTC facilities as appropriate. Corrective action plans may be issued to address and resolve deficiencies in the quality of care of residents.

For Intermediate Care Facility for Developmentally Disabled (ICF/DD) Homes, quality monitoring includes the review of compliance findings and data from CDPH as well as service delivery findings from the Regional Centers established in the Memoranda of Understanding. Activities and monitoring are discussed at joint Alliance and Regional Center meetings on an on-going basis to ensure the quality and appropriateness of care, but not limited to:

- Any applicable performance measures (as mutually agreed upon)
- QI initiatives as well as reports that track cross-system referrals.
- Member engagement
- Service utilization and to prevent duplication of services rendered.

On-going monitoring reports are reported to the quality committees, including A&A Committee or IQIC and QIHEC on an as needed basis.

Health Equity Activities

The Alliance is committed to Health Equity by mitigating social determinants of health to prevent and reduce health disparities and health inequities that adversely affect vulnerable populations. Health Equity is integrated throughout the organization and is a collaborative effort across multiple departments. Additional data beyond the historical HEDIS or MCAS measures might be needed to better understand the systemic barriers or SDOHs faced by our members. As part of the QIHE Program, the Alliance monitors and addresses member access, experience, and clinical outcome disparities by analyzing data stratified by race, ethnicity, and language (REL). According to specific standards and/or strategies, the QIHE Program involves implementing systematic and continuous activities to monitor, evaluate, and improve upon the health equity and health care delivered to our members. There is alignment with the Alliance Population Health Strategy and related activities. The QIHEC is responsible for overseeing the QIHE Program, including activities to identify and close health disparity gaps, providing feedback to meet goals/benchmarks as set forth by governing agencies (i.e., DHCS, DMHC, or NCQA), and to recommend required actions.

ACCESS AND AVAILABILITY

The Alliance implements mechanisms to maintain an adequate network of primary care providers (PCP) and high volume and high impact specialty care providers. Alliance policy defines the types of practitioners who may serve as PCPs. Policies and procedures establish standards for the number and geographic distribution of PCPs and high-volume specialists. The Alliance monitors and assesses the cultural, ethnic, racial, and linguistic needs and preferences of members, and adjusts availability of network providers, if necessary.

The following services are also monitored for access and availability:

- Children's preventive periodic health assessments/EPSDT
- Adult preventative health screenings
- Initial health appointments

The QIHE Program collaborates with the Provider Services Department to monitor access and availability of care including member wait times and access to practitioners for routine, urgent, emergent, and preventive, specialty, and after-hours care. Access to medical care is ensured by monitoring compliance with timely access standards for practitioner office appointments, telephone practices, and appointment availability. The QIHEC also oversees appropriate access standards for appointment wait times. Alliance appointment access standards are no longer than DMHC and DHCS established standards. The Provider Manual, virtual/onsite visits, and periodic fax blasts are some of the mechanisms to educate providers on Timely Access Standards.

The QIHEC reviews the following data and makes recommendations for intervention and quality activities when network availability and access improvement is indicated:

- Member complaints about access.
- CAHPS 5.1H and CG-CAHPS results for wait times and telephone practices.
- HEDIS measures for well child and adolescent primary care visits.
- Immunizations.
- Emergency room utilization.

- Facility site review findings.
- The review of specialty care authorization denials and appeals.
- Additional studies and surveys may be designed to measure and monitor access.

BEHAVIORAL HEALTH QUALITY

The Alliance maintains procedures for monitoring the coordination and quality of behavioral healthcare provided to all members including, but not limited to, all medically necessary services across the health care network. The Alliance reports activities in behavioral healthcare at QIHEC meetings to monitor, support, and improve behavioral healthcare aspects of QI.

Per DHCS contract, the Alliance is responsible for the administration of the mild to moderate non-specialty mental health benefit. Specialty Behavioral Health for Medi-Cal members with severe mental health conditions is excluded from the Alliance contract with DHCS. The Specialty Behavioral Health Services are coordinated under a Memorandum of Understanding between the Alliance and Alameda County Behavioral Health (ACBH). Some primary care physicians may choose to treat mild mental health conditions. The Alliance insourced the management and oversight of the non-specialty mental health and autism behavioral health services. The Alliance includes the involvement of a Senior Director of Behavioral Health in program oversight and implementation. The Alliance reviews reports of behavioral health quality, utilization, and surveys (i,e. timely access via member experience surveys, provider satisfaction) in its standing sub-committee meetings (i.e. A&A and IQIC subcommittees) to ensure members obtain necessary and appropriate behavioral health services.

Please see the UM / CM Program Description for additional information.

COORDINATION, CONTINUITY OF CARE AND TRANSITIONS

Member care transitions present the greatest opportunity to improve quality of care and decrease safety risks by ensuring coordination and continuity of health care as members transfer between different locations or different levels of care within the same location and/or across the healthcare continuum.

The Alliance Health Care Services focuses on interventions that support planned and unplanned transitions and promote chronic disease self-management. Primary goals of the department are to reduce unplanned transitions, prevent avoidable transitions and maintain members in the least restrictive setting possible.

Comprehensive case management services are available to each member. It is the PCP's responsibility to act as the primary case manager to all assigned members. Members have access to these services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability. All services are provided in a culturally and linguistically appropriate manner.

Members who may need or are receiving services from out-of-network providers are identified. Procedures ensure these members receive medically necessary coordinated services and joint case management, if indicated. Written policies and procedures direct the coordination of care for the following:

- Services for Children with Special Health Care Needs (CSHCN).
- California Children's Service (CCS) eligible children are identified and referred to the local CCS

program.

- Overall coordination and case management for members who obtain Child Health and Disability Prevention Program (CHDP) services through local school districts or sites.
- Early Start eligible children are identified and referred to the local program.
- Members with developmental difficulties are referred to the Regional Center of the East Bay for evaluation and access to developmental services.

All new Medi-Cal members are expected to receive an Initial Health Appointment (IHA) within 120 days of their enrollment or provider assignment with the plan. Members are informed of the importance of scheduling and receiving an IHA from their PCP. The Provider Manual informs the PCP about the IHA, the HRA (for SPDs), and recommended forms. All new Medi-Cal non-SPD members also receive a Health Information Form\Member Information Tool (HIF\MET) in the New Member Packet upon enrollment. The Alliance ensures coordination of care with primary care for all members who return the form with a condition that requires follow up.

The Alliance coordinates with PCPs to encourage members to schedule IHAs. The medical record audit of the site review process is used to monitor coordination, and whether baseline assessments, diagnosis/treatment, and medically necessary follow-up services and referrals are documented.

COMPLEX CASE MANAGEMENT PROCESS

All Alliance members are potentially eligible for participation in the complex case management program. The purpose of the complex case management program is to provide the case management process and structure to a member who has complex health issues and medical conditions. The components of the Alliance complex case management program encompass member identification and selection; member assessment; member-centered care plan development, implementation, and management; evaluation of the member care plan; and closure of the case. Program structure is designed to promote quality case management, client satisfaction and cost efficiency using collaborative communication, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

The complex case management program's objectives are concrete measures that assess effectiveness and progress toward the overall program goal of making high-quality health care services accessible and affordable to Alliance membership. The Chief Medical Officer, Senior Director of Health Care Services, Director of Social Determinants of Health, and Manager of Case and Disease Management develop and monitor the objectives. The QIHEC reviews and assesses program performance against objectives during the annual program evaluation, and if appropriate, provides recommendations for improvement activities or changes to objectives. The objectives of the program include:

- Preventing and reducing hospital and facility readmissions as measured by admission and readmission rates.
- Preventing and reducing emergency room visits as measured by emergency room visit rates.
- Achieving and maintaining member's high levels of satisfaction with case management services as measured by member satisfaction rates.
- Improving functional health status of complex case management members as measured by member self-reports of health condition.

The complex case management program is a supportive and dynamic resource that the Alliance uses to achieve these objectives as well as respond to the needs and standards of consumers, the healthcare provider community, regulatory and accrediting organizations.

The Alliance annually measures the effectiveness of its complex case management program based on the following measures (detailed information can be found in the Case Management Program Description):

1. Satisfaction with case management services - members are mailed a survey after case closure and are asked to rate experiences and various aspects of the program's service.
2. All-cause readmission rates - the Alliance measures admission rates for all causes within six months of being enrolled in complex case management.
3. Emergency room visit rate - the Alliance measures emergency room visit rates among members enrolled in complex case management.
4. Health status rate - the Alliance measures the percentage of members who received complex case management services and responded that their health status improved because of complex case management services.

The Chief Medical Officer and the Senior Director of Health Care Services collaboratively conduct an annual evaluation of the Alliance complex case management program. This includes an analysis of

performance measures, an evaluation of member satisfaction, a review of policies and program description, analysis of population characteristics and an evaluation of the resources to meet the needs of the population. The results of the annual program evaluation are reported to the QIHEC for review and feedback. The QIHEC makes recommendations for improvement and interventions to improve program performance, as appropriate.

DISEASE MANAGEMENT PROGRAM

The Alliance offers its members a disease management program. The purpose of the disease management program is to provide coordinated health care interventions and communications to both pediatric and adult members with chronic asthma and adults with diabetes, cardiovascular disease, and depression to support disease self-management and promote healthy outcomes. This is accomplished through the provision of interventions based on member acuity level. The intervention activities range from case management for those members at high risk, offering health coaching, educational materials, and care coordination to those members who may have gaps in care. The components of the Alliance disease management program include member identification and risk stratification, identification of gaps in care and health inequities, member outreach, provision of case management and health coaching services, and condition-specific education.

Program structure is designed to follow the National Committee for Quality and Assurance (NCQA) Population Health Management (PHM) standards. The program promotes quality condition management, member satisfaction and cost efficiency using collaborative communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes. In 2025, the Alliance Disease Management Program focuses on four conditions Asthma, Diabetes, Perinatal Depression and Cardiovascular Disease.

The objectives of the disease management program are concrete measures that assess effectiveness and progress toward the overall program goals of meeting the health care needs of members and actively supporting members and practitioners to manage chronic asthma and diabetes. The QIHEC reviews and assesses program performance against objectives during the annual program evaluation, and if appropriate, provides recommendations for improvement activities or changes to objectives. The objectives of the disease management program include:

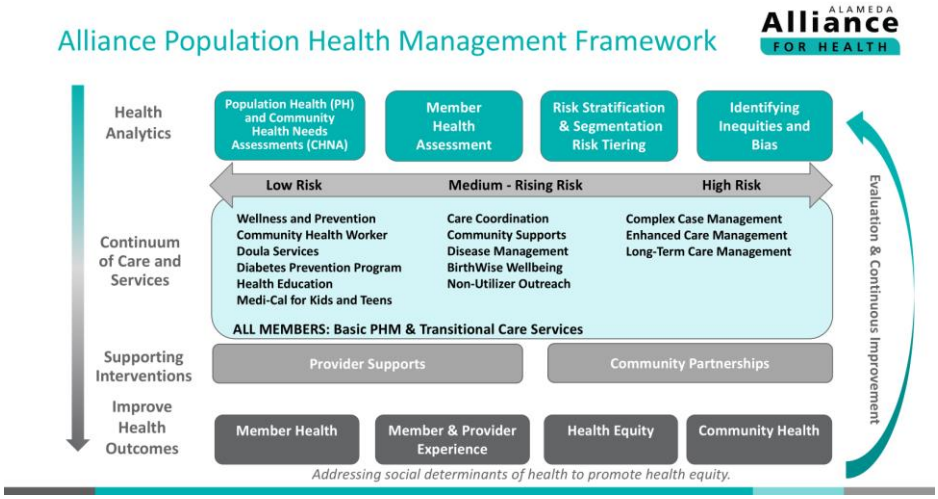
- Achieving and maintaining member's high levels of satisfaction with disease management services as measured by member satisfaction rates.
- Reducing gaps in care as measured by HEDIS clinical effectiveness measures specific to the management of asthma and diabetes.
- Addressing inequities related to chronic conditions.
- Increasing the rate of member engagement through targeted outreach activities regarding disease management services.
- Validating the efficacy of disease management health coaching as measured by post health coaching evaluations of member’s knowledge and confidence.

POPULATION HEALTH MANAGEMENT (PHM) PROGRAM

Alameda Alliance for Health has a Population Health Management (PHM) Program that identifies member needs across the continuum of care and ensures access to a comprehensive set of services with the aim of improving health outcomes and supporting an enhanced quality of life. This continuum includes intensive case management and support for members with the highest levels of needs, programs and interventions for those with emerging risks, and basic population health management for all members. The Alliance PHM Program follows the NCQA 2025 Population Health Program Standards and Guidelines and aligns with the California Department of Health Care Services Population Health Management Policy Guide.

The PHM Program strives to target and close gaps in care and address upstream drivers of health disparities by addressing the social drivers of health (SDOH) that cause those disparities. The PHM Program is monitored via the Internal Quality Improvement Committee (IQIC), which is comprised of representatives from Quality Improvement, Utilization Management, Case Management, Behavioral Health, Pharmacy and Quality Assurance. In addition, overall outcomes, and findings from the Alliance population health assessments, population health strategy and evaluations are presented, reviewed, and approved by theQIHEC.

The Alliance PHM Framework illustrates how health analytics, a continuum of care and services, and supporting interventions, and evaluation lead to improved health outcomes. The Alliance's continuum of care and services aims to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through best practice and culturally affirming member needs.



The Alliance conducts an annual Population Assessment

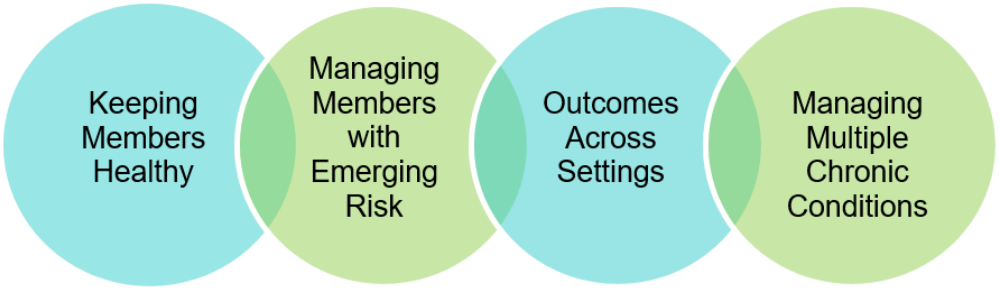
The Alliance annual PHM Assessment uses multiple data sources including member demographics, claims and encounters, HEDIS performance results, and social determinants of health to understand the health needs of our members. The HEDIS measures analyzed in the assessment include Department of Managed Health Care Health Equity Measure Set (DMHC HEQMS) and NCQA health equity measures, which are stratified by NCQA-defined race and ethnicity categories. The PHM team conducts a disparity analysis and leads cross-functional discussion of activities and resources needed to close disparities and improve measure performance. The Alliance prioritizes which programs and disparities to address in the development of the annual PHM Strategy.

The Alliance updates its PHM Strategy annually and uses it to:

- Improve case management programs including Complex Case Management (CCM), Enhanced Care Management (ECM), Community Supports (CS), and Transitional Care Services (TCS).
- Support development of basic population health activities to promote self-management of conditions and preventative care.
- Inform quality improvement projects.
- Guide development of health education materials and programs.
- Influence interventions that target member safety and outcomes across settings.
- Better understand utilization and identify high-risk members.
- Address identified health inequities.

The Alliance PHM strategy addresses four focus areas of population health that promote a whole-person approach to identify members at risk, and to provide strategies, programs, and services to mitigate or reduce that risk. The strategy has 4 areas of focus:

Four Areas of Focus



The Population Health Strategy includes:

- Population health assessment results
- Population risk stratification and segmentation
- PHM Strategy goals and programs

- Integration of Community Resources
- Delivery systems provider support structures
- Sharing data – provider measures and gaps in care
- Quality Dashboards – HEDIS measure-specific data
- Comparable Data – Peer performance, local averages, and national benchmarks
- Value-Based Payment Programs
- Ongoing Education/Support – Provider Newsletters & Education

The Alliance Population Health Management Assessment and Strategy can be found in separate documents. The Alliance Population Health Evaluation is included in the QIHE Evaluation.

SENIORS AND PERSONS WITH DISABILITY (SPD)

The Alliance categories all new SPD members as high risk. High risk members are contacted for an HRA within 45 calendar days and low risk members are contacted within 105 calendar days from their date of enrollment. Existing SPD members receive an annual HRA on their anniversary date. The objectives of an HRA are to assess the health status, estimate health risk, and address members' needs relating to medical, specialty, pharmacy, and community resources. Alliance staff uses the responses to the HRAs, along with any relevant clinical information, to generate care plans with interventions to decrease health risks and improve care management.

DHCS has established performance measures to evaluate the quality of care delivered to the SPD population using HEDIS measures and a hospital readmissions measure.

PROVIDER COMMUNICATION

The Alliance contracts with its providers to foster open communication and cooperation with QIHE activities:

- Provider cooperation with QIHE activities.
- Plan access to provider medical records to the extent permitted by state and federal law.
- Provider maintenance of medical record confidentiality.
- Open provider-patient communication about treatment alternatives for medically necessary and appropriate care.
- Provider regulatory requirements

Provider involvement in the QIHE Program occurs through membership in standing and ad-hoc committees, Joint Operating Committee meetings, and attendance at BOG and QIHEC meetings. Providers and members may request copies of the QIHE Program description, work plan, and annual evaluation. These documents are also posted on the Alliance website. Provider participation is essential to the success of QIHE studies including HEDIS and those that focus on improving aspects of member care. Additionally, providing feedback on surveys and questionnaires is encouraged as a means of continuously improving the QIHE Program.

Providers have an opportunity to review the findings of the QIHE Program through a variety of

mechanisms. The QIHEC reports findings from QIHE activities to the BOG through CMO reports (monthly), QIHE Trilogy documents (annually), and on an on-going basis. Findings include aggregate results, comparisons to benchmarks, deviation from threshold, drill-down results for provider group or type, race/ethnicity, and language, and other demographic or clinical factors. Findings are distributed directly to the provider when data is provider specific. Findings are included in an annual evaluation of the QIHE Program and made available to providers and members upon request. The Provider Bulletin contains a calendar of future BOG and standing committee dates and times.

EVALUATION OF QIHE PROGRAM (SEPARATE DOCUMENT)

The QIHEC reviews, makes recommendations, and approves a written evaluation of the overall effectiveness of the QIHE Program on an annual basis. The evaluation includes, at a minimum:

- Changes in staffing, reorganization, structure, or scope of the program during the year.
- Allocation of resources to support the program.
- Comparison of results with goals and targets.
- Tracking and trending of key indicators.
- Description of completed and ongoing QIHE activities.
- Analysis of the overall effectiveness of the program, including assessment of barriers or opportunities.
- Recommendations for goals, targets, activities, or priorities in subsequent QIHE Work Plan.

The review and revision of the program may be conducted more frequently as deemed appropriate by the QIHEC, CMO, CHEO, CEO, or BOG. The QIHEC's recommendations for revision are incorporated into the QIHE Program Description, as appropriate, which is reviewed by the BOG and submitted to DHCS on an annual basis.

ANNUAL QIHE WORK PLAN (SEPARATE DOCUMENT)

A QIHE Work Plan is received and approved annually by the QIHEC. The work plan describes the QIHE goals and objectives, planned projects, and activities for the year, including continued follow-up on previously identified quality issues, and a mechanism for adding new activities to the plan as needed. The QIHE work plan delineates the responsible party and the time frame in which planned activities will be implemented.

The work plan is included as a separate document and addresses the following:

- Quality of clinical care
- Quality of service
- Safety of clinical care
- Members' experience
- Health equity activities
- Yearly planned activities and objectives
- Time frame within which each activity is to be achieved.
- The staff member responsible for each activity
- Monitoring previously identified issues.
- Evaluation of the QIHE Program

Progress on completion of activities in the QIHE work plan is reported to the QIHEC quarterly. A summary of this progress will be reported by the CMO to the BOG.

SUPPORTING DOCUMENTS

In addition to this program description, the annual evaluation and work plan, the other additional documents important in communicating QI policies and procedures include and not limited to:

- "Provider Manual" provides an overview of operational aspects of the relationship between the Alliance, providers, and members. Information about the Alliance's QIHE Program is included in the provider manual. It is distributed to all contracted provider sites.
- "Provider Bulletin" is a newsletter distributed to all contracted provider sites on topics of relevance to the provider community, and can include QIHE policies, procedures, and activities.
- "Alliance Alert" is the member newsletter that also serves as a vehicle to inform members of QIHE policies and activities.

These documents, or summaries of the documents, are available upon request to providers, members, and community partners. In addition, the QIHE Program information is available on the Alliance website.

CONFIDENTIALITY AND CONFLICT OF INTEREST

All employees, contracted providers, delegated medical groups and sub-contractors of the Alliance maintain the confidentiality of personally identifiable health information, medical records, peer review, internal and external, and internal electronic transmissions, and quality improvement records. They will ensure that these records and information are not improperly disclosed, lost, altered, tampered with, destroyed, or misused in any manner. All information used in QIHE activities is maintained as confidential in compliance with applicable federal and state laws and regulations.

Access to member or provider-specific peer review and other QI information is restricted to individuals and/or committees responsible for these activities. Outside parties asking for information about QIHE activities must submit a written request to the CMO. Release of all information will be in accordance with state and federal laws.

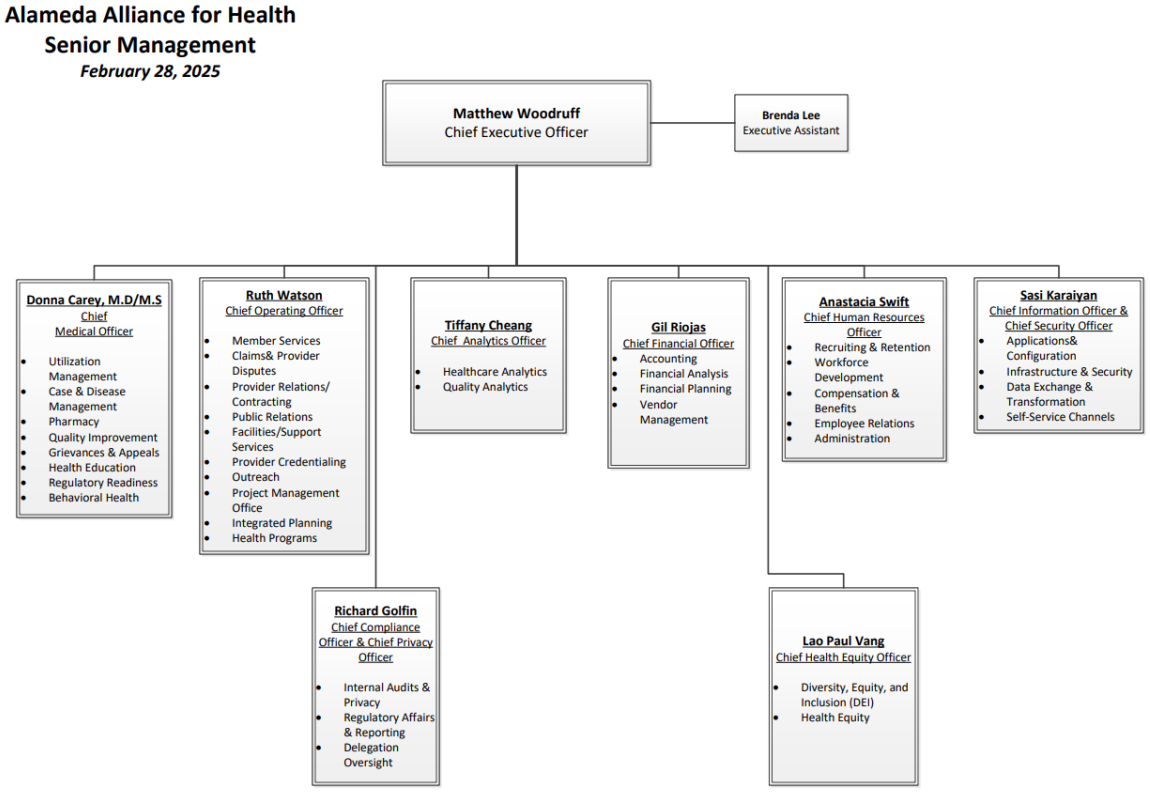
All providers participating in the QIHEC or any of its subcommittees, or other QIHE Program activities involving review of member or provider records, will be required to sign and annually renew confidentiality and conflict of interest agreements. Guests or additional Alliance staff attending QIHEC meetings will sign a confidentiality agreement.

Committee members may not participate in the review of any case in which they have a direct professional, financial, or personal interest. It is each committee member's obligation to declare actual or potential conflicts of interest.

All QIHEC meeting materials and minutes are marked with the statement "Confidential". Copies of QIHE meeting documents and other QIHE data are maintained separately and secured to ensure strict confidentiality.

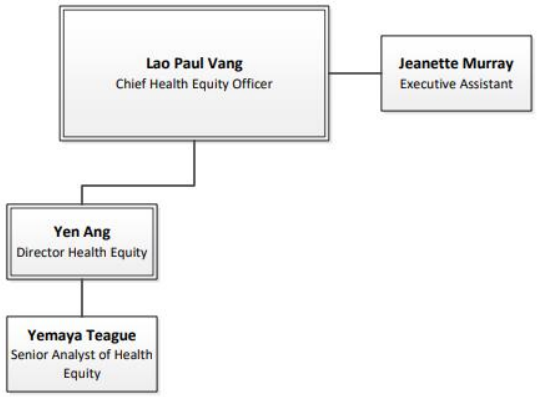
APPENDIX A: Organizational Charts

Senior Management

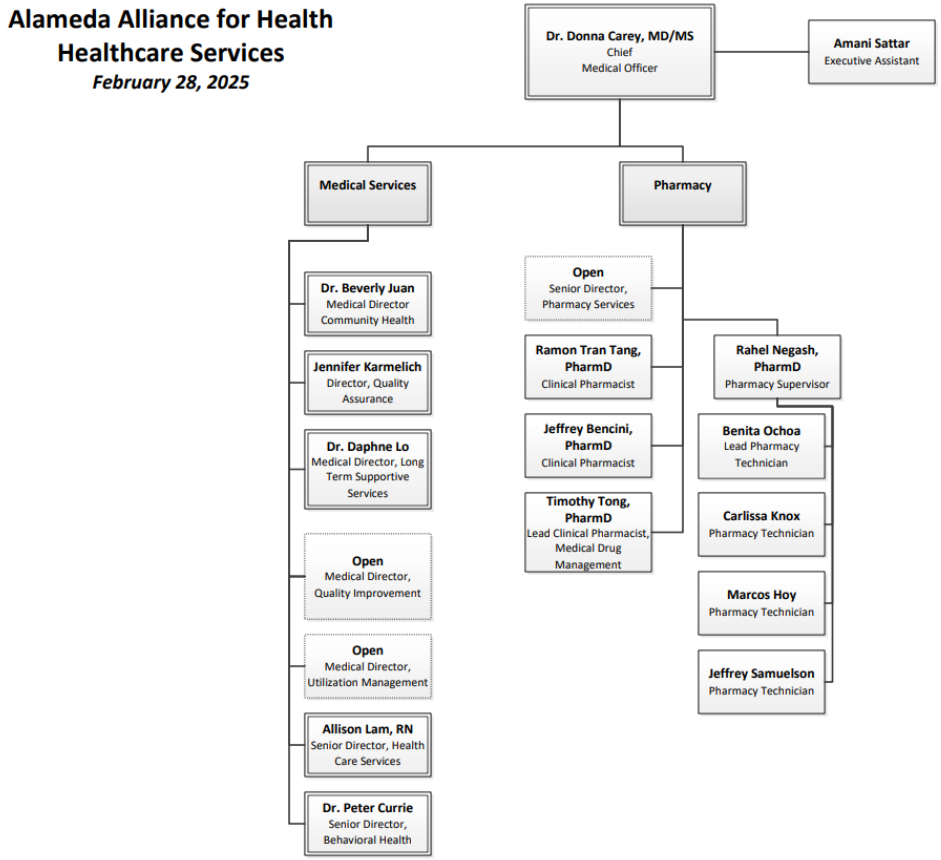


Health Equity

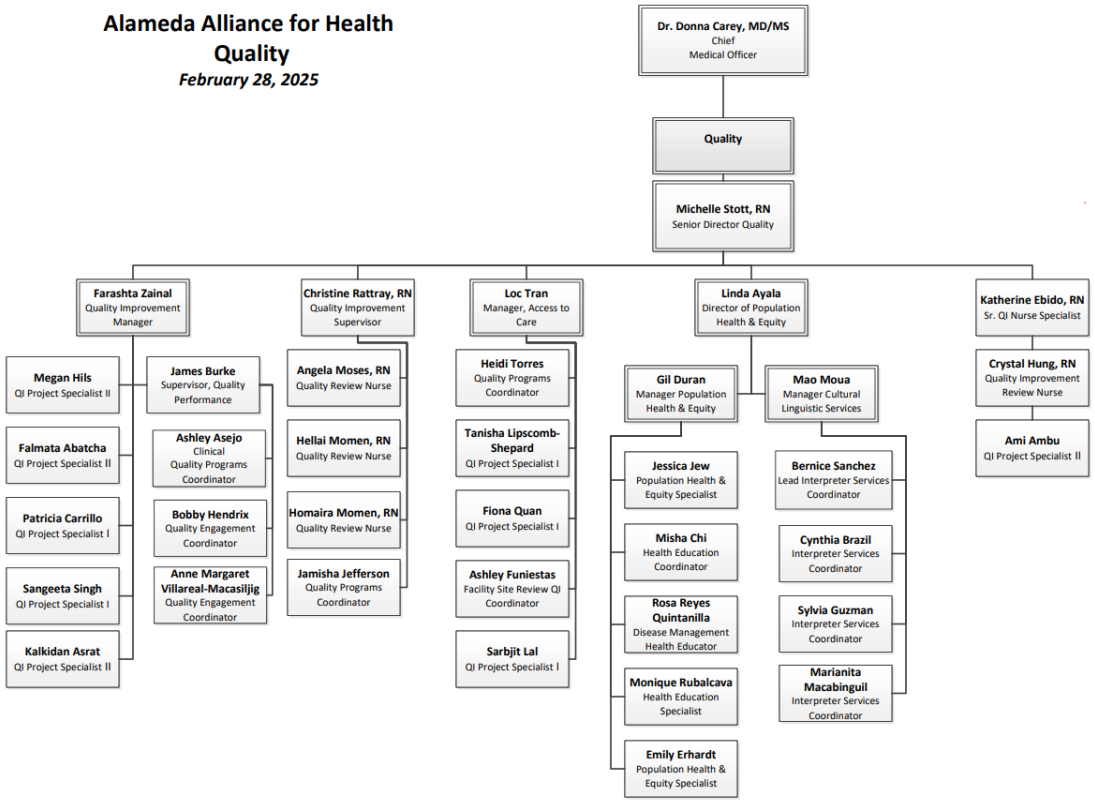
Alameda Alliance for Health
Health Equity
February 28, 2025



Medical Services and Pharmacy

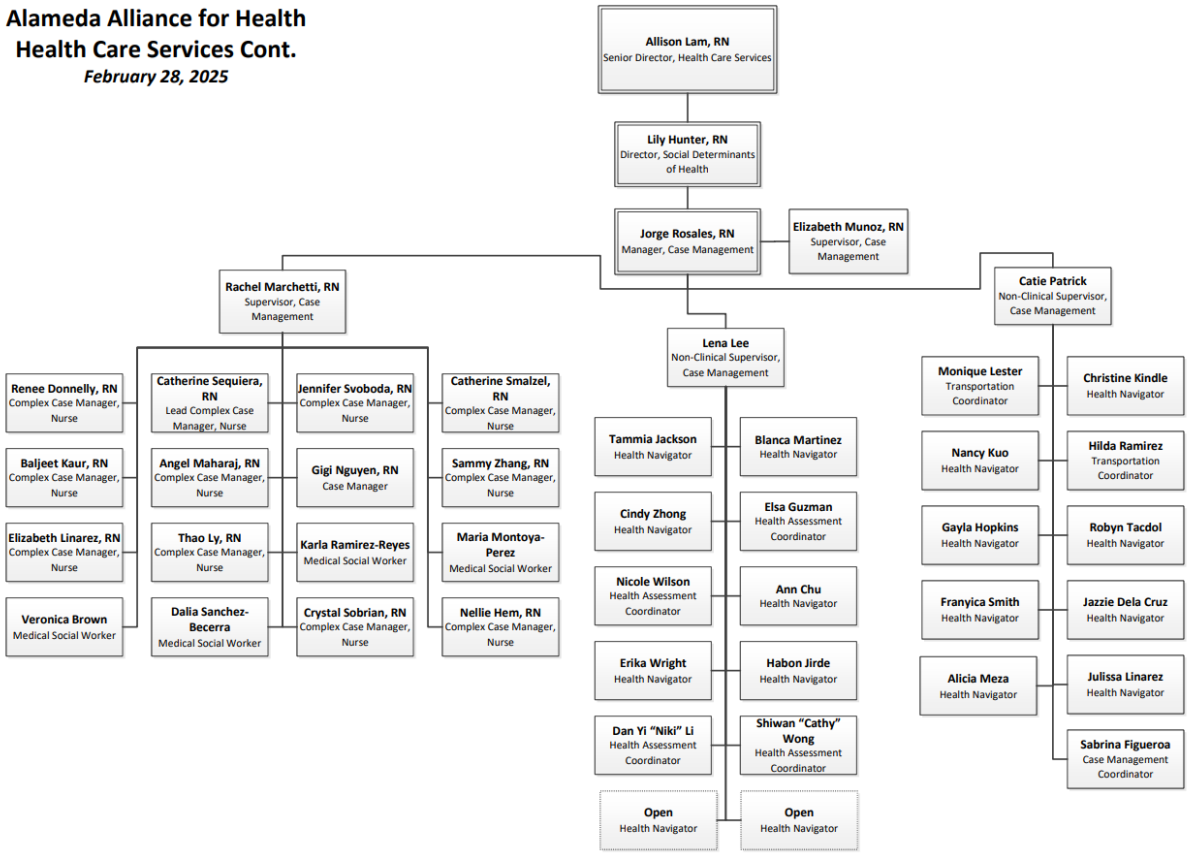


Health Care Services – Quality

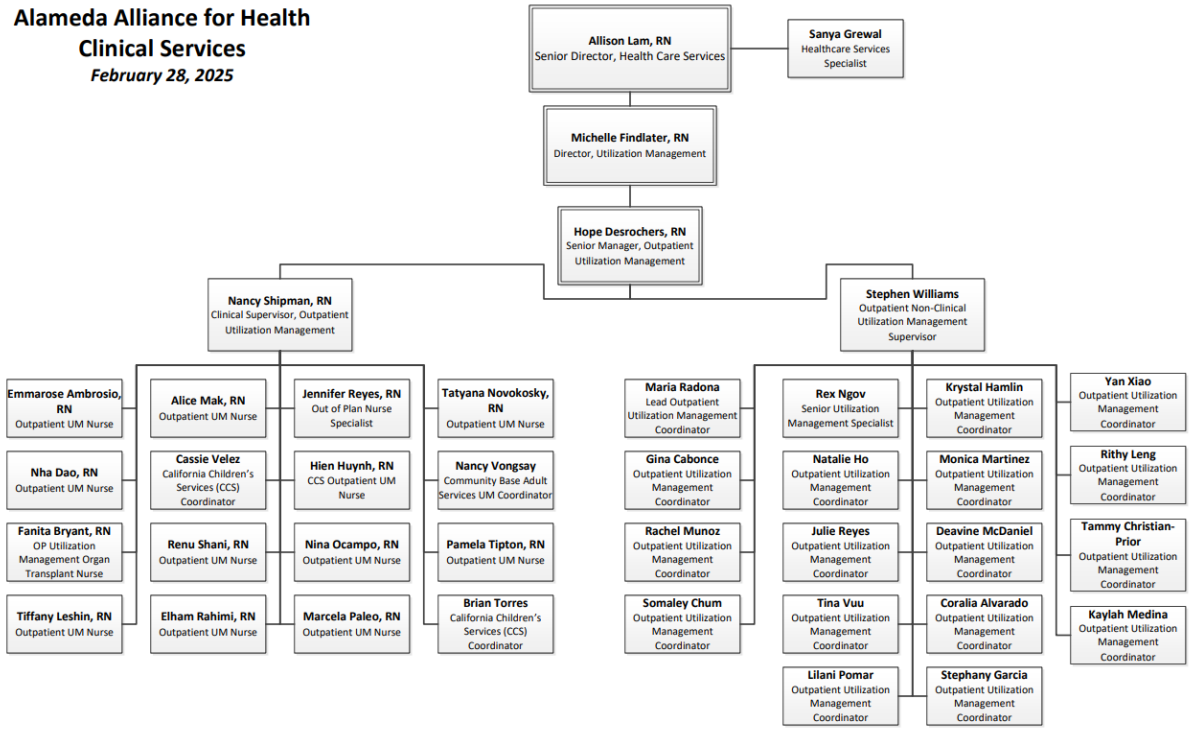


* Added Accreditation Manager, Accreditation & Regulatory Compliance Specialist (2), and Clinical Review Nurses (2) in April 2025

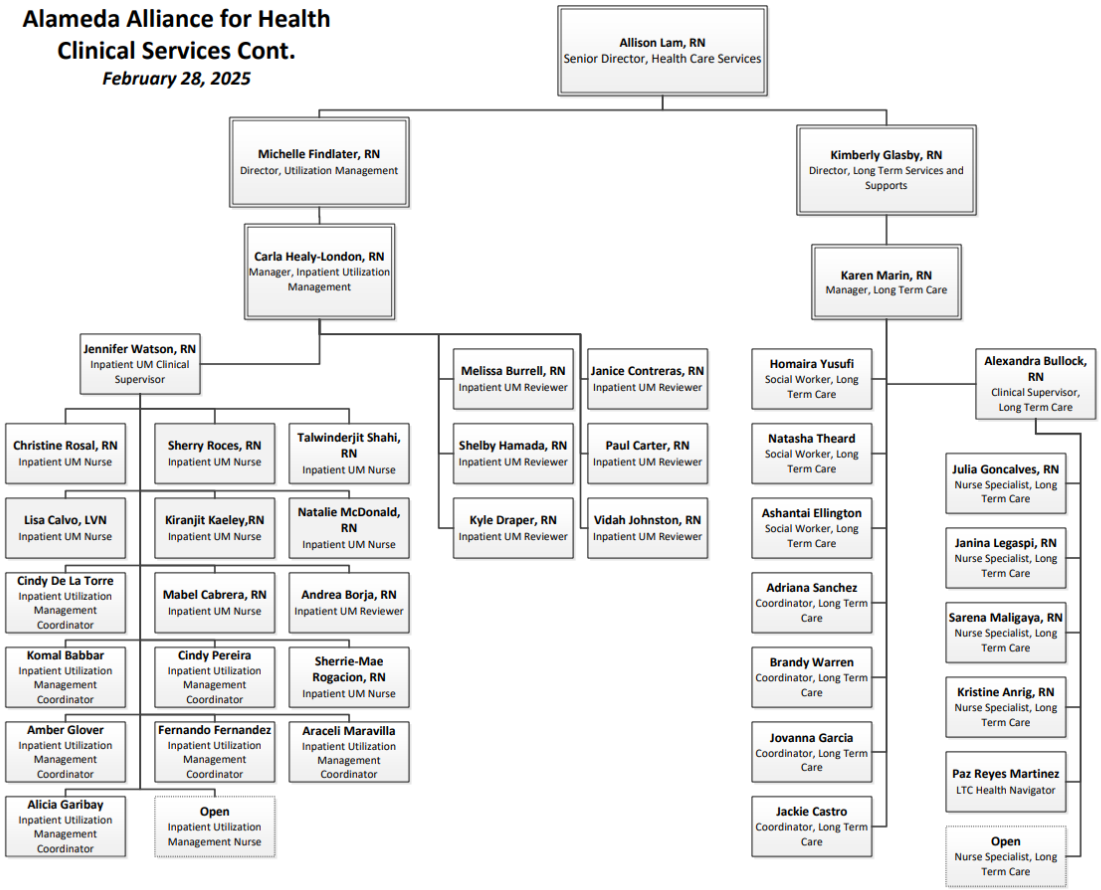
Case Management



Utilization Management – Outpatient

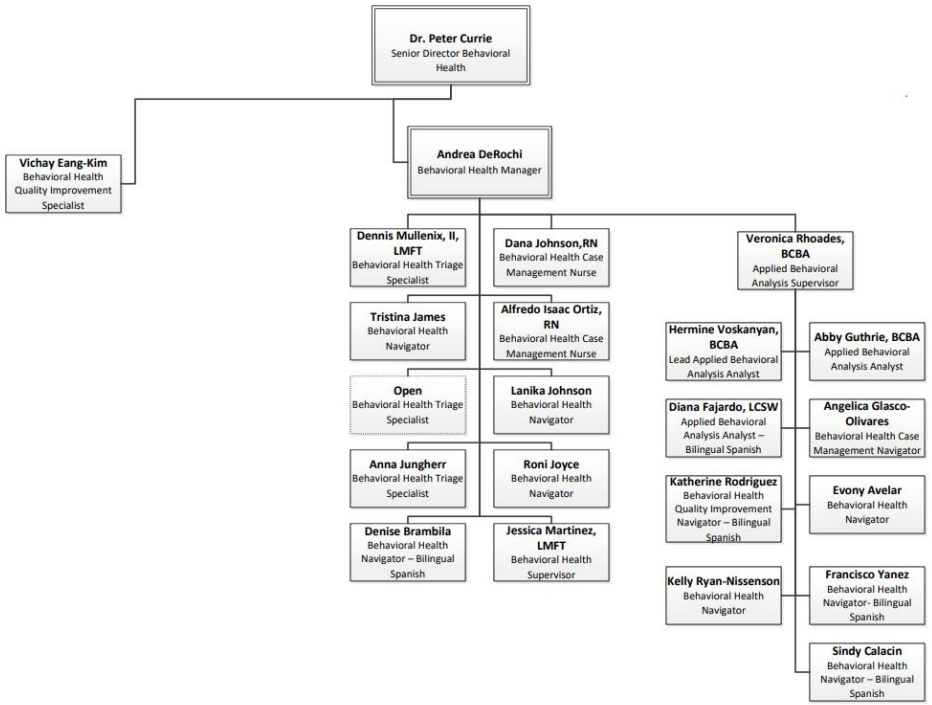


Utilization Management – Inpatient and Long Term Care

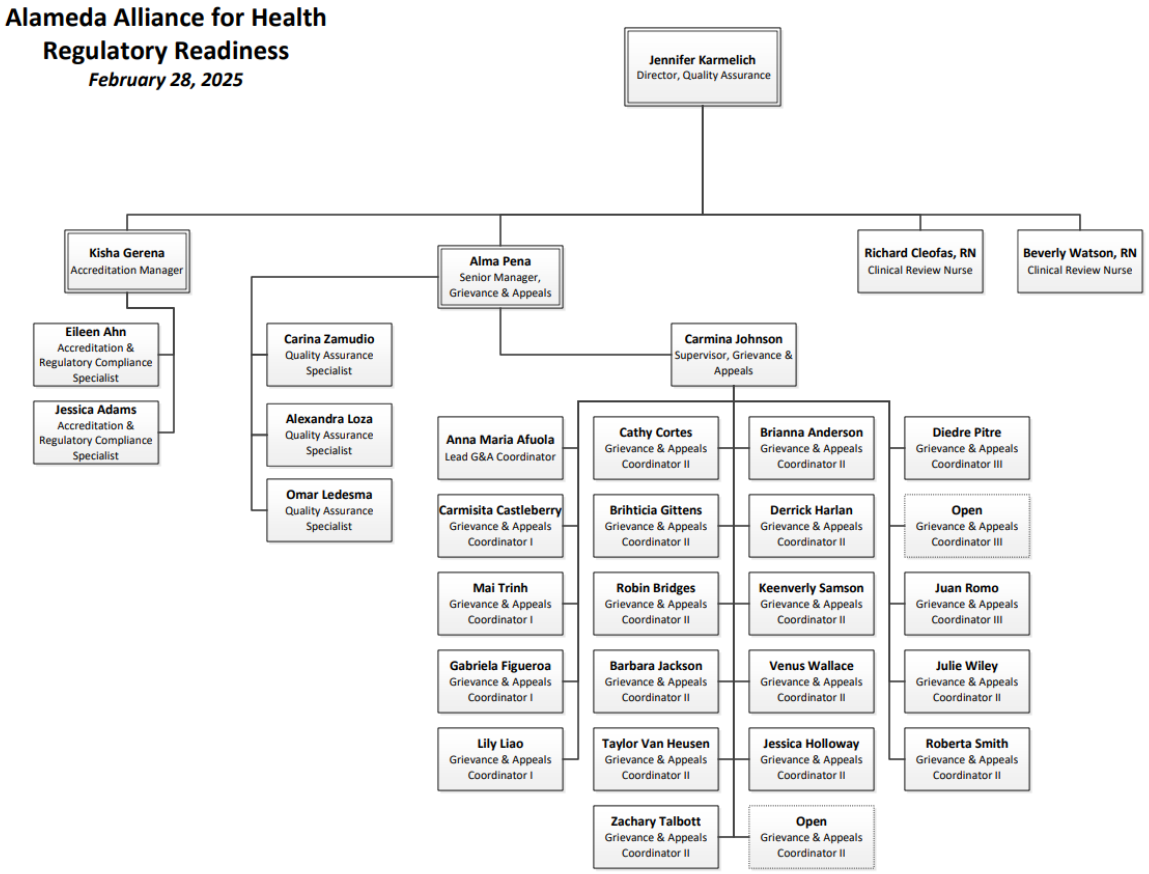

Alameda Alliance for Health
Clinical Services Cont.
February 28, 2025
Allison Lam, RN
Senior Director, Health Care Services
Michelle Findlater, RN
Director, Utilization Management
Kimberly Glasby, RN
Director, Long Term Services and Supports
Carla Healy-London, RN
Manager, Inpatient Utilization Management
Karen Marin, RN
Manager, Long Term Care
Jennifer Watson, RN
Inpatient UM Clinical Supervisor
Melissa Burrell, RN
Inpatient UM Reviewer
Janice Contreras, RN
Inpatient UM Reviewer
Shelby Hamada, RN
Inpatient UM Reviewer
Paul Carter, RN
Inpatient UM Reviewer
Kyle Draper, RN
Inpatient UM Reviewer
Vidah Johnston, RN
Inpatient UM Reviewer
Christine Rosal, RN
Inpatient UM Nurse
Sherry Roces, RN
Inpatient UM Nurse
Talwinderjit Shahi, RN
Inpatient UM Nurse
Lisa Calvo, LVN
Inpatient UM Nurse
Kiranjit Kaeley,RN
Inpatient UM Nurse
Natalie McDonald, RN
Inpatient UM Nurse
Cindy De La Torre
Inpatient Utilization Management Coordinator
Mabel Cabrera, RN
Inpatient UM Nurse
Andrea Borja, RN
Inpatient UM Reviewer
Komal Babbar
Inpatient Utilization Management Coordinator
Cindy Pereira
Inpatient Utilization Management Coordinator
Sherrie-Mae Rogacion, RN
Inpatient UM Nurse
Amber Glover
Inpatient Utilization Management Coordinator
Fernando Fernandez
Inpatient Utilization Management Coordinator
Araceli Maravilla
Inpatient Utilization Management Coordinator
Alicia Garibay
Inpatient Utilization Management Coordinator
Open
Inpatient Utilization Management Nurse
Homaira Yusufi
Social Worker, Long Term Care
Alexandra Bullock, RN
Clinical Supervisor, Long Term Care
Natasha Theard
Social Worker, Long Term Care
Ashantai Ellington
Social Worker, Long Term Care
Adriana Sanchez
Coordinator, Long Term Care
Brandy Warren
Coordinator, Long Term Care
Jovanna Garcia
Coordinator, Long Term Care
Jackie Castro
Coordinator, Long Term Care
Julia Goncalves, RN
Nurse Specialist, Long Term Care
Janina Legaspi, RN
Nurse Specialist, Long Term Care
Sarena Maligaya, RN
Nurse Specialist, Long Term Care
Kristine Anrig, RN
Nurse Specialist, Long Term Care
Paz Reyes Martinez
LTC Health Navigator
Open
Nurse Specialist, Long Term Care

Behavioral Health

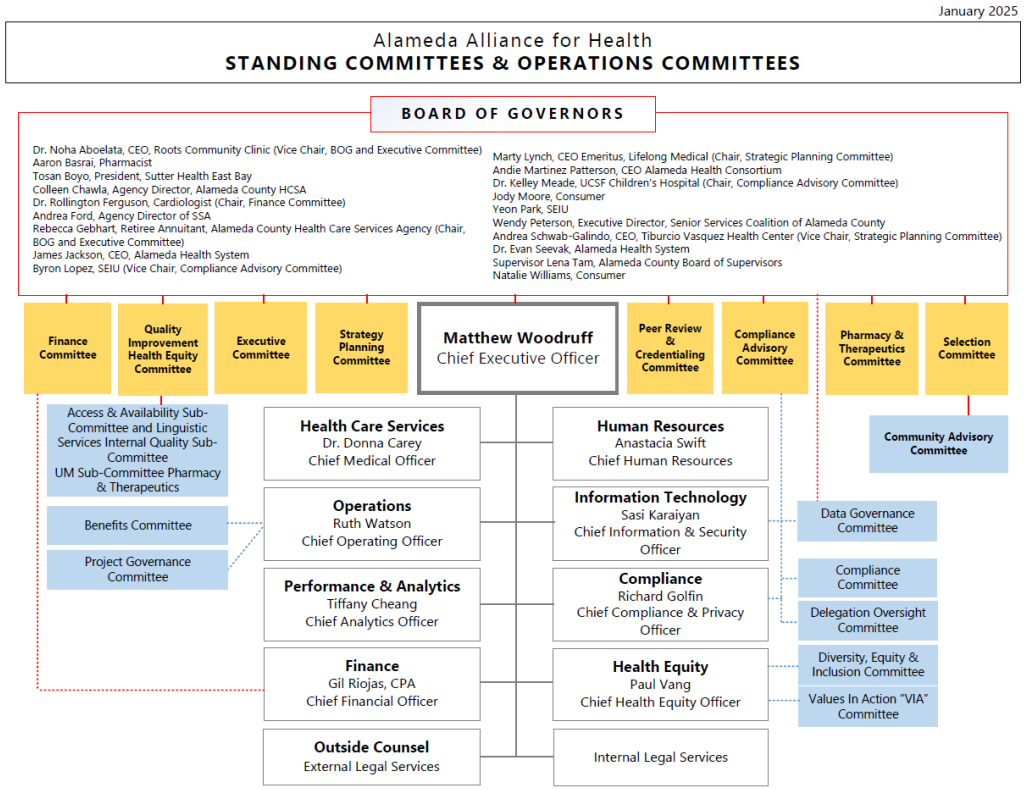
Alameda Alliance for Health
Behavioral Health
February 28, 2025



Regulatory Readiness


Alameda Alliance for Health
Regulatory Readiness
February 28, 2025
Jennifer Karmelich
Director, Quality Assurance
Kisha Gerena
Accreditation Manager
Alma Pena
Senior Manager, Grievance & Appeals
Richard Cleofas, RN
Clinical Review Nurse
Beverly Watson, RN
Clinical Review Nurse
Eileen Ahn
Accreditation & Regulatory Compliance Specialist
Jessica Adams
Accreditation & Regulatory Compliance Specialist
Carina Zamudio
Quality Assurance Specialist
Alexandra Loza
Quality Assurance Specialist
Omar Ledesma
Quality Assurance Specialist
Carmina Johnson
Supervisor, Grievance & Appeals
Anna Maria Afuola
Lead G&A Coordinator
Carmisita Castleberry
Grievance & Appeals Coordinator I
Mai Trinh
Grievance & Appeals Coordinator I
Gabriela Figueroa
Grievance & Appeals Coordinator I
Lily Liao
Grievance & Appeals Coordinator I
Cathy Cortes
Grievance & Appeals Coordinator II
Brihticia Gittens
Grievance & Appeals Coordinator II
Robin Bridges
Grievance & Appeals Coordinator II
Barbara Jackson
Grievance & Appeals Coordinator II
Taylor Van Heusen
Grievance & Appeals Coordinator II
Zachary Talbott
Grievance & Appeals Coordinator II
Brianna Anderson
Grievance & Appeals Coordinator II
Derrick Harlan
Grievance & Appeals Coordinator II
Keenverly Samson
Grievance & Appeals Coordinator II
Venus Wallace
Grievance & Appeals Coordinator II
Jessica Holloway
Grievance & Appeals Coordinator II
Open
Grievance & Appeals Coordinator II
Diedre Pitre
Grievance & Appeals Coordinator III
Open
Grievance & Appeals Coordinator III
Juan Romo
Grievance & Appeals Coordinator III
Julie Wiley
Grievance & Appeals Coordinator II
Roberta Smith
Grievance & Appeals Coordinator II

APPENDIX B: Alameda Alliance Committees



2025 Quality Improvement & Health Equity (QIHE) Work Plan

	Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification *(Update this column)*	Q1, 2025	Q2, 2025	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues (if applicable)
QIHE Evaluation	Title: Sr. QI Director Name: Michelle N. Stott	Title: Sr. QI Director Name: Michelle N. Stott	N/A	**Annual QIHE Program Evaluation**	Y	**Continued**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee	The QIHE Program Evaluation was updated and approved in IQIC, with final approval by QIHEC on May 9, 2025.		All Sub-Committees and QIHEC	12/31/25	Incorporated BH and SNF/LTC Quality Monitoring
Quality of Care	Title: Senior Director, Quality Name: Michelle Stott	Title: Manager, Quality Improvement Name: Fareshta Zainal	Title: Manager, Quality Improvement Name: Fareshta Zainal	**HEDIS Rates MY 2025**	N	**Continued**	Increase the HEDIS/MCAS measures below MPL in MY2025 to meet or exceed MPL by December 31, 2025	Measure below MPL AMR, CBP, TFL. Continue work providers below MPL for these measures to identify gaps and design interventions to improven rates. Provide support through member incentives, provider incentive, provider specific reports and educate staff on measure specification and coding.		Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/25	Due to the pandemic AAH saw a decline in HEDIS measures with multiple years of service. Furthermore, state wide insufficient lead screening kits may be a factor in declining lead screening rates.
	Title: Senior Director, Quality Name: Michelle Stott	Title: Manager, Quality Improvement Name: Fareshta Zainal	Quality Performance Team	**Pay For Performance (P4P) Program**	N	**Continued**	By 12/31/2025, the Quality Performance Team will help clinics meet or exceed their established P4P goals (50th or 75th Percentile). This will be accomplished by providing performance updates to clinics, sharing best practices, and offering project support during their established Quality Meetings.	Continued to meet with providers/delegates to share rates, educate on measure specificatin, share best practices and support on QI projects. Offered 4 webinars on HEDIS/MCAS measures to educate provider on measure specification and share best practices.		Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/25	The P4P program has been a successful tool used to support providers improve HEDIS rates
	Title: Senior Director, Quality Name: Michelle Stott	Title: Manager, Quality Improvement Name: Fareshta Zainal	Title: Supervisor, Quality Performance Name: James Burke	**Learning Academy**	N	**Continued**	By December 31, 2025, the Quality Performance Team will: -<u>QP PDSA Cycle Trainings</u>: Offer two QI PDSA Cycle Training opportunities for providers to learn and apply the PDSA (Plan-Do-Study-Act) methodology, with at least 70% of registered providers attending each session. -<u>MCAS Trainings</u>: Offer four learning opportunities to the provider network on MCAS measures. These sessions will cover measure specifications and best and promising practices. -<u>Member Education</u>: Will develop and deliver, in collaboration with Health Education and Health Equity, at least one member education session on the importance of preventive care. This session will be presented to a minimum of one Community-Based Organization (CBO) identified by the team.	Completed webinars for Measure Highlight Webinars on the following topics: Initial Health Appointments (IHAe) and Childhood Domain), and a three-part series for ABCs of QI. Continuing planning for other Measure Highlight Webinars for Behavioral Health, Chronic Disease, Cancer Prevention, and Reproductive Health.	Completed Measure Highlight Webinars on topics: Behavioral Health and Chronic Disease. Planning is continuing for Cancer Prevention and Reproductive Health.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/25	As quality improvement (QI) projects spread throughout the Health Care Service team, it is essential that all staff have an understanding of the PDSA model for improvement. The model provides a vehicle to drive QI projects
	Title: Senior Director, Quality Name: Michelle Stott	Title: Manager, Quality Improvement Name: Fareshta Zainal	Title: Qi Project Specialist II Name: Kaiti Aerat	**Priority PIP: Improve FUA/FUM - improve 30 day follow-up rate**	N	**Continued**	By December 31, 2025, Alameda Alliance will improve the 7-day provider notifications rate by 2% for members visiting the ED with SUD/SMH diagnoses.	In MY 2024, the Alliance was providing a report of members visiting the ED with SUD/SMH diagnoses daily to AHS, CHCN, Roots, and weekly to CFMG. Beginning 2Y/2025, the Alliance has started providing the same type of reprot weekly to 11 direct primary care providers to improve the 7-day provider notification rate.		Internal Quality Improvement Committee	12/31/25	This is a continued PIP topic that was assigned by the state based on low performance.
	Title: Senior Director, Quality Name: Michelle Stott	Title: Manager, Quality Improvement Name: Fareshta Zainal	Title: QI Project Specialist II Name: Fatmata Abatcha	**Equity PIP: Improve Well Child - W15 (6) for African American Children**	Y	**Continued**	To address the disparity that exists with Well Child visits, by December 31, 2025, increase the percentage of well-child visits (W30-6) amongst African American children between the ages of 0-15 months from 30.54% to MPL.	Telephonic Outreach for Well-Care Visits. Through out First Quarter of 2025, each month QI Engagement Coordinators conducted two rounds of telephonic reminder calls to the target population (W15 Well child Visits 0-15 months) . The purpose of these calls was to: Remind members to complete their well-care visits Provide navigation support to connect with their primary care providers Assess transportation needs and assist with connections to Modivcare, if necessary These outreach efforts will continue into Q2 to further support member engagement and access to care.	The QI Coordinators conduct monthly outreach calls to members to remind them to schedule Well-Child visits with their primary care provider (PCP). In collaboration with CFMG Provider Relations Manager, Sharon Wright, we are working closely with providers whose patients have no recorded visits. The goal is to identify strategies to engage these members—whether by encouraging them to seek care with their assigned PCP or supporting a PCP change if preferred. In addition to phone outreach, we are developing targeted mailers focused on preventive care. These mailers will specifically reach members who have no valid phone number on file or whose contact numbers are currently disconnected, ensuring continued outreach efforts to this hard-to-reach population. We are also partnering with Alameda Health System to promote well-child visits through their Centering Program for Black American babies aged 0–15 months. As part of this initiative, participating families are eligible to receive a $25 MasterCard incentive to encourage early childhood care engagement and support positive health outcomes.	Internal Quality Improvement Committee	12/31/25	This is a newly assigned PIP. PIP topic was assigned by the state based on low performance
	Title: Senior Director, Quality Name: Michelle Stott	Title: Manager, Quality Improvement Name: Fareshta Zainal	Title: QI Project Specialist II Name: Sangeeta Singh	**Workgroup: Reproductive Health and Cancer Prevention**	Y	**Continued**	By December 31, 2025, the Alliance will improve on cancer prevention and reproductive health measures in the MCAS/P4P, by conducting improvement projects to increase the MY2025 rates by 3% over MY2024 rates. - Increase breast and cervical cancer screening rates for Alliance direct providers to 3 percent over prior years rate by end of 2025 - As of 1/7/2025: -BCS-1 of 1/7/2025- 53.03% to 56% - As of 1/7/2025- - CCS-MY2024 40.37% to 42.37% - Continue to focus increasing BCS rates for African American women - As of 1/7/2025- MY2024 the rate is 52.36% below MPL at 52.68%. Aim to increase final rate by 3 percent. Continue to focus increasing CCS rates for age band 24-30 As of 1/7/2025- MY2024 rate is 37.83%. Aim to increase the final rate by 3 percent. Cancer Prevention and Reproductive Health Measures: CCS, BCS, COL, PPC 1, PPC 2, and CHL.	In Q1, the Cancer Prevention & Reproductive Health workgroup focused on targeted outreach. The following projects were launched in Q1: •CCS- Incentive Birthday Card outreach for Alliance Direct Providers (10 providers) with follow up outreach calls from our internal engagement coordinators •BCS- Flyer + outreach call outreach for African American members under the Alliance Direct providers with follow up outreach calls from our internal engagement coordinators •BCS Flyer +outreach task -For African American Bayaeli members. to members via texting and offer $25.00 •CCS Incentive Outreach for 24-30 year olds- Bayaeli will outreach to members via texting and offer $25.00 for completed paps. Bayaeli will send a report biweekly for AAH to upload for Nations to mail gift cards. Axis is also interested however awaiting confirmation to begin the project. •CBO- In collaboration with Health Education, a PowerPoint to present at CBO's was developed and submitted for C&O approval. •Mobile mammography is continuing with the providers and a member incentive of $25.00 is offered for completed mammograms •Continuing to outreach to providers for support with CCS •CCS and BCS measure highlight created as a provider resource. CCS has been completed however BCS is undergoing final review. •Exploring HPV self-testing kits with 2 vendors, and creating a workflow for providers Practice Facilitation with Roots Community Health to improve CCS workflow		Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/25	
	Title: Senior Director, Quality Name: Michelle Stott	Title: Manager, Quality Improvement Name: Fareshta Zainal	Title: QI Project Specialist II Name: Fatmata Abatcha Title: QI Project Specialist I Name: Patty Carrillo	**Workgroup: Well Child**	N	**Continued**	By December 31, 2025 the Alliance will improve on well-child measures in the MCAS, by: -Conducting improvement projects to increase the rates from below the MPL and to further increase rates to meet the 90th percentile: Well Child Measures: W15, W30, WCV, CIS10, IMA, DEV, TFL -By Dec 31,2025, CFMG will increase the number of MPLs achieved from 3 to 5 by implementing targeted training, process optimizations, and performance monitoring, ensuring all teams have equitable access to the necessary resources and support. Progress will be reviewed quarterly to maintain momentum and adjust strategies as needed.	In Q1, the Well Child Workgroup contributed to the following initiatives: -Birthday Card Distribution for NAHC and Axis Community Health. Planning with Roots Community Health Center began in Q1 for a Q2 launch. -Immunization flyers/posters in provider clinics. -Billboards and public transportation flyers around Alameda County promoting well-visits. -PSA on Radio Stations to promote well-visits. -Video PSA on DMV to promote well-visits. -Planning for HEDIS Crunch began in collaboration with CFMG.	Workgroup Activities and Member Engagement Initiativesin Q2 2025, the Workgroup continues to support initiatives aimed at increasing well-child visits by contributing ideas and strategies to improve member engagement. Collaborative efforts include working with the Communications & Outreach (C&O) team and the Health Education Department to develop disease awareness posters focused on Pneumococcal and Hepatitis B (Hepb) vaccines. The Workgroup also remains actively involved in the Birthday Card Initiative and the HEDIS Sprint, ensuring that all outreach campaigns receive the appropriate planning, execution, and support needed to maximize member outreach and improve health outcomes.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/25	This workgroup is committed to fostering collaboration among QI department teams to enhance performance on Well-Child measures.
	Title: Senior Director, Quality Name: Michelle Stott	Title: Manager, Quality Improvement Name: Fareshta Zainal	Title: QI Project Specialist II Name: Megan Hils	**Workgroup: Chronic Disease Management**	N	**Continued**	By December 31, 2025, Alameda Alliance for Health (AAH) will improve the administrative rates for chronic disease management hybrid measures as follows: CBP: 49% (MY2023) to 65% (MPL) GSD: 32% (MY2023 HBD) to 29% (90th pctl) By December 31, 2025, Alameda Alliance for Health (AAH) will improve the rate for chronic disease management AMR as follows: AMR: 68% (MY2024) to 77% (90th pctl) By December 31, 2025, Alameda Alliance for Health (AAH) will improve data collection for CBP and GSD measures among direct providers from: CBP: 79% to 50% missing or incomplete GSD: 37% to 25% missing	QI engagement team is conducting two outcall campaigns for CBP and GSD: 1 focused on members assigned to direct PCPs with no PCP visit in the last year: includes members who are missing A1c and/or BP, noncompliant for either or both, or compliant for both. The second campaign is in partnership with Alameda Health System: call members with no record of receiving a BP monitor, ask if they want to have a monitor delivered; 100 members on outcall list		Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/25	This workgroup supports the goal of creating a culture of quality improvement goals throughout the organization and increases alignment of quality improvement efforts across QI department teams. These goal were developed in the context of challenges collecting data for CBP and GSD measures, especially among direct providers, consistent administrative performance below hybrid rates, and steadily decreasing rates for AMR after several years of high performance.
	Title: Senior Director, Quality Name: Michelle Stott	Title: Manager, Quality Improvement Name: Fareshta Zainal	Title: QI Project Specialist II Name: Kaiti Aerat	**Workgroup: Behavioral Health**	N	**Continued**	By December 31, 2025, Alameda Alliance for Health will sustain FUA HEDIS rates and improve FUM HEDIS rate by 2% from MY2024 to MY2025 to meet/exceed MPL. MY 2024 rates as of 5/1 FUA: 41.44% FUM:66.38 % Collaborate with BH Department in development of disease management for depression. Collaborate with ACBH to deseminate resources to providers and encourage data sharing.	1st round of PDSA for outreaching members on FUA/FUM report: QI engagement coordinators called 100 members who were on the the FUA/FUM reprot. The coordinators were able to make 17 successful contact, i.e. 17 members picked up the phone and were either transfered to their PCP or given information on how to connect with their PCP or confirmed they had a follow up. During the next PDSA in Q2, the QI engagement coordinators will warm transfer the member to the Behvioral Health team who will complete an assessment and connect the member to the appropriate level of care. QI collaborated with Behavioral Health and ACBH to plan a Behavioral Health Town Hall to deseminate resources to primary care providers.		Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/25	This workgroup supports the goal of creating a culture of quality improvement goals throughout the organization and increases alignment of quality improvement efforts across QI department and the Behavioral Health Departments. These goals were developed in the context of challenges of data sharing with Alameda County for the FUA and FUM measures.
	Title: Senior Director, Quality Name: Michelle Stott	Title: Manager, Quality Improvement Name: Fareshta Zainal	Title: Supervisor, Quality Performance Name: James Burke	**Member Engagement Program**	N	**Continued**	By 12/31/2025, the Member Engagement Program will close care gaps in the DHCS MCAS measures by reaching or exceeding the MPLs. This will be achieved through the following actions: -Conducting at least 3,000 outcalls quarterly to engage with members and identify care gaps. -Collaborate with at least one provider, quarterly, to implement member-focused campaigns. -Actively participate in at least four quality improvement projects, in the year, related to member engagement, contributing to measurable improvements.	Conducted outreach to members to provide health reminders and assist in accessing care to visist that correlate to the following measures: BCS, CBP, CCS, FUA, FUM, GSD, W15, and WCV.		Internal Quality Improvement Committee	12/31/25	
	Title: Senior Director, Quality Name: Michelle Stott	Title: Manager, Quality Improvement Name: Fareshta Zainal	Title: Supervisor, Quality Performance Name: James Burke	**IHI/DHCS Equity Learning Collaborative - Children's Health**	Y	**Continued**	The focus of the Child Health Equity Collaborative is to improve the completion of well-child visits, ages 0-21. The Alliance will conduct Evidence-Based Interventions: -Equity & Transparent, Stratified, and Actionable Data (April-May 2024) -Understand Provider and Patient/Caregiver Experiences (June-July 2024) -Plan and Implement PDSAs with Provider Partners (August-October 2024) -Asset Mapping & Community Partnerships (November-December 2024) -Partnering for Effective Education & Communication (January-March 2025)	Project concluded with IHI/DHCS. Roots abandoned their PDSA and is starting a new one on Birthday Cards. LeNoir stopped their participatoin. IHI announced another learning collaborative will be announced in Summer 2025.		N/A	3/31/25	
Population Health Management	Title: Sr. QI Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Population Needs Assessment**	Y	**New**	Provide meaningful contributions to LHJ CHA/CHIPs (including resources, in-kind staffing, and data sharing) by Q4 of 2025.	Received and processing resource contribution and in-kind staffing requests from Alameda County and data request from City of Berkeley. Continued monthly meetings with both LHJs and Kaiser Permanente for collaboration updates and discussion.		Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Population Health Management - PHM Monitoring**	Y	**Continued**	Implement population-based PHM framework to inform monitoring processes and RSS guidance by the end of 2025.	PHM consultant ideas42 drafted a measurement framework with input from other departments involved in population health. Proposed dashboard design and functions under review by Analytics.		Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Population Health Management - PHM Strategy**	Y	**Continued**	Develop the Alliance 2025 PHM Strategy to address priority gaps in care and disparities in compliance with DHCS and NCQA requirements.	Completed 2024 PHM Evaluation, 2025 PHM Assessment, and activities and resources update for 2025 PHM Strategy development.		Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025	
Quality of Care	Title: Sr. Director, Pharmacy Services Name:	Title: Clinical Pharmacist Name: Ramon Tran Tang	N/A	**QIP #5: Opioid / SUD - Continuation**	N	**Continued**	Goal 1: By 12/31/25, educate chronic opioid users on health habits, management of chronic pain, and alternative therapy and care (< 120 MME/day). Goal 2: By 12/31/25, educate opioid users at risk of becoming chronic users (i.e., 50 to 119 MME/day).	Next automated mailing on 6/7/25. All educational handouts are updated. C&O request will be sent in May.		Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025	Staff bandwidth and staffing transition
	Title: Sr. Director, Pharmacy Services Name:	Title: Clinical Pharmacist Name: Ramon Tran Tang	N/A	**QIP #5: Opioid / SUD - Continuation**	N	**Continued**	Goal 3: By 12/31/25, educate providers who are assigned members that utilize high dose opioids (>120MME) and who are presenting to the Emergency Department with opioid and / or benzodiazepine overdose.	Next automated mailing on 6/7/25. All educational handouts are updated. C&O request will be sent in May.		Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025	Staff bandwidth and staffing transition
	Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name:	Title: QI Supervisor Name: Christine Rattray	**Potential Quality Issues (PQIs) Continuation- Quarterly**	N	**Continued**	Monitor, evaluate, and take effective action with +/- 95% PQI closure within 120 days to address any needed improvements in the quality of care delivered by all providers rendering services on behalf of the Alliance in any setting along with internal data validation.	Q1 results for PQI QOC case closure met the threshold at 97.63%		Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. Medical Director Name:	Title: QI Supervisor Name: Christine Rattray	**PQI Corrective Action Plan Tracking & Trending**	N	**New**	Monitor, evaluate and take effective action where appropriate on all Corrective Action Plans (CAPs) issued. Assess effectiveness of track and trend reports and refine if needed.	In Q1 2025 there were a total of 5 CAPs issued with no trends identified. These included 3 LTC providers and 2 Modivcare QOC issues.		Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025	2024 CAP report presented at BOG and IQIC in March 2025
	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. Medical Director Name:	Title: QI Supervisor Name: Christine Rattray	**Exempt Grievances Auditing- Biannual**	N	**Continued**	Ensure clinical monitoring of Exempt Grievances for Quality of Care, Service, Access and Language issues per P&P QI-104 through bi-annual review of 100 randomly selected Exempt Grievances.	An Exempt Grievance audit was performed in January which returned a compliant score of 100%. Next audit will be performed in June 2025		Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. Medical Director Name:	Title: QI Supervisor Name: Christine Rattray	**Potential Quality Issues (PQIs) Annual Training**	N	**Continued**	Plan provides documented evidence of ongoing annual training on PQIs by clinical staff for both new and seasoned customer service staff who serve as the front-line entry for the intake of all potential quality of care grievances	PQI annual training was done in Februrary at HCS All Staff meeting and with CHCN in March ; MSD provides training to their staff.		Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025	

2025 Quality Improvement & Health Equity (QIHE) Work Plan

	Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification *(Update this column)	Q1, 2025	Q2, 2025	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues (if applicable)
QIHE Evaluation	Title: Sr. QI Director Name: Michelle N. Stott	Title: Sr. QI Director Name: Michelle N. Stott	N/A	**Annual QIHE Program Evaluation**	Y	**Continued**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee	The QIHE Program Evaluation was updated and approved in IQIC, with final approval by QIHEC on May 9, 2025.		All Sub-Committees and QIHEC	12/31/25	Incorporated BH and SNF/LTC Quality Monitoring
Safety	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. Medical Director Name:	Title: QI Supervisor Name: Christine Rattray	**Provider Preventable Conditions (PPCs) workflow**	N	**New**	Refine Provider Preventable Conditions (PPCs) workflow in collaboration with other departments.	The PPC workflow was reviewed and updated with appropriate State portal access for reporting puposes. Collaboration between Claims and QI occurred in Q1 and led by QI Sr Director		Internal Quality Improvement Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. Medical Director Name:	Title: QI Supervisor Name: Christine Rattray	**PQI Modiv/Care Focus**	N	**New**	On tracking and trending of PQI cases as well as a review of grievances, we note a substantial number of C1 / C2 cases and member complaints related to missed rides. Collaborate with Modivcare and Vendor Management to address any preventable system issues.	Ongoing collaboration between Modivcare and AAH Vendor Mgt, CMDM, G&A and QI continues to be an ongoing effort in order to reduce the number of missed rides for AAH members. The PQI team meets as needed to review PQI cases to address trends, obtain responses from Modivcare and obtain CAP responses.		Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. Medical Director Name:	Title: QI Coordinator Name: Jamisha Jefferson	**IHA Audit**	N	**New**	Perform IHA audit bi-annually and distribute educational letters to providers. Determine if there are any provider trends for two consecutive audits and implement a follow up plan.	The DHCS focused audit was completed in March 2025 and IHA deliverables were submitted as requested. During the on-site audit, the main focus was on immunizations and activities to support completion. The next IHA chart audit is planned for June 2025		Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Access to Care Manager Name: Loc Tran	Title: Sr. QI Nurse Specialist Name: Kathy Ebido	**Facility Site Review (FSR) Continuation**	N	**Continued**	100% of corrective action plans for periodic (full-scope) site reviews (FSR/MRR) are received within 30 days and closed within 90 days of FSR/MRR Report. CAP closure do not exceed 120 days from FSR/MRR Report.	24 CAPs (88%) received within 30 days for Q1 reviews. There are 9 open CAPs active and pending closure as of 3/31/25. 24 CAPs (96%) closed within 90 days for which includes 2024 Q4 reviews. All CAPs were closed before 120 days from the FSR/MRR Report date.		Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/25	
	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. Medical Director Name:	Title: QI Supervisor Name: Christine Rattray	**Inter-rater Reliability (IRR) Continuation-Annual**	N	**Continued**	IRR is performed annually to ensure >/=90% IRR consistency and accuracy of review criteria applied by all clinical reviewers - physicians and non-physicians - who are responsible for conducting clinical reviews and to act on improvement opportunities identified through this monitoring.	An IRR was performed in January which included 2 MD reviewers and 5 RN reviewers. The results were 100%. Next IRR planned for Jan 2026.		Internal Quality Improvement Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. QI Director Name:	Title: Sr. QI Nurse Name: Kathy Ebido	**Skilled Nursing Facility/Long Term Care (SNF/LTC) Quality Monitoring**	N	**Continued**	Continue to monitor SNF/LTC quality monitoring tools to meet APL 23-004 SNF/LTC Benefit Standardization: 1) Obtain 60% of the SNF attestation by 12/31/25. 2) Draft standard operating procedures (SOP) as to actions taken for providers with quality of care trends 3) Monitor quality measures (i.e. HEDIS/MCAS) with the LTC team and develop interventions for trends.	As of 3/31/25, 64 attestations were received out of 104 SNF sites (62%) We will continue to closely monitor and update the ratings of skilled nursing facilities each month, ensuring that all contracted locations meet high-quality standards. In addition to tracking census data, we collect and verify CAPI attestations to support continuous improvement in patient care across facilities.		Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025	
Member Experience/Access & Availability	Title: Sr. QI Director Name: Michelle Stott	Title: QI Manager Name: Fareshta Zainal	Title: Manager of Quality Improvement Name: Fareshta Zainal	**QIP #4: Increase Initial Health Appointment rates**	N	**Continued**	By 12/31/2025 Improve IHA completion rates from MY2024 to MY2025 by 3%.	Included IHA in the P4P program. During provide/delegate QI meetings IHA rates are shared with providers. Included IHA as part of the QIP for extended office hours. Conducted IHA webinar on 2/20/2025.	r	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025	State issued CAP for IHA
	Title: Sr. QI Director Name: Michelle Stott	Title: Access to Care Manager Name: Loc Tran	Title: QI Specialist Name: Tanisha Shepard	**CG-CAHPS Survey Continuation (Quarterly)**	N	**Continued**	Ensure that quarterly survey questions align with DMHC timely access and language requirements to evaluate member clinical & group satisfaction/experience with Timely Access Standards - Office Wait Time, Call Return Time, Time to Answer Call. To ensure that the survey results are actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. The compliance threshold goal for Call Return Time and Time to Answer Call remains 70% (with a stretch goal of 80%). In Office Wait Time goal remains 80% for 2025. Started Q2 2024, CG-CAHPS will includes BH providers. Specialist providers will be added to CG-CAHPS survey starting Q1 2025.	Q4 2024 CG-CAHPS data pending with Analytics		Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Access to Care Manager Name: Loc Tran	Title: QI Specialist Name: Tanisha Shepard	**Provider Satisfaction Survey Continuation (Annual)**	N	**Continued**	Annually, timely completion of measures for provider and staff satisfaction/experience with the health plan and department services. To ensure that the survey meets NCQA requirements and is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. **Fielding Sep - November 2025.** Goal: 2% increase from previous year overall satisfaction rate.	Results received Dec, 2024. Overall Satisfaction Plan Rating for MY2024 is 80.7% up by 2.3% points from MY2023 - 78.4%. Met or significantly higher scores compared to PG Commercial and Aggregated BoB. Results shared with COO/CEO for review and evaluation of next steps. Nas meeting with PG on Feb 19, 2025		Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Access to Care Manager Name: Loc Tran	Title: QI Specialist Name: Fiona Quan	**CAHPS 5.1 (Member Satisfaction Survey) Continuation (Annual)**	N	**Continued**	Measures member experience with health plan and affiliated providers. To ensure that the annual survey aligns with NCQA standards and is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities for member experience. **Fielding: Feb. - May of 2025.** Goal: 2% increase from previous year overall satisfaction rate.	MY2024 Survey Results still in pending from PG		Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Access to Care Manager Name: Loc Tran	Title: QI Specialist Name: Tanisha Shepard	**After Hours Care Continuation (Annual)**	N	**Continued**	Audits provide after-hours protocols (Emergency Instructions/Access to Provider) and availability according to DMHC/NCQA methodology/standards for PCP, Spec. and BH providers. To ensure that the survey is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. Maintains 80% compliance rate for After Hour Survey. **Fielding September 2025.**	**Primary Care Providers** Numerator: 57 Denominator: 63 Compliance Rate: 90.8% Goal Met: Y Goal: 80% **Specialists** Numerator: 151 Denominator: 172 Compliance Rate: 88.8% Goal Met: Y Goal: 80% **Behavioral Health** Numerator: 63 Denominator: 81 Compliance Rate: 77.8% Goal Met: N Gap to Goal: 2.2% Goal: 80%		Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Access to Care Manager Name: Loc Tran	Title:QI Specialist Name: Fiona Quan	**Initial Pre-Natal Visits Continuation (Annual)**	N	**Continued**	To ensure that the survey aligns with DHCS requirements and is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities related to OB/GYN appts offered according to Timely Access Standards. Reach or exceed 75% compliance rate for First Prenatal appointment. **Fielding Sep - Oct. 2025** **HEDIS Prenatal visits: 85.36 baseline to 85.40 admin (MPL) - increase by 3%**	MY2024 Survey Results were presented at the March 25, 2025 A&A Sub Committee Numerator: 31 1 Denominator: 63 Compliance Rate: 49.2% Goal: 75% Goal Met: No Gap to Goal: 25% 1.Non-Responding provider/delegates: Provider education regarding the First Pre-Natal Visit survey and regulatory requirements. A&A have issued corrective action plans (CAPs) to non-responding providers. 2.Ineligible providers: The list of ineligible providers will be shared with Provider Services and the Data Analytics department with the intent of ensuring optimal provider database integrity to generate a reliable provider sample. 3.Non-Compliant Providers / delegates / groups: Provider education regarding the First Pre-Natal Visit survey and regulatory requirements. A&A have issue corrective action plans (CAPs) to non-compliant providers. 4.Track and trend OB/GYN QOA PQI reports to identify non-compliant providers for education and ongoing compliance.		Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name:	Title: QI Specialist Name: Fiona Quan	**PAAS (Provider Appt Availability Survey) Continuation (Annual)**	N	**Continued**	To ensure that the annual survey aligns with DMHC requirements to assess appointment availability is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. Maintains a 75% compliance rate for urgent and non-urgent appointment. **Fielding Sep - Dec. 2025**	MY2024 Survey Results pending from QMetric		Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name:	Title: QI Specialist Name: Fiona Quan	**Provider Visits and Training**	N	**Continued**	Conduct at least 4 site visits per quarter to provider offices/clinics and provide training on timely access standards through the end of 2025.	03/13/2025 TVHC 03/28/2025 AXIS Community Health		Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025	
Health Education	Title: Sr. QI Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Health Education Operations**	N	**Continued**	1.1 - Maintain a 95% fulfillment rate for health education material requests and referrals within 10 business days for threshold languages and within 30 business days for translated materials through the end of 2025. 1.2 - Support coordination and logistics of Community Advisory Committee meetings, monthly and quarterly team meetings through the end of 2025.	Maintained a 98.9% fulfillment rate for health education material requests in Q1 2025. Successfully supported coordination of March CAC meeting and monthly PHE team meetings.		Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Health Education Programs**	N	**New**	2.0 - Develop at least one strategy to support senior (DSNP) populations with health education or wellness and prevention services by the end of 2025. 2.1 - Conduct annual health education program evaluations to drive process and program improvements by Q4 2025.	2.0 - Reviewed DSNP Model of Care and DSNP Assessment questions to identify opportunities for health education resource development. Attended Senior Injury Prevention Partnership conference to identify population needs. 2.1 - Completed evaluation summary tables for the Diabetes Prevention Program and Comment Card Incentive Surveys.		Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Health Education Programs**	Y	**New**	3.0 - Measure the impact of doula utilization on maternal and child health outcomes by the end of 2025.	Developed key questions for member story spotlight in member newsletter and to share at a doula event for members. Identified metrics to review with Diversity Uplifts to measure maternal health outcomes. Initiated Sutter Health Perinatal collaboration.		Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Disease Management**	Y	**New**	4.0 - Implement at least one new strategy to engage members in a Disease Management program by the end of 2025.	Incentive program for participation; advertise in DM mailing, texting option. Journey Health CHWs will conduct outreach to Anthem and AE members with uncrtrolled hypertension and diabetes. Targeted health coaching outreach to Group Care members.		Utilization Management/Quality Improvement and Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Disease Management**	N	**New**	5.0 - Develop tailored disease management outcomes measures for subpopulations by the end of 2025.	Included additional subpopulations in the 2025 PHM Assessment: members with a diagnosis of diabetes and hypertension. Characteristics include: utilization of primary care, ED, admissions, readmissions, mental health. Potential target for Journey Health CHW outreach.		Utilization Management/Quality Improvement and Health Equity Committee	12/31/2025	
Cultural & Linguistic Services	Title: QI Senior Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Member Cultural and Linguistic Assessment**	Y	**Continued**	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.	1. CLS needs assessed at 01/22/2025 CLSS Meeting.		Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	
	Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name:	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Language Assistance Services Fulfillment**	Y	**Continued**	Reach or exceed an average fulfillment rate of ninety-five percent (95%) or more for in-person, video, and telephonic interpreter services.	1. Q1- 99% fulfillment rate for all modalities.		Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	
	Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name:	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Language Assistance Services Fulfillment**	Y	**Continued**	Increase monthly use of on-demand vs in-person services by 2 percentage through improvements to on-demand access.	1. Planned implementation in Q2.		Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	

2025 Quality Improvement & Health Equity (QIHE) Work Plan

	Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification *(Update this column)	Q1, 2025	Q2, 2025	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues (if applicable)
QIHE Evaluation	Title: Sr. QI Director Name: Michelle N. Stott	Title: Sr. QI Director Name: Michelle N. Stott	N/A	**Annual QIHE Program Evaluation**	Y	**Continued**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee	The QIHE Program Evaluation was updated and approved in IQIC, with final approval by QIHEC on May 9, 2025.		All Sub-Committees and QIHEC	12/31/25	Incorporated BH and SNF/LTC Quality Monitoring
Cultural and Linguistic Ser	Title: QI Senior Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Language Assistance Services for Behavioral Health**	Y	**Continued**	Ensure tracking, analysis and reporting of interpreter services utilization for behavioral health services.	1. The Alliance met with the vendor to re-evaluate the call prompt categories. The vendor confirmed they would review the data collection points within the call flow to explore alternative methods for inputting date into the platform, specifically to accurately indicate whether it was a BH call.		Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	
	Title: QI Senior Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Provider Language Capacity (Member Satisfaction)**	Y	**Continued**	Based on the Member CG-CAHPS Survey 81% of adult members and 92% of child members who need interpreter services will report receiving a non-family qualified interpreter through their doctor's office or health plan.	1. Q4 2024-Adult: 87.4%; Child: 92.1% (Metric Met). 2. Q1 2025-Planned implementation Q2.		Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	
	Title: QI Senior Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Language Assistance Services (Member Satisfaction)**	Y	**New**	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%)	1. Mail Dropped: 03/11/2025		Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	
	Title: QI Senior Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Provider Language Capacity and Race and/or Ethnicity (Provider Network)**	Y	**New**	Conduct NCQA NET 1 A Report: Analysis of Capacity of Alliance Provider Network to meet Cultural and Linguistic and share findings with internal and external stakeholders by May 31, 2025	1. Completed gathering of data and reports. 2. Started on draft Net 1 A Report.		Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	
	Title: QI Senior Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Community Engagement: Community Advisory Committee (CAC)**	Y	**New**	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).	1. Connected and presented information about the CAC as part of membership recruitment efforts to the following organizations: • Greater New Beginnings on 01/17/2025 and received two (2) CAC candidate applications. • Asthma Start Program, ACPHD, 1/29/2025 • Oakland Catholic Worker on 3/13/2025 2. Conducted initial outreach and provided information to Native American Health Center and Asian Health Services via email.		Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	
	Title: QI Senior Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Potential Quality Issues-Quality of Language (PQI-QOL)**	Y	**Continued**	Monitor, evaluate, and conduct appropriate interventions for PQI-QOLs with a closure rate of 95% or more within 60 business days.	1. Q1-95% closure rate.		Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	
Inter-department	Title: QI Senior Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Emergency Visits alignment**	Y	**New**	**Outcome measure: Reduce preventable ED visit rates** **Goal**: Collaborate with internal departments to align on an ED visit definition(s) and data sources, analyze for health disparities, and identify populations that might benefit from interventions/programs. **Process measure**: Completion of ED current state mapping/documentation.	Analytics and other departments in PHM Workgroup (UM, CM, QI, PHE) met to review ED definitions used in population health reports (1/17/2025). Subset of CareAnalyzer ED visit categories (not potentially avoidable, potentially avoidable, primary care treatable, and non-emergent) were added as a metric in the PHM Assessment to identify subpopulations that might benefit from interventions.		Internal Quality Improvement Committee	12/31/2025	
	Title: QI Senior Director Name: Michelle Stott	Title: Manager, Quality Improvement Name: Farashta Zainal	Title: QI Specialist Name: Kaiti Aerat	**Follow up for Emergency Visits for SUD and Mental Health**	Y	**New**	**Outcome measure: Reduce preventable ED visit rates** **Goal**: Develop a coordinated (non-duplicated) process to conduct member outreach utilizing AHS ED Navigators and SUNs at other hospital, and QI Engagement Coordinators to obtain ED follow up appointments for FUM/FUA. Leverage the extended office hours incentive. **Outcome measure:** Refer to BH above. By December 31, 2025, Alameda Alliance for Health will sustain FUA HEDIS rates and improve FUM HEDIS rate by 2% from MY2024 to MY2025 to meet/exceed MPL. **Process measure**: Refer to PIP above. By December 31, 2025, Alameda Alliance will improve the 7-day provider notifications rate by 2% for members visiting the ED with SUD/SMH diagnoses	QI engagement coordinators called 100 members who were on the the FUA/FUM reprot. The coordinators were able to make 17 successful contact, i.e. 17 members picked up the phone and were either transfered to their PCP or given information on how to connect with their PCP or confirmed they had a follow up. During the next PDSA in Q2, the QI engagment coordinators will warm transfer the member to the Behvioral Health team who will complete an assesment and connect the member to the appropriate level of care.		Internal Quality Improvement Committee	12/31/2025	The Alliance discovered last year that many of the EDs in the Alliance network have Substance Use Navigators (SUNs) that are funded by the CA Bridge Program. In 2025, the Alliance will work to make sure that the work being peformed by the SUNs at various hospitals is captured by appropriate coding/claims submission.
	Title: QI Senior Director Name: Michelle Stott	Title: Manager, Access to Care Name: Loc Tran	Title: Manager, Acces to Care Name: Loc Tran	**Emergency Visits**	Y	**New**	**Outcome measure: Reduce preventable ED visit rates** **Goal**: Develop alternative access document and a communication plan for members **Outcome measure:** Monitor access metrics (i.e. Follow up visits after an ED, CAHPS timely access to care, urgent care visits, NAL, Teladoc) **Process measure:** Monitor outreach methods from the communication plan	Currently under C&O reviews.		Access to Care Internal Quality Improvement Committee	12/31/25	

Alameda Alliance for Health

Population Health Management (PHM)

2024 Evaluation

For Medi-Cal and Group Care lines of business

Presented to the Quality Improvement and Health Equity Committee on 5/9/2025

Introduction

Alameda Alliance for Health (Alliance) conducts an annual comprehensive analysis of the impact of its Population Health Management (PHM) Strategy. The PHM Evaluation includes quantitative results for relevant clinical, utilization, and experience measures. Quantitative and qualitative analysis is conducted on the results for evidence of program effectiveness and continuous improvement.

The PHM workgroup conducts this analysis to support Alliance members and promote an effective PHM Strategy. Representation from various departments at the Alliance comprises the workgroup, including Population Health and Equity, Case Management, Access and Availability, Utilization Management, Analytics, Quality Improvement, Long Term Services and Supports, and Pharmacy. The workgroup analyzes progress on goals on a quarterly basis. Facilitators, barriers, and solutions are discussed and implemented.

The Alliance uses the results of the PHM Evaluation as well as the PHM Assessment to review and update PHM programs, services, activities, and resources such as staffing ratios, clinical qualifications, job training, external resource needs and contacts, and cultural competency in order to meet member needs. The Alliance Quality Improvement and Case Management Program Descriptions also describe the process used to update PHM programs, activities, and resources.

2024 PHM Strategy Goals and Results

Managing Multiple Chronic Illnesses

The Alliance offered case management, health coaching, and self-management tools to members with multiple chronic conditions. The goal of 80% for increased confidence in the program post-assessment was met for Complex Case Management but not for Multiple Chronic Disease Management Medi-Cal members. The number of survey responses was low for Group Care, but the goal was met for Multiple Chronic Disease Management.

Complex Case Management (Medi-Cal and Group Care)

Complex Case Management (CCM) provides ongoing chronic care coordination, interventions for temporary needs, and disease-specific management interventions for members who are high and medium-rising risk and have conditions in which the degree and complexity of illness or conditions are typically severe. The level of management necessary and the resources required for the member to regain optimal health or improved functionality is often intensive. After a CCM case is closed, members are asked to complete a satisfaction survey which includes a question about their confidence in being able to better manage their health condition since receiving case management services.

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

- **Quantitative analysis:** Medi-Cal 82% (14/17), Group Care N/A (0)

	GOAL	Jul 2024	Oct 2024	Jan 2025	Apr 2025
Increased confidence	**80%**	N/A (0 members)	N/A (0 members)	MC: 71% (10/14) GC: N/A	MC: 82% (14/17) GC: N/A

- **Source**: Case Management Satisfaction Surveys
- **Met Goal:** The goal was met for Medi-Cal. There were no Group Care members who took the survey.
- **Qualitative analysis:** The satisfaction survey was mailed for the first half of the year with no response, so the Case Management team began calling members to complete the survey over the phone. Mailed surveys were unsuccessful in part because they did not include a prepaid envelope due to cost. The Manager of Case Management analyzed the survey results and shared that while most members agreed they could better manage their health condition, members who did not report increased confidence may have been unsatisfied with their case managers for not being able to influence provider prescriptions or utilization management denials.

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

The Disease Management program provides health coaching and self-management tools for diabetes, hypertension, and asthma. Members are asked about their knowledge, attitude, and behaviors in self-managing their chronic conditions, with each question on a 5-point Likert scale. This assessment is completed after 2 to 3 health coaching sessions.

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

- **Quantitative analysis:** Medi-Cal 79% (11/14), Group Care 100% (2/2)

	GOAL	Jul 2024	Oct 2024	Jan 2025	Apr 2025
Increased confidence	**80%**	MC: 67% (2/3) GC: N/A	MC: 67% (4/6) GC: N/A	MC: 82% (9/11) GC: 100% (1/1)	MC: 79% (11/14) GC: 100% (2/2)

- **Source**: Disease management health coaching assessments
- **Met Goal:** The goal was nearly met for Medi-Cal. The goal was met for Group Care but with only two members completing the survey.
- **Qualitative analysis:** The Manager of Population Health and Equity, Disease Management Health Educator, and Population Health and Equity Specialist reported success in engaging more members with increased outreach through the wellness request form, health equity outreach campaign, blood pressure monitoring collaboration with Quality Improvement, and Group Care member outreach. More than half of Medi-Cal (14/25) and Group Care (2/3) health coaching participants completed at least two sessions and the post-assessment. The other participants only completed one session, lost contact, or declined the assessment. Most members who participated in health coaching and completed the assessment questions met the goal of increased confidence, but the goal for Medi-Cal was not quite met. A barrier discussed was the challenge of helping members with social needs because resources are limited. The confidence score for Medi-Cal might also be below the goal because some people felt one health coaching session was enough.

Managing Members with Emerging Risk

The BirthWise Wellbeing program worked on communicating with members and providers about the doula benefit and expanding the provider network, but utilization remained low for 2024. The Black (African American) Breast Cancer Screening QI Project continued to work with providers on multiple initiatives, but no-shows or cancellations continued to be a barrier in meeting the goal. The Diabetes Prevention Program was successful in reaching its goal of maintaining weight loss.

BirthWise Wellbeing (Medi-Cal)

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

and connecting members to supportive services such as doulas. Black (African American), Hispanic (Latino), and American Indian or Alaskan Native Alliance members had the highest prevalence or count of depression among pregnant and postpartum members, so this goal aimed to increase support for these members through doula services.

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

- **Quantitative analysis:** 0.22% (9/4,031)

	GOAL	Jul 2024	Oct 2024	Jan 2025	Apr 2025
Doula utilization	**3%**	0% (0/1,456)	0% (0/2,887)	0.23% (8/3,591)	0.22% (9/4,031)

- **Source**: Doula claims
- **Met Goal:** The goal was not met.
- **Qualitative analysis:** Barriers to reaching the doula utilization goal were discussed at the PHM workgroup meeting. The Population Health and Equity Manager and Population Health and Equity Specialist explained that despite many member and provider communications that went out in 2024, there is still limited awareness of doulas and their services in the community. Expanding the doula provider network so that there is more availability has also been challenging because of complicated Alliance contracting processes and documents and the need to build trust and relationships with the doula community. After contracting, doulas also need assistance to learn Alliance systems such as submitting claims for payment.

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

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

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

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

- **Quantitative analysis:** Medi-Cal 52.34% (961/1,836), Group Care 61.54% (96/156) as of April 2025

	GOAL	Jul 2024	Oct 2024	Jan 2025	Apr 2025
BCS	**MC: 52.96%** **GC: 66.61%**	MC: 43.22% (857/1,983) GC: 54.02% (94/174)	MC: 47.66% (916/1,922) GC: 59.76% (98/164)	MC: 52.36% (964/1,841) GC: 61.54% (96/156)	MC: 52.34% (961/1,836) GC: 61.54% (96/156)

- **Source**: HEDIS dashboard
- **Met Goal:** No for both Medi-Cal and Group Care
- **Qualitative analysis:** Barriers to reaching the goal were discussed at the PHM workgroup meeting. The Quality Improvement Manager and Quality Improvement Specialist shared that there were multiple efforts with clinics to increase mammography through incentives, text messaging, and mobile mammography events, but the largest barrier to reaching this goal was appointment no-shows and cancellations. Mobile mammography has been successful for providers who are able to partner, but this may not be an option for smaller, directly contracted providers. The Alliance partnered with a faith-based organization on a community event to connect members to mammograms, but other events and the weather resulted in low attendance.

Diabetes Prevention Program (Medi-Cal)

The Diabetes Prevention Program (DPP) is an online program that helps participants adopt healthy habits, lose weight, and significantly decrease their risk of developing type 2 diabetes. The year-long program follows an approved curriculum by the Centers for Disease Control and Prevention (CDC). The DPP providers send participation reports with self-reported weight.

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

- **Quantitative analysis:** 40% (36/89)

	GOAL	Jul 2024	Oct 2024	Jan 2025	Apr 2025
Weight loss maintained	**20%**	N/A (0 members)	33% (1/3)	29% (17/58)	40% (36/89)

- **Source**: DPP participation reports
- **Met Goal:** The goal was met.
- **Qualitative analysis:** The Population Health and Equity Manager and Health Education Specialist reported success with expanding DPP participation with two providers. One provider executed contracts with clinics for more effective patient referrals. The Alliance also offered member incentives for participants to join and stay engaged. About 40% of participants who have tracked their weight through 26 weeks have maintained a 5% weight loss.

Keeping Members Healthy

For the Black (African American) Well-Child Visit QI Project, one of the three HEDIS measures reached the goal. The non-utilizer outreach project involved outreach calls to over 2,000 members 0-6 years old as well as over 9,000 members 50 years and older. The outreach and connection to primary care goals were met.

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

Well-child visits and recommended vaccinations are essential in helping make sure infants, children, and adolescents stay healthy and prevent disease outbreaks. Vaccine-preventable diseases can be extremely contagious, especially for babies. Well-child visits are important for tracking growth and developmental milestones and identifying and addressing concerns early. Alliance rates showed inequities experienced by Black (African American) members as compared to other racial/ethnic groups.

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

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

- **Quantitative analysis:** W30-6+ 38.57% (27/70), W30-2+ 67.26% (152/226), CIS-10 15.79% (33/209) as of April 2025

	GOAL	Jul 2024	Oct 2024	Jan 2025	Apr 2025
W30-6+	**42.62%**	23.94% (17/71)	31.43% (22/70)	34.29% (24/70)	38.57% (27/70)
W30-2+	**63.91%**	61.80% (144/233)	64.94% (150/231)	67.26% (152/226)	67.26% (152/226)
CIS-10	**18.74%**	13.43% (29/216)	14.55% (31/213)	15.31% (32/209)	15.79% (33/209)

- **Source**: HEDIS dashboard
- **Met Goal:** Goal was not met for W30-6+ and CIS-10. Goal was met for W30-2+.
- **Qualitative analysis:** The Quality Improvement Manager and Quality Improvement Specialist described multiple initiatives to promote well-child visits and immunizations, including outreach calls, member incentives, and an advertising campaign. Barriers to reaching the W30-6+ and CIS-10 goals were discussed at the PHM workgroup meeting. A challenge is that the population is small and distributed across multiple clinics, so it is difficult to partner with clinics on campaigns for their patients. First 5 conducted a survey with families and found that the transportation benefit was difficult for members to use for appointments less than five days away. Members also shared that wait times at provider offices can be significantly long, which discourages them from coming back for care. Although First 5 began offering to assist with coordinating transportation in addition to scheduling appointments during outreach calls, members did not utilize the benefit.

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

Non-utilization of services refers to members who are not receiving health care services from the Alliance. This could be due to many factors like member choice but could also signal barriers like access to care. Encouraging members to play a more active role in their care is crucial for staying healthy and prevention and management of health conditions. The Alliance conducts outreach to educate members on the importance of regular care and connect members a primary care provider.

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

- **Quantitative analysis:** Outreached to 48% (4,538/9,527) for Medi-Cal and 56% (354/629) for Group Care. Connected 3% (290/9,527) to primary care services for Medi-Cal and 5% (33/629) for Group Care.

	GOAL	Jul 2024	Oct 2024	Jan 2025	Apr 2025
Outreach	**20%**	MC: 48% (4,538/9,527) GC: 56% (354/629)	Program ended	Program ended	Program ended
Connected	**2%**	N/A	MC: 3% (290/9,527) GC: 5% (33/629)	Program ended	Program ended

- **Source**: Non-utilizer outreach pilot results
- **Met Goal:** Goals were met.
- **Qualitative analysis:** The Quality Improvement Manager and Specialist reported that the outreach goal was exceeded in part because leaving a voicemail was counted as a successful outreach. The connection to primary care rate was anticipated to be lower, so these goals were met. Reasons for the lower rate of primary care connection include incorrect phone numbers, calls appearing to be spam, or members saying they would schedule their own appointments instead of agreeing to be transferred to the PCP. This strategy was slightly more successful for Group Care members.

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

- **Quantitative analysis:** Outreached to 50% (1,096/2,179). Connected 5% (108/2,179) to primary care services. All were Medi-Cal members.

	GOAL	Jul 2023	Oct 2023	Jan 2024	Apr 2024
Outreach	**20%**	50% (1,096/2,179)	Program ended	Program ended	Program ended
Connected	**2%**	N/A	5% (108/2,179)	Program ended	Program ended

- **Source**: Non-utilizer outreach pilot results
- **Met Goal:** This goal was met.

- **Qualitative analysis:** The Quality Improvement Manager and Quality Improvement Specialist found similar successes and barriers with Medi-Cal children as with the adults.

Patient safety or outcomes across settings

Follow-up after ED visits for mental illness (FUM) and Transitional Care Services care manager contact have improved and reached their goals.

Follow-up after ED Visit for Mental Illness and Substance Use QI Project (Medi-Cal)

Many members go to emergency departments for urgent mental health problems. Getting follow-up mental health care after leaving the ED can improve health and prevent the need for future ED visits. Care management staff help members get follow-up care and resources that can improve their health and quality of life. Follow-up care after being seen in the ED with mental illness has shown a decrease in repeat ED visits, better physical and mental function, and increased compliance with follow-up instructions.

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

- **Quantitative analysis:** 66.38% (1,390/2,094) as of April 2025

	GOAL	Jul 2024	Oct 2024	Jan 2025	Apr 2025
FUM	**54.87%**	19.6% (218/1,112)	21.19% (353/1,666)	26.95% (562/2,085)	66.38% (1,390/2,094)

- **Source**: HEDIS dashboard
- **Met Goal:** Yes
- **Qualitative analysis:** Monitoring this goal throughout the year is a challenge because the Alliance did not receive all claims data from Alameda County Behavioral Health until April 2025. In 2024, Quality Improvement educated primary care providers through meetings and posted a webinar and measure highlight sheet about the measure specifications to make sure the follow-up visits are properly captured. The Alliance is sending daily or weekly notifications of ED visits for mental illness to delegate providers to encourage follow-up or referral to Alameda County Behavioral Health for severe mental health needs.

Transitional Care Services (Medi-Cal and Group Care)

Case Management staff promote continuity of care for members who have been discharged from the hospital or transfer from one setting or level of care to another. Staff outreach to members identified as high-risk for frequent hospitalization and/or emergency services and address medical or non-medical barriers that could cause a readmission. They coordinate follow-up with appropriate providers and connect members to plan or community resources.

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

Revised Goal (8/2024): Increase the percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7 days post-discharge from 20.7% for Medi-Cal and 21.3% for Group Care in August 2024 by 1 percentage point in March 2025. [Clinical measure]

- **Quantitative analysis:** Medi-Cal 23.3% (6,287/27,036), Group Care 28.5% (53/186)

	GOAL	Jul 2024	Oct 2024	Jan 2025	Apr 2025
Care manager contact	**MC: 21.7%** **GC: 22.3%**	Revised goal for August	MC: 21.6% (4,771/22,060) GC: 22.7% (39/172)	MC: 23.0% (5,630/24,526) GC: 25.5% (47/184)	MC: 23.3% (6,287/27,036) GC: 28.5% (53/186)

- **Source**: Transitional Care Services records
- **Met Goal:** Yes for both Medi-Cal and Group Care
- **Qualitative analysis:** The baseline for this goal was reset in August; previously the denominator was based on a subset of high-risk TCS groups plus the Alliance “high risk” RSS tier, but the Alliance expanded the “high risk” definition to include all high-risk TCS groups. The Manager of Case Management reported that their department has been focusing on hiring and training staff for TCS to manage the increased volume of cases.

PHM Overall Strategy Effectiveness

On review of the 2024 Population Health Strategy outcomes, the Alliance noted success with expanding programs through outreach and incentive projects to reach more members to offer support and facilitate access to primary care services. There are opportunities for improvement in reaching members in the community and developing internal staff capacity.

Successes of the PHM Program included outreach campaigns for Multiple Chronic Disease Management, non-utilizers, and well-child visits; clinic partnerships for the Diabetes Prevention Program and follow-up after ED visits for mental illness; and care manager outreach in the Transitional Care Services program. Although the goal was not reached, clinic and mobile mammography partnerships have been successful in maintaining the breast cancer screening rate for Black (African American) members. Goals were reached for Medi-Cal Complex Case Management, the Diabetes Prevention Program, one of the three well-child visit measures, non-utilizer outreach, follow-up after ED visits for mental illness, and Transitional Care Services care manager contact. In Group Care, goals were reached for Multiple Chronic Disease Management, non-utilizer outreach, and Transitional Care Services.

It was challenging to reach members successfully for Case and Disease Management programs and preventive services, and then for members to schedule and complete appointments after being reached. Members also had other health or social needs that were challenging for Alliance staff and outreach partners to help with. Utilization of the doula benefit remained low in 2024 while the Alliance worked on communications and building relationships with the doula community. Well-child visits under 30 months and immunizations continue to be a persistent disparity with rates below the DHCS minimum performance levels of 50th percentile among health plans.

Opportunities for Improvement

On review of the evaluation results, opportunities include:

- Increase outreach and follow-up efforts by Alliance staff for Case and Disease Management program surveys, mammography standing orders, and well-child visits.
- Improve staff training and internal coordination of referrals among Case Management, Disease Management, Quality Improvement, and Behavioral Health.
- Continue to develop and expand partnerships with hospitals, community health workers, community-based organizations, and faith-based organizations.
- Consider which projects and target populations would benefit the most from incentives.
- Explore how to improve outreach to members in ways that are compliant with regulations regarding use of technology.

Actions Based on Opportunities

Actions based on opportunities are listed below:

1. Member outreach – Quality Improvement staff will assist directly contracted providers with follow-up calls to encourage breast cancer screening completion. They will also pilot outreach calls for follow-up after ED visits for mental illness.
2. Staff training and coordination – Case Management and Quality Improvement will train staff on workflows, Alliance programs and benefits, and coordination of referrals to other departments and programs. Alliance program engagement referral workflows will also be developed for members who are using community health worker and Community Supports services.
3. Community partnerships – The Alliance will work to launch projects involving community health workers and hospital ED navigators with perinatal mental health, follow-up after ED for mental illness, and Transitional Care Services. Health Equity and Quality Improvement will also partner with faith-based and community organizations to deliver health education on preventive services and promote services such as the doula benefit.
4. Member Incentives – Quality Improvement will strategically use member incentives to promote member engagement in wellness activities, such as well visits and the Diabetes Prevention Program.

Alameda Alliance for Health

Population Health Management (PHM)

2025 Strategy

For Medi-Cal and Group Care lines of business

Presented to the Quality Improvement and Health Equity Committee
on 5/9/2025

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Overview

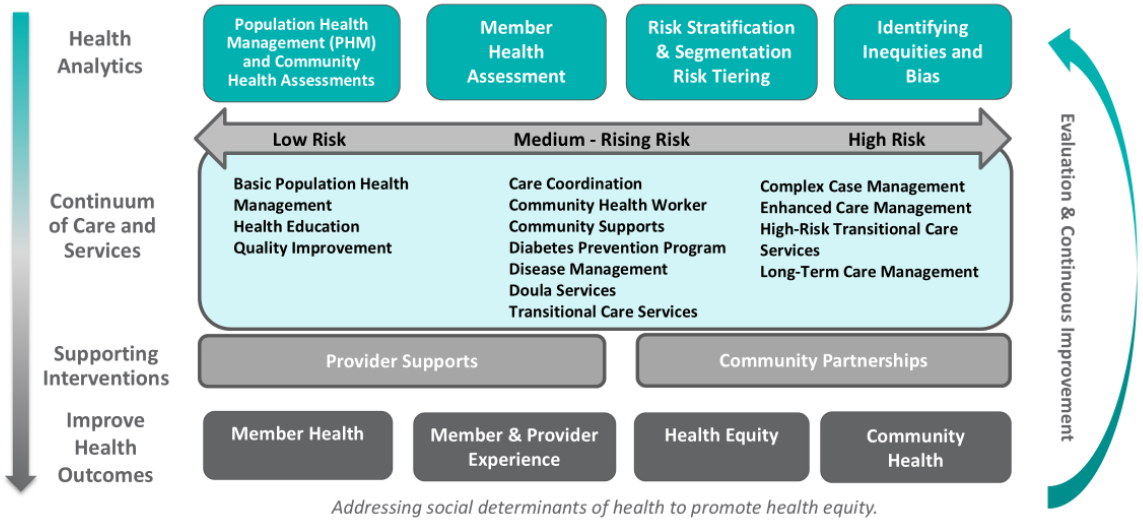
Alameda Alliance for Health (Alliance) is a local, public, not-for-profit managed care health plan committed to improving the health and well-being of our members by collaborating with our provider and community partners to deliver high quality and accessible services. Our vision is that all residents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

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

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

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

Alliance Population Health Management Framework



The Alliance PHM Strategy aligns with the NCQA 2025 Population Health Program Standards and Guidelines and the California Department of Health Care Services (DHCS) Population Health Management Policy Guide. The PHM Strategy is updated yearly based on an annual population assessment and outcomes from the previous year.

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

The PHM Strategy is used to:

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

The Population Health Management (PHM) workgroup convenes twice a month and is comprised of representatives from across the organization to guide the development and implementation of the Alliance PHM Strategy and population health program goals. PHM activities are reported to the Internal Quality Improvement Committee and the Quality Improvement and Health Equity Committee.

Health Equity

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

At the Alliance, Health Equity has four key priority focus areas: 1) enhance diversity, equity, inclusion, and belonging among Alliance staff, 2) develop a systems-based approach to leverage physical and psychosocial data to analyze, understand, and address avoidable and unjust

differences in health status and well-being among historically marginalized and underserved populations, including addressing social determinants of health (SDOH); 3) ensure members have equal access to cultural and linguistic responsive services; and 4) employ value contracting strategies to ensure equal opportunities for women and minority owned businesses to do business with the Alliance.

Also, the Health Equity Department contracted consultants and collaborated with departments across the organization to develop an organizational equity roadmap containing six milestones and goals for a three-year duration. The milestones are organization, data-driven, education, communication, community engagement, and SDOH mitigation measures.

Starting in 2025, the Alliance Health Equity Department will implement a DEI (diversity, equity, and inclusion) training program. The DEI training program includes sensitivity, diversity, cultural competency and cultural humility, and health equity training. The DEI training is required for individuals managing member care. Training content includes, but is not limited to:

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

Implementation timeline:

- Pilot the DEI training program between January and July 2025.
- Implement DEI training program between July and December 2025.
- Annual evaluation of the DEI training program thereafter.

The Alliance continues to be committed to health equity, but we will also stay up to date with the changing landscape of DEI due to executive orders at the Federal level.

Evaluation

The Alliance conducts an annual impact evaluation of its PHM strategy that includes quantitative and qualitative analysis for evidence of program effectiveness and identifies opportunities for improvement. The PHM Strategy yearly evaluation is available in a separate document, "2024 PHM Evaluation."

Data integration

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

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

Many of the data sources are imported into the CareAnalyzer health analytics platform. CareAnalyzer combines elements of patient-level and group-level risk, care opportunities and provider performance to provide insight into Alameda Alliance's member population. In

addition, it utilizes the industry-leading predictive modeling capabilities and analytics of The Johns Hopkins ACG System. CareAnalyzer data is viewed in their online reporting user interface as well as exported and integrated into other analyses.

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

Population Assessment

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

Data Sources

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

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

Methodology and results from these data sources are found in the document "2025 NCQA PHM Assessment Methods and Data." Analysis of the results is in the Member Needs section below.

Social Determinants of Health

As defined in Healthy People 2030, social determinants of health (SDOH) are conditions in the environments where people are born, live, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes. The SDOH characteristics included in this report for all Alameda County residents, which includes both Medi-Cal and Group Care members, were people living below poverty level, California Healthy Places Index, Food Insecurity Index, and Mental Health Index. SDOH characteristics specific to individual Medi-Cal and Group Care Alliance members were homelessness and language.

Members were categorized as "housed" or "unhoused" through several indicators for potential homelessness, including diagnosis codes, Homeless Management Information System (HMIS) data, and member home addresses that indicate social services agencies or programs. This is different than the U.S. Department of Housing and Urban Development definition of homelessness that is used for programs such as ECM but helps indicate who may have experienced housing instability at some time during the year. In 2024, 7.3% of Medi-Cal members (24,873 members) and 1.5% of Group Care members (72 members) had one or more homelessness indicators.

Limited English proficiency was both a subpopulation and an SDOH characteristic. Members who preferred a language other than English were analyzed as having limited English proficiency. In 2024, 39.6% of Medi-Cal members (99,023 members) and 41.9% of Group Care members (1,965 members) preferred a language other than English. Almost 40% of the Alliance membership may need interpreters, translation services, and/or bilingual staff to access health care.

Alameda County Statistics

Population and Geography

As of April 2024, Alameda County had a population of 1,634,785 persons (Healthy Alameda County, data provided by Claritas). The map below shows the cities within the county.

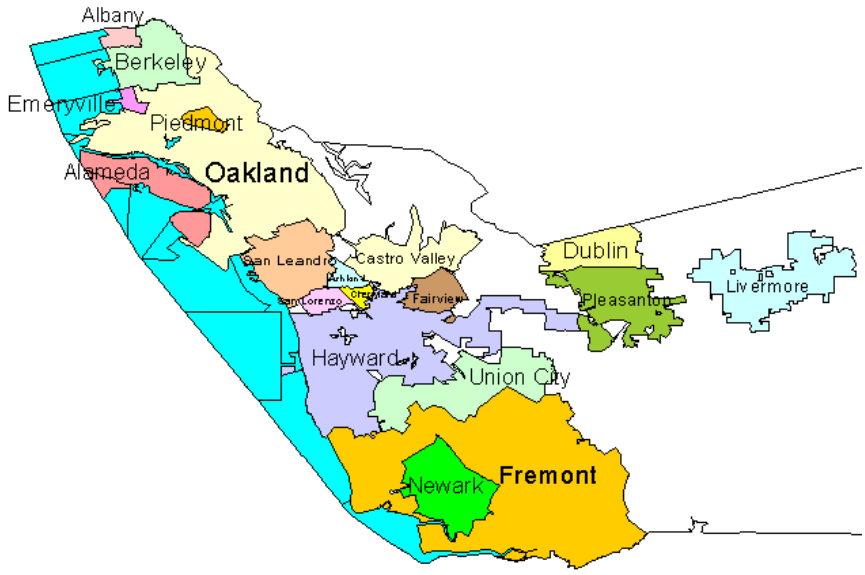


Figure 1: Map of Alameda County (Image source: UC Berkeley Library)

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

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

People Living Below Poverty Level

This indicator shows the percentage by zip code of estimated people who had income in the past 12 months below the federal poverty level according to the American Community Survey 5-Year, 2018-2022. Adults qualify for Medi-Cal with a household income of less than 138% of federal poverty level. In Alameda County, 9.2% of county residents were living below poverty level. The zip codes with the highest percentages were 94704 in Berkeley (Downtown Berkeley and South Berkeley) and 94613 in Oakland (Northeastern University), areas that have a high concentration of students. The next highest zip codes were also in Oakland and Berkeley.

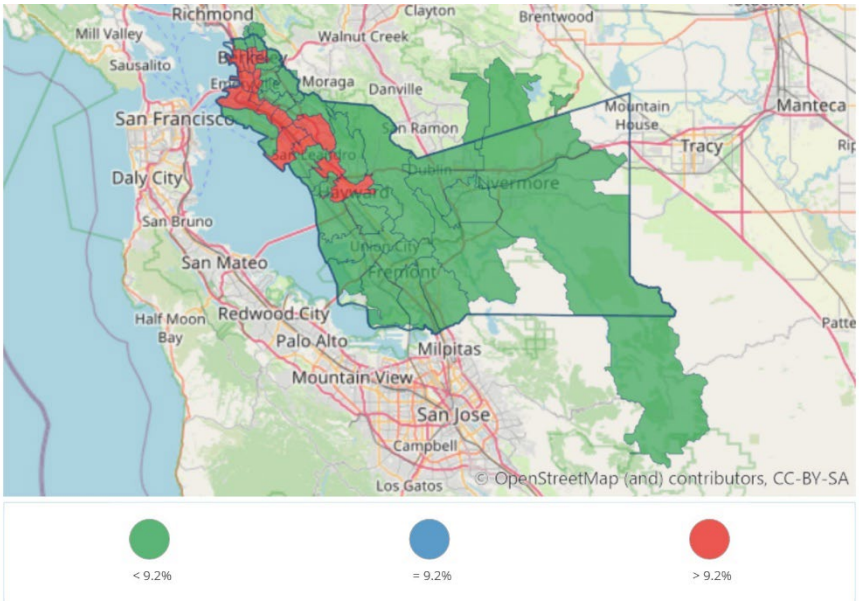


Figure 2: People Living Below Poverty Level, 2018-2022 (Image source: Healthy Alameda County)

California Healthy Places Index

The California Healthy Places Index, developed by the Public Health Alliance of Southern California, combines 25 community characteristics, like access to healthcare, housing, education, and more, into a single indexed HPI score. The zip codes with the lowest (least healthy) HPI Score were 94621, 94603, and 94601 in the Fruitvale and Coliseum area of East Oakland.

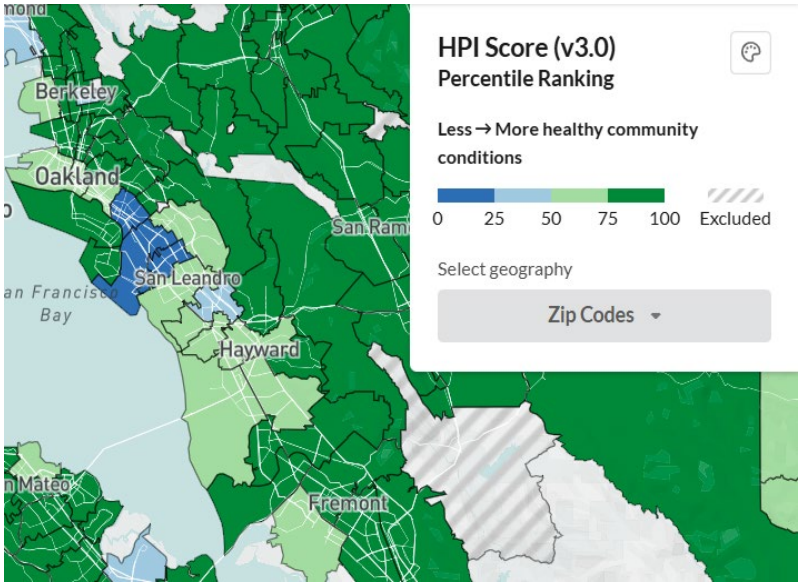


Figure 3: California Healthy Places Index, 2022 (Image source: Healthy Places Index)

Food Insecurity Index

The 2024 Food Insecurity Index, created by Conduent Healthy Communities Institute, is a measure of economic and household hardship correlated with poor food access. Overall, Alameda County's index score was 17.9 out of 100 (lower is better). In Alameda County, the zip codes with the greatest need related to food insecurity were 94621, 94601, 94603, and 94607, which include the Fruitvale and Coliseum area of East Oakland as well as West Oakland.

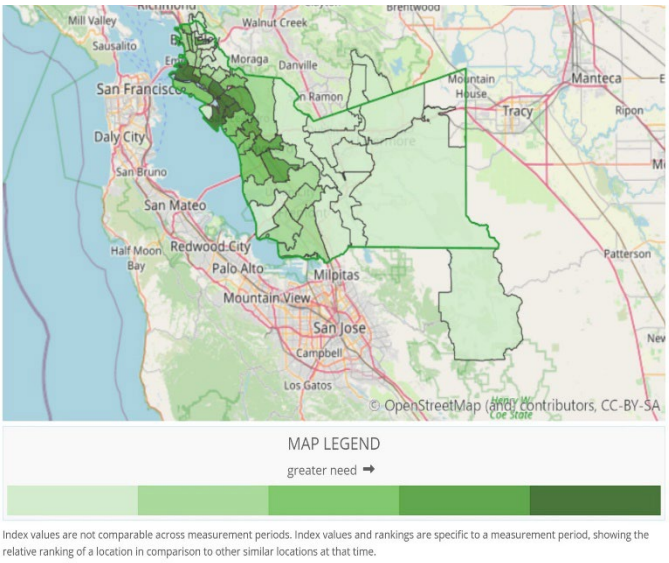


Figure 4: Food Insecurity Index, 2024 (Image source: Healthy Alameda County)

Mental Health Index

The 2024 Mental Health Index, created by Conduent Healthy Communities Institute, is a measure of socioeconomic and health factors correlated with self-reported poor mental health. Overall, Alameda County's index score was 34.9 out of 100 (lower is better). In Alameda County, the zip codes with the greatest need related to mental health were 94612, 94607, and 94605, which include Downtown Oakland, West Oakland, and the Eastmont area of East Oakland.

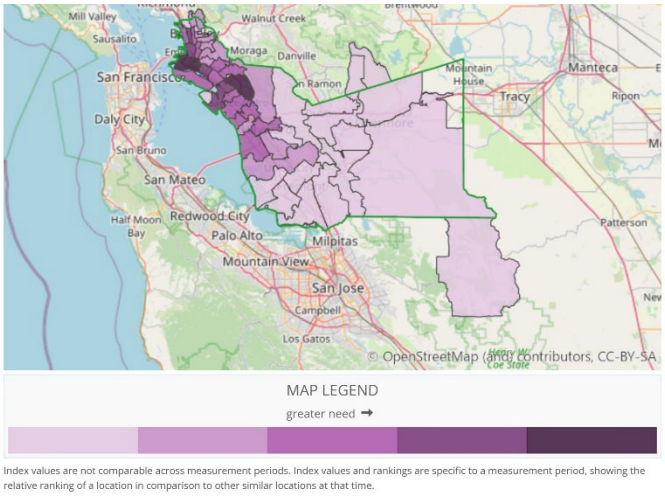


Figure 5: Mental Health Index, 2024 (Image source: Healthy Alameda County)

Alameda County Community Health Needs Assessment and Improvement Plan (CHNA/CHIP)

The Alameda County 2022-2025 Community Health Needs Assessment prioritized a list of health needs based on the severity and magnitude of need, community priority, and clear disparities or inequities. The five priority health needs highlighted were employment, housing, access to care, community safety, and mental and behavioral health.

Access to care issues in Alameda County included transportation and the cost of insurance and health care. People who qualify for Medi-Cal have difficulty finding high quality providers accepting new patients or who speak languages other than English. Oakland respondents liked that community clinics were accessible, but East Oakland had no major hospitals, pharmacies, or specialty care services. Dental services were limited in Oakland. Respondents also shared

that when people try to access mental health services, there is a long waitlist that is even longer for bilingual or bicultural therapists. Livermore respondents noted a lack of mental health providers in the Tri-Valley area and the need to address substance use in the unhoused community. Suggestions to address these issues included mobile care, increasing both in-person appointments and access to internet for telehealth appointments, investing in a diverse health care workforce, and deeper partnerships between hospitals and nonprofit organizations to integrate services.

From the CHNA findings, the Alameda County Public Health Department (ACPHD) selected three priority areas for the 2023-2025 Community Health Improvement Plan: Access to Care, Economic Security & Opportunities, and Communities and Individuals Free from Violence. The graphic below describes the actions that signature programs within ACPHD will take in each of these areas.

Figure 6: Alameda County CHIP Priority Program Areas, 2023-2025

City of Berkeley Community Health Assessment and Improvement Plan (CHA/CHIP)

The City of Berkeley completed their initial Community Health Assessment in 2024 and identified five key priority areas: housing, community safety, environmental health hazards, mental health, and health disparities. There were differences across populations; for example, mental health ranked as the second highest priority for African American survey respondents but was not in the top three overall.

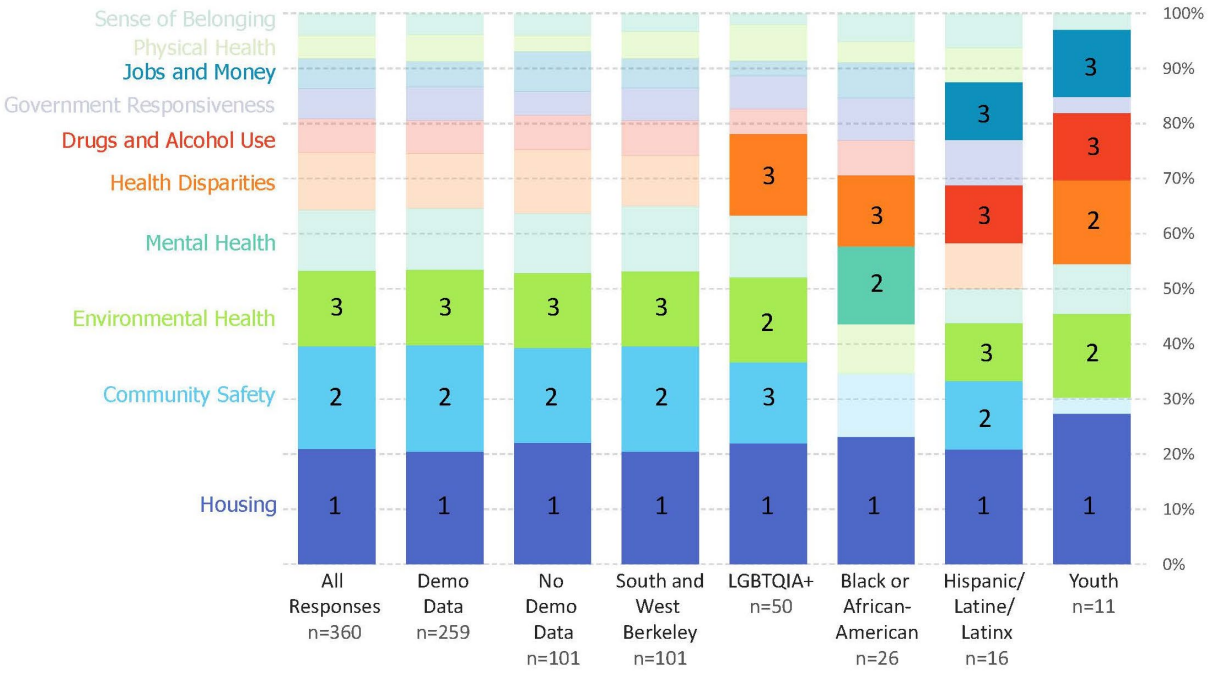


Figure 7: City of Berkeley Community Survey Responses by Population

In the first half of 2025, the steering committee will be divided into work groups corresponding to the first four priority areas listed above, with health equity as a theme for each work group. They will decide which strategies to include in the CHIP under the priority areas.

Membership

Medi-Cal Membership

There were 340,744 members enrolled in Medi-Cal for at least 11 months during 2024 and eligible in December 2024. Their characteristics are listed below.

Medi-Cal Member Demographics Table

MEDI-CAL	Count	Percent
GENDER		
Female	178,257	52.3%
Male	162,487	47.7%
AGE BAND		
0-2	7,583	2.2%
3-10	39,400	11.6%
11-20	54,155	15.9%
21-64	188,116	55.2%
65+	51,490	15.1%
COUNTY REGION		
North	167,993	49.3%

Central	97,042	28.5%
South	50,742	14.9%
East	23,211	6.8%
Other	1,756	0.5%
PRIMARY RACE/ETHNICITY		
Hispanic (Latino)	118,556	34.8%
Other	66,935	19.6%
Black (African American)	45,588	13.4%
Chinese	31,278	9.2%
White	27,140	8.0%
Other Asian	14,884	4.4%
Vietnamese	10,467	3.1%
Unknown	10,037	2.9%
Filipino	8,312	2.4%
Pacific Islander	6,877	2.0%
American Indian or Alaskan Native	670	0.2%
PRIMARY LANGUAGE		
English	205,721	60.4%
Spanish	84,792	24.9%
Chinese	26,627	7.8%
Vietnamese	7,402	2.2%
Unknown	6,896	2.0%
Other Non-English	5,157	1.5%
Farsi	2,438	0.7%
Tagalog	1,711	0.5%
HOMELESSNESS		
Housed	315,871	92.7%
Unhoused	24,873	7.3%

Group Care Membership

There were 4,690 members enrolled in Group Care for at least 11 months during 2024 and eligible in December 2024. Their characteristics are listed below.

Group Care Demographics Table

GROUP CARE	Count	Percent
GENDER		
Female	3,386	72.2%
Male	1,304	27.8%
AGE BAND		
0-64	3,748	79.9%
65+	942	20.1%
COUNTY REGION		
North	1,913	40.8%
Central	1,291	27.5%

South	884	18.8%
Other	364	7.8%
East	238	5.1%
PRIMARY RACE/ETHNICITY		
Other Asian	1,408	30.0%
Unknown	1,073	22.9%
Chinese	716	15.3%
Black (African American)	482	10.3%
Other	431	9.2%
Hispanic (Latino)	222	4.7%
Vietnamese	153	3.3%
White	90	1.9%
Filipino	59	1.3%
Pacific Islander	53	1.1%
American Indian or Alaskan Native	3	0.1%
PRIMARY LANGUAGE		
English	2,725	58.1%
Chinese	1,180	25.2%
Spanish	253	5.4%
Vietnamese	188	4.0%
Unknown	156	3.3%
Other Non-English	88	1.9%
Farsi	78	1.7%
Tagalog	22	0.5%
HOMELESSNESS		
Housed	4,618	98.5%
Unhoused	72	1.5%

Member Needs

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

- Child and adolescent members (Medi-Cal only)
- Members with disabilities
- Members with serious mental illness or serious emotional disturbance (Medi-Cal only)
- Members of racial and ethnic groups
- Members with limited English proficiency
- Relevant subpopulations:
    - Pregnant or postpartum members
    - Members with both diabetes and hypertension

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

All members

A common theme across the subpopulations was primary care utilization, which in turn affects many quality and utilization measures. To improve this, members need timely access to providers as well as follow-up support, reminders, and education about what services and appointments they need. About half of Alliance members live in the northern part of the county where Oakland is the largest city. The Healthy Places Index, Food Insecurity Index, and Mental Health Index maps show that Alliance members living in East, West, and Downtown Oakland also likely need assistance with food, housing, and other needs to support their health.

Gaps and disparities:

- *No PCP visits:* Over half of Medi-Cal members and a third of Group Care members had no PCP visit in 2024.
- *Avoidable ED visits:* According to CareAnalyzer definitions of primary care treatable and non-emergent ED visits, about two-thirds of emergency visits were avoidable.
- *Getting needed care and getting care quickly:* Medi-Cal children and Group Care members were both significantly below benchmark on CAHPS composite measures for getting needed care and getting care quickly.
- *Cancer screenings:* In Group Care, breast cancer, cervical cancer, and colorectal cancer screening HEDIS measures were below the 50th percentile for commercial plans in MY2023.

Child and adolescent members

There were 101,138 child and adolescent Medi-Cal members ages 0 to 20 in 2024. Group Care has very few child and adolescent members because they are In-Home Supportive Services (IHSS) paid caregivers for IHSS recipients. As was the case with the full membership, primary care visits were a gap of concern. Getting well-child visits according to the recommended schedule also helps with other quality measures like immunizations and lead screening. Parents and caregivers need education, outreach, and support with transportation and other social needs that could be barriers especially for the youngest children with multiple visits. Members have also reported being discouraged from scheduling appointments by provider availability and in-office waiting time.

Gaps and disparities:

- *No PCP visits*: Overall, 41.1% of children did not have a PCP visit. This percentage increases from 25.8% for ages 0-2 to 46.2% for ages 11-20.

- *Avoidable ED visits*: Ages 0-2 had the highest number of emergency visits per 1,000 member months among children and adolescents, 80% of which were categorized as primary care treatable or non-emergent. This age group also requires the most frequent well-child visits.
- *Dental care*: Although data issues with dental care led to Topical Fluoride for Children being excluded from DHCS sanctions, Alliance was under MPL for this measure, and disorders of teeth became the top diagnosis for children and adolescents in 2024.

Members with disabilities

In Medi-Cal, there were 2,733 children and adolescents ages 0 to 20 and 31,307 adults ages 21 and over in the SPD (seniors and people with disabilities) aid category. This includes adult and children receiving Supplemental Security Income (SSI) program cash assistance, which is provided to people who are blind, disabled, or 65 years of age and above with low income and assets. SSI defines "disability" for adults as the inability to undertake substantial gainful activity due to a significant physical or mental condition and for children as a physical or mental impairment that results in marked and severe functional limitations. Conditions could include Parkinson's disease, cancer, coronary heart disease, schizophrenia, and cerebral palsy. In Group Care, there were 837 members with disabilities defined by a selection of CareAnalyzer diagnosis codes detailed in "2025 NCQA PHM Assessment Methods and Data." People with disabilities need support with managing chronic conditions. Members with disabilities also may have more health-related social needs.

Gaps and disparities:

- *Chronic disease:* Chronic disease and multiple chronic disease were all higher in the various groups of members with disabilities listed above compared to overall members in the same age group. Adults with disabilities had about two times the prevalence of asthma, diabetes, hypertension, and diabetes with hypertension when compared to adults overall.
- *Emergency visits:* Children and adults with disabilities had a higher number of visits per 1,000 member months and a higher percentage of members with 4+ ED visits compared to overall members in the same age group.
- *Homelessness:* The percentage of children and adults with disabilities with an indicator for homelessness was higher than that of members in the same age group.

Members with serious mental illness or serious emotional disturbance

This category was analyzed for Medi-Cal members only. Care for members with serious mental illness or serious emotional disturbance is carved out to Alameda County Behavioral Health. Serious mental illness includes significant functional impairment resulting in an inability to

manage activities of daily living. Examples of diagnoses are schizophrenia and severe bipolar and major depressive disorders, often with psychotic features. Alameda County Behavioral Health also provides services for Medi-Cal members with moderate-to-severe presentation of mental disorder, usually with a history of episodic use of acute services that require stabilization with psychiatric medication. There were 8,197 Medi-Cal members who received services from Alameda County Behavioral Health in 2024. Members need health navigation while they are in the emergency department to connect them to further assistance with health care and community services to get treatment and support with social needs and to prevent future emergency visits. Members need access to mental health providers, especially those that are bicultural and bilingual.

Gaps and disparities:

- *Homelessness:* Nearly a third (31.4%) of members with serious mental illness had a homelessness indicator compared to 7.3% of all Medi-Cal members.
- *Emergency and hospital visits:* Emergency department visits per 1,000 member months was 100.0, compared to 27.5 for all Medi-Cal members. The percentage of high ED use (4 or more visits) was 6.8% compared to 0.5% for all Medi-Cal members. Admissions per 1,000 member months (14.9) and readmission rate (24.1%) were also higher than for all Medi-Cal members (5.2 and 18.4%).
- *Follow-up after ED visit for mental illness*: This HEDIS measure (FUM) rate was below MPL (54.87%) for males (49.59%) and ages 35-49 (50.10%).

Members of racial or ethnic groups

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

Gaps and disparities:

- American Indian or Alaskan Native members are 0.2% of Medi-Cal (670 members) and 0.1% of Group Care (3 members). For Group Care, the population is too small for comparison.
    - *Homelessness:* The prevalence of homelessness was 5.3% of American Indian or Alaskan Native Medi-Cal children and 17.7% of Medi-Cal adults.
    - *Depression:* The prevalence of depression by race/ethnicity was highest for American Indian or Alaskan Native members: 3.3% of Medi-Cal children and 10.6% of Medi-Cal adults.

  - *Cancer screening:* The rate of breast cancer screening for American Indian or Alaskan Native Medi-Cal members was 33.33%, below the MPL of 52.60%. For colorectal cancer screening, the rate was 24.76%, below the MPL of 33.84%.
  - *Emergency and hospital visits:* The rates of admissions, readmissions, emergency visits, and high ED use were higher for American Indian or Alaskan Native Medi-Cal adult members. The emergency visit rate was highest among children.
- Asian American and Pacific Islander members are 21.1% of Medi-Cal (64,941 Asian American and 6,877 Pacific Islander members) and 50.9% of Group Care (2,336 Asian American and 53 Pacific Islander members).
  - *Diabetes and hypertension:* The prevalence of diabetes, hypertension, and diabetes with hypertension were higher in various Asian American and Pacific Islander groups, which was expected since this is an older population. About a fifth of Filipino members and Other Asian Medi-Cal members had both diabetes and hypertension. Other Asian American groups still had significant numbers of members with both diabetes and hypertension.
  - *Cancer screenings:* In Group Care, Other Asian members made up a quarter of the breast, cervical, and colorectal cancer screening HEDIS samples and were below the 50th percentile for all. “Other Asian” is mostly Asian Indian members in the Group Care line of business.
  - *No PCP visits:* While Chinese and Vietnamese groups had lower rates of no PCP Visits, Filipino Medi-Cal members had higher no PCP visit rates for children (55.3%) and adults (66.5%), and Pacific Islander members had higher rates for Group Care (39.6%). Asian children rated the CAHPS getting routine care quickly measure significantly below White children.
- Black or African American members are 13.4% of Medi-Cal (45,588 members) and 10.3% of Group Care (482 members).
  - *Homelessness:* The prevalence of homelessness indicators was 11.3% of Medi-Cal children, 20.6% of Medi-Cal adults, and 6.6% of Group Care. By count they were the largest group for Medi-Cal adults and Group Care.
  - *Child preventive services:* Well-Child Visits in the First 15 Months (W30-6) and Ages 15 to 30 Months (W30-2), Childhood Immunization Status (CIS-10), and Lead Screening in Children (LSC) were all below MPL. In addition, they had the highest rate of no PCP visits for children and adolescents at 59.4%.
  - *Blood pressure control:* Controlling High Blood Pressure (CBP) in Black (African American) members was 45.00%, below the MPL of 61.31%.
  - *Chronic disease:* Asthma had both high prevalence and count for Black (African American) members. The prevalence of diabetes and hypertension were similar to the overall population but still had large numbers.

  - *Emergency visits and admissions:* Black (African American) adult Medi-Cal members had the highest rates of admissions, emergency, and high ED use. ED use and admissions were also high for Medi-Cal children and Group Care members. Almost a quarter of members used the ED more than primary care.
  - *Perinatal health:* For both lines of business about 20% of Black (African American) pregnant members had depression compared to 13.6% for Medi-Cal and 8.5% for Group Care pregnant members. Black (African American) perinatal Medi-Cal members had a higher prevalence of premature birth (3.2% compared to 2.5% overall).
- Hispanic (Latino) members were 34.8% of Medi-Cal (118,556 members) and 4.7% of Group Care (222 members).
  - *Chronic disease:* Although Hispanic (Latino) members had a lower prevalence of chronic diseases, in Medi-Cal they are still the largest group.
  - *Perinatal health:* Hispanic (Latino) members are also the largest group among perinatal members. They had the highest count of depression, low birth weight, and prematurity.
- White members were 8.0% of Medi-Cal (27,140 members) and 1.9% of Group Care (90 members).
  - *Homelessness:* The prevalence of homelessness indicators was higher for White Medi-Cal adults (11.3%) and Group Care (4.4%).
  - *No PCP visits:* White Medi-Cal adults had the highest rate of no PCP visits (72.1%). Medi-Cal children were also higher at 55.0%.
  - *Breast cancer screening:* White Medi-Cal members had a breast cancer screening rate of 48.56%, below the MPL of 52.60%.
  - *Depression:* The prevalence of depression was 10.4% for White Medi-Cal adults and 11.1% for Group Care compared to 6.4% for all Medi-Cal adults and 4.4% for all Group Care members.

Members with limited English proficiency

In 2024, 39.6% of Medi-Cal members (99,023 members) and 41.9% of Group Care members (1,965 members) preferred a language other than English. Members with limited English proficiency often were the same as or better than English-speaking members for the assessment measures. They need culturally and linguistically concordant chronic disease management support.

Gaps or disparities:

- *Diabetes and hypertension:* There was a higher prevalence of diabetes, hypertension, and diabetes with hypertension for non-English speaking Medi-Cal adults compared to English-speaking, which correlates with the higher prevalence of these diseases in

Chinese and Vietnamese adults. These ethnic groups have a high proportion of non-English speakers. Although the numbers are small, Medi-Cal adults with unknown language had the highest prevalence of diabetes, hypertension, and diabetes and hypertension.

Members with both diabetes and hypertension

There were 21,881 Medi-Cal members and 462 Group Care members who had diagnoses of both diabetes and hypertension. This group of members have multiple chronic diseases and more complex health needs and need more assistance navigating the healthcare system and accessing community resources. Many are older adults who need more support and resources.

- *Multiple chronic disease:* Besides having both diabetes and hypertension, these members also had about two times the prevalence of asthma and depression compared to Medi-Cal adults and Group Care overall.
- *Mental health services:* For Group Care members, the utilization of mental health services was low (1.9%) compared to the prevalence of depression (7.8%).
- *Emergency visits and admissions:* Emergency visits and admissions were higher than for all Alliance members. They also had better PCP utilization.

Pregnant or postpartum members

There were 7,344 pregnant or postpartum Medi-Cal members and 59 Group Care members ages 12 to 55. Pregnant and postpartum members need awareness and connection to services such as doulas, mental health providers, and other programs.

Gaps or disparities:

- *Homelessness:* The prevalence of homelessness indicators was 12.1% for Medi-Cal and 3.4% in Group Care compared to 6.2% for all Medi-Cal members and 1.5% for all Group Care members.
- *Depression:* The prevalence of depression for pregnant or postpartum Medi-Cal members was 13.6% and for Group Care 8.5%, which were both higher than overall members (5.1% Medi-Cal and 4.4% Group Care). Mental health services utilization could be improved for Medi-Cal pregnant and postpartum members (9.8%).
- *Emergency visits:* Pregnant and postpartum members had higher rates of emergency visits and high ED use compared to members overall. According to CareAnalyzer categories, about a third of them may have been avoidable.

Population Assessment Analysis

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

Programs, Services, and Activities

The Alliance is building on the previous year's programs and services with increased outreach by staff and planned projects with community health workers. Alliance staff will be doing mailings, calls, and outreach campaigns to address gaps in care and offer support with chronic disease management. Community health workers and health navigators will expand support for Alliance members and connections to community resources in the areas of disease management, perinatal mental health, and follow-up after emergency visits for mental illness.

Staffing, Systems, and Community Resources

The Alliance is continuing to expand the community health worker and doula network and partnerships with clinics and community organizations to increase reach to members. Clinic partnerships will encourage preventive services for Black children, cancer screenings, and follow-up after emergency visits for mental illness. In response to disparities for pregnant members in utilizing mental health services, the Alliance is launching a CHW program focused on perinatal mental health and working with Behavioral Health to connect members to services. The PHM Strategy section "Integration of Community Resources" describes the ways that the Alliance collaborates with other organizations and refers members to community resources. Programs are also working to train staff and providers on referrals to services and more integrated efforts and workflows.

CHA/CHIP Collaboration

The findings from the Alameda County and City of Berkeley CHA/CHIP emphasized the importance of access to care and mental health for county residents, as well as the social needs such as food and housing that also impact mental and physical health. The Alliance recognizes access to care and social needs as member needs for all, with some subpopulations having more complex needs. The CHA/CHIP informed the development and refinement of wellness and prevention programs, including the Diabetes Prevention Program and CHWs. To make wellness and prevention strategies more responsive to member needs, the Alliance conducts both mailings and one-on-one outreach calls to engage members and offer support with health care appointments, community resources, and any other member concerns. In addition to Alliance staff outreach, partnerships with CHW providers, clinics, and community organizations help with meeting members where they are and connecting them to Alliance services and other community resources. The Alliance prioritizes contracts or collaborations with providers and

groups with bicultural or bilingual capacity to meet the diverse cultural and language needs of members.

The Alliance has a shared goal with Alameda County Public Health on increasing doula utilization for Black or African American residents. The collaboration has provided vital information and input in standing up the doula benefit at the Alliance. Alameda County does not yet have enough doulas to support its perinatal population. The County has partnered with community-based organizations to train doulas to become Medi-Cal service providers. Some of these trained doulas are provided with information on contracting with the Alliance and a point of contact at the Alliance. Alameda County and the Alliance are working on tailored supports for all County-trained doulas to become Medi-Cal providers and contracted with the Alliance. This will help increase the number of trained doulas and doula utilization by Medi-Cal members in Alameda County. Additionally, the Access to Care CHIP Workgroup has brought stakeholders from across Alameda County together to brainstorm ways to improve access to doulas. This input has helped to inform the Alliance Doula Strategic Roadmap for future programs for doulas and members.

Population Assessment Analysis Table

Subpopulation Needs	**Current Activities and Resources**	**Updates Needed**
All members -Access to providers -Support, reminders, and education about needed services -Food, housing, and other social needs	*Activities:* Completed a second round of non-utilizer outreach to educate members about primary care. *Resources:* Hired Quality Engagement Coordinators to conduct outreach for gaps in care.	*Activities:* Developing projects with Community Health Worker organizations to support more members in engaging with their care and resources. *Resources:* Health Equity team building relationships with faith-based organizations for community education.
Child and adolescent members -Education, outreach, and support with transportation and other social needs -Provider availability for preventive services	*Activities:* QI project to improve well-child visits for Black children under 30 months and advertising campaign. *Resources:* First 5 conducted outreach to families and coordinates care.	*Activities:* Conduct outreach with Alliance staff calls and birthday cards. *Resources:* Continue partnership with First 5 as a CHW provider. New partnership with Beloved Birth Black Centering program at Alameda Health System.

Subpopulation Needs	Current Activities and Resources	Updates Needed
Members with disabilities -Support with managing chronic conditions and social needs	*Activities:* Disease management programs offer health coaching and health navigation support for asthma, diabetes, and high blood pressure. *Resources:* Care coordination for members with disabilities.	*Activities:* Consider expansion of disease management and CHWs to members with high ED use. *Resources:* Continue to make referrals for care coordination and other programs for members with disabilities.
Members with serious mental illness or serious emotional disturbance -Health navigation while in the ED -Access to mental health providers	*Activities:* Explored opportunities for CHWs and navigators in the ED. *Resources:* Submitted reports to delegates and direct providers so they can reach out to members.	*Activities:* Alliance staff conduct member outreach. *Resources:* Funding clinics for ED navigator and member incentives. Increase capacity for internal behavioral health assessments.
Members of racial or ethnic groups -Culturally concordant education and outreach -Support with housing and social needs	*Activities:* QI projects to improve well-child visits for Black children and breast cancer screening for Black women. *Resources:* Partnership with clinics for outreach and events.	*Activities:* Develop outreach and education campaigns that target populations with disparities. *Resources:* Expand clinic and community partnerships for culturally concordant outreach and education.
Members with limited English proficiency -Culturally and linguistically concordant chronic disease management support	*Activities:* Sending disease management outreach letters in threshold languages. *Resources:* Developed multicultural cookbook translated into threshold languages.	*Activities:* Distribute translated health education materials. *Resources:* Improve use of culturally and linguistically congruent staff, CHW providers, and interpreter services. Support DPP provider in developing

Subpopulation Needs	Current Activities and Resources	Updates Needed
		curriculum with Asian Health Services FQHC.
Members with both diabetes and hypertension -Care coordination -Support and resources for older adults	*Activities:* Health coaching outreach calls. *Resources:* Referrals to hospital and community programs.	*Activities:* Launch project with CHW organization to increase nutrition education and health coaching. *Resources:* Explore food as medicine opportunities. Better integrate department projects and workflows to enhance care coordination.
Pregnant or postpartum members -Awareness and connection to doulas, mental health services, and community programs	*Activities:* Developed doula education materials. *Resources:* Partnered with community organizations to develop and train a culturally concordant doula network.	*Activities:* Launch perinatal mental health CHW program. Expand member outreach about programs and services. *Resources:* Continue to train doulas and internal staff on perinatal resources.

Population Risk Stratification

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

The Alliance RSS methodology includes predictive and status metrics from CareAnalyzer, which uses The Johns Hopkins ACG System. Metrics include probabilities for persistent high utilizers, high cost, inpatient or ED utilization, and predicted need for care coordination. Additional metrics that incorporate non-cost or utilization factors are criteria for Enhanced Care Management (ECM) and Complex Case Management (CCM) identification, which include homelessness, multiple chronic conditions, and other populations with care management or social needs. Members are stratified into three main tiers: High Risk, Medium-Rising Risk and Low Risk. As members are identified and assessed, including social needs, they may move to a higher tier for more intensive support. Members in one tier may be eligible for or receive interventions listed in other tiers based on individual need.

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

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

According to the population assessment data on risk tiers as of December 2024, there is an association between racial/ethnic group and risk tier. For Medi-Cal adults and children, the groups at higher versus lower risk corresponded well with utilization. One group of concern was Hispanic (Latino) because of the adult expansion members who joined the Alliance in 2024. For adults, their no PCP visit rate was 59.1% which was the same as the overall rate of 60.3%. Their low-risk proportion was 74.3% compared to 69.4% overall, which may be slightly too high because of underutilization. For Medi-Cal children, a potential area for concern with

underutilization was Filipino children, most of whom (86.6%) were in the low-risk tier but also had a higher no PCP visit rate. However, their emergency visits and admissions were still low. Group Care has fewer members, making the racial/ethnic groups less reliable for comparison, but overall the risk tiers appear as expected. Overall, the Alliance RSS appears to correlate well with events in agreement with the Johns Hopkins analysis.

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

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

Alliance Risk Stratification Table - Medi-Cal
(December 2024, Total Medi-Cal Membership 340,744)

Medi-Cal Subset of Population	Programs and Services for Eligible Members	Number of Eligible Members	Percentage of Membership
High Risk Tier		**48,190**	**14%**
High Risk as defined by predictive utilization metrics, enrollment in ECM or CCM, and high-risk Transitional Care Services.	• Complex Case Management • Enhanced Care Management • Long-Term Care Management • Transitional Care Services (High Risk)		
Medium-Rising Risk Tier		**45,318**	**13%**
Not High Risk; high care coordination need.	• BirthWise Wellbeing • Care Coordination • Community Health Worker Services • Community Supports • Diabetes Prevention Program		

Medi-Cal Subset of Population	Programs and Services for Eligible Members	Number of Eligible Members	Percentage of Membership
	• Disease Management • Doula Services • Follow-up after ED Visit for Mental Illness QI Project • Transitional Care Services (Not High Risk)		
Low Risk Tier		**247,236**	**73%**
Low risk for care coordination.	• Cancer Prevention QI Project • Health Education • Well-Child Visits QI Project		

Alliance Risk Stratification Table – Group Care
(December 2024, Total Group Care Membership 4,690)

Group Care Subset of Population	Programs and Services for Eligible Members	Number of Eligible Members	Percentage of Membership
High Risk Tier		**241**	**5%**
High Risk as defined by predictive utilization metrics, enrollment in CCM, or high-risk Transitional Care Services.	• Complex Case Management • Transitional Care Services (High Risk)		
Medium-Rising Risk Tier		**911**	**19%**
Not High Risk; high care coordination need.	• Care Coordination • Disease Management • Doula Services • Transitional Care Services (Not High Risk)		
Low Risk Tier		**3,538**	**75%**
Low risk for care coordination.	• Cancer Prevention QI Project • Health Education		

Population Health Program Goals

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

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

Alliance Strategic Pillars

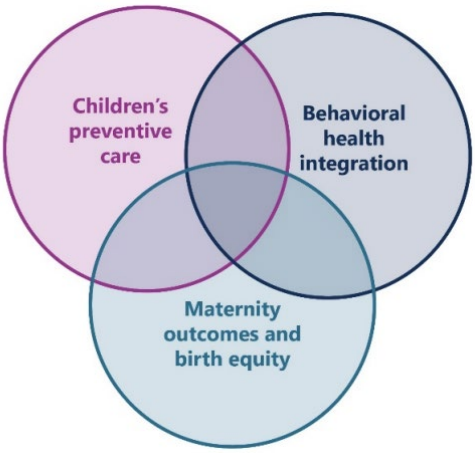
Strategic Pillars	2025 Programs
Address primary care gaps and inequities	• Cancer Prevention • Under 30 Months Well-Visits – Equity
Support members managing health conditions	• BirthWise Wellbeing – Equity • Blood Pressure Monitoring • Diabetes Prevention Program (DPP) • Disease Management Health Education
Connect members in need to whole person care	• Doula Services • Multiple Chronic Case Management • Post ED Visit for Mental Illness • Transitional Care Services (TCS)

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

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

Lastly, the Department of Health Care Services (DHCS) clinical focus areas and Bold Goals for 2025 were also an important factor in prioritizing goals under each of the NCQA areas of focus. To further the DHCS Bold Goals, the Alliance PHM Strategy includes programs to reduce disparities for well-child visits and immunizations, promote maternal depression screening, and increase follow-up for mental health after emergency department visits.

DHCS Clinical Focus Areas and Bold Goals



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

Alliance PHM Strategy Alignment

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

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

Managing Multiple Chronic Illnesses

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

Case Management provides ongoing chronic care coordination, interventions for temporary needs, and disease-specific management interventions for members who are high and medium-rising risk. The level of management necessary and the resources required for the member to regain optimal health or improved functionality are determined by member need. Multiple chronic illnesses are addressed with members in all Case Management programs, including Complex Case Management, Care Coordination, and Transitional Care Services. Complex Case Management (CCM) is a member-centered collaborative process between primary and/or specialty care providers, the member, and the care manager. Care Coordination provides health navigation support. Transitional Care Services (TCS) offers support for members transitioning from one level of care to another.

Goal: At least 80% of members with at least 2 or more comorbidities that are enrolled in any CM program (CCM, Care Coordination, TCS) between April 2025 and March 2026 will report a confidence level of at least 6 out of 10 in being able to better manage their health condition since receiving care management services on the case management satisfaction survey.

Target Population: Members with 2 or more comorbidities (diabetes, hypertension, asthma, or depression).

Programs or services:

- Complex Case Management: Nurse case managers provide intensive work with members to regain optimal health or improved functionality. The case manager directs care, assists members in understanding disease processes, and works with members and their providers to prioritize and achieve goals.
- Care Coordination: Case Management health navigators will coordinate disease management care including health navigation, complex case management, or other programs.
- Transitional Care Services: TCS care managers will assist members post-discharge in navigating through the health care system, educate on appropriate follow-up, reconnect them to their medical homes, and address coordination of care needs.

Disease Management Health Education (Medi-Cal and Group Care)

Disease Management programs offer health education, health coaching, and self-management tools for diabetes, hypertension, and asthma. The Alliance will conduct

mailings and targeted outreach calls to encourage member participation. The programs will provide health education, referrals to case management programs, and assistance with connecting to community health worker services that provide access to healthy foods, cooking classes and recipes, education from nutritionists and fitness experts, and support groups.

Goal: At least 80% of members with 2 or more chronic conditions who participated in health education between April 2025 and March 2026 will have a confidence score in disease self-management knowledge and behaviors of at least 24 out of 30 after receiving health coaching sessions as measured by a post health coaching assessment.

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

Programs or services:

- Disease management health education: Health Educator works with members in setting goals and provides education regarding disease management and referrals to case management and community resources.
- Community health worker program: Offer healthy food, cooking workshops, movement sessions, bi-weekly support groups, and guest lectures by nutritionists, fitness experts, and community elders.

Managing Members with Emerging Risk

BirthWise Wellbeing (Equity Focus, Medi-Cal)

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

The PHM assessment data identified depression and connection to non-specialty mental health services as issues for Medi-Cal pregnant and postpartum members. Among pregnant and postpartum members, Black (African American) and American Indian or Alaskan Native members had a higher prevalence of depression. Hispanic (Latino) had the highest count of Medi-Cal members with depression, so all three of these racial/ethnic groups are an equity focus for this program.

The Alliance will partner with community health workers that will connect Black, Indigenous, and other people of color (BIPOC) peer support coaches to BIPOC, low-

income birthing people to prevent perinatal depression and anxiety. Birthing parents meet with coaches weekly over a virtual video platform. Members work with their coach for up to 10 weeks. They participate in exercises with their coach, learn tools and tips to manage their stress, and prepare to navigate the postpartum period. Satisfaction surveys are completed at the end of the peer coaching sessions to evaluate the impact of the support.

Goal: By March 2026, at least 80% of members that receive peer coaching support will rate the usefulness of the information received at a 4 or above out of 5 using the program satisfaction survey.

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

Programs or services:

- Community health worker coaching and outreach: Targeted outreach to low-risk perinatal members to inform them of the CHW services. The program will include support coaching provided by coaches with lived-experiences to low-risk perinatal members, with an emphasis on Black, American Indian and Alaskan Native, and Hispanic members. CHWs will conduct standardized depression and anxiety screenings and refer to appropriate behavioral health providers for follow-up and treatment.
- Behavioral health referrals and treatment: Alliance Member Services and Behavioral Health staff assess and refer members who respond to the mailing and are interested in behavioral health services to the appropriate level of behavioral health treatment.
- Health education resources: Referrals to prenatal classes, parenting classes, and lactation consults as needed.

Blood Pressure Monitoring QI Project (Medi-Cal and Group Care)

This project will assist members in utilizing their pharmacy or durable medical equipment benefit to obtain a blood pressure monitor. High blood pressure increases the risk of heart attack, stroke, heart failure, kidney disease, and other conditions. Managing high blood pressure is a cost-effective way to reduce those risks. However, many people with high blood pressure remain untreated, and a key component of treatment is regular tracking of blood pressure readings. Blood pressure monitors are a covered benefit, allowing for increased access to monitoring equipment.

Goal 1: At least 20% of members outreached will receive a blood pressure monitor.

Target Population: Members assigned to Alameda Health System FQHC clinics with no record of having received a blood pressure monitor through the Alliance and who do not have a current BP reading recorded in the measurement year.

Goal 2: Increase Controlling High Blood Pressure (CBP) administrative rate for Alameda Health System by 2 percentage points from MY2024 (as of April 2025) to MY2025.

- Medi-Cal: 62.72% to 64.72%
- Group Care: 63.08% to 65.08%

Target Population: Members 18-85 years of age with a diagnosis of hypertension assigned to Alameda Health System.

Programs or services:

- Blood pressure monitor outreach: QI Engagement Coordinators will conduct outreach to members assigned to Alameda Health System FQHC clinics with no record of having received a blood pressure monitor through the Alliance and who do not have a current BP reading recorded in the measurement year to offer delivery of a BP monitor to their home.
- Health education resources: Coordinators will refer members to health education for materials and classes.
- Health coaching: Members will be offered health coaching to learn about high blood pressure monitoring and self-management.

Cancer Prevention QI Project (Medi-Cal and Group Care)

This project includes outreach efforts and accessible screening methods to encourage more members to complete cancer prevention screenings. Screenings for breast cancer, cervical cancer, and colorectal cancer play a vital role in early detection by identifying precancerous changes or tumors before symptoms appear. Detecting cancer at an early stage significantly increases the chances of successful treatment, improves survival rates, and can even prevent the disease from developing in some cases. There is a continued equity focus for breast cancer screening because African Americans experience higher cancer incidence and mortality rates compared to other racial and ethnic groups in the U.S. due to a combination of genetic, socioeconomic, and systemic healthcare factors.

Breast Cancer Screening

Goal 1: Increase Breast Cancer Screening (BCS) rates for Black (African American) women ages 40-74 by 3 percentage points from MY2024 (as of April 2025) to MY2025.

- Medi-Cal: 52.34% to 55.34%
- Group Care: 61.54% to 64.54%

Target Population: Black (African American) women 40-74 years of age.

Programs or services:

- Mobile mammography: Coordinate and sponsor mobile mammography services for members at target clinics with a high volume of Black women and low screening rates.
- Mammogram incentive program: Provide gift cards to members for completing mammograms at target clinics.
- Reminder calls and mailings: The Alliance will educate African American members on breast cancer screening through mailed flyers which have been tailored to include images and facts representing the target population. Engagement coordinators will follow up and call members who are non-compliant to remind them they are due for a mammogram to encourage members to complete it.

Cervical Cancer Screening

Goal 2: Increase Cervical Cancer Screening (CCS) rates by 3 percentage points from MY2024 (as of April 2025) to MY2025.

- Medi-Cal: 52.89% to 55.89%
- Group Care: 62.05% to 65.05%

Target Population: Members 21-64 years of age.

Program or Services:

- CCS birthday cards and reminders: Members assigned to nine direct Alliance providers will receive a birthday card, during their birthday month, to remind the member they are due for a pap smear and eligible to receive a $25.00 gift card for completing the services. They will also receive an outreach reminder call encouraging the member to complete the CCS screening.
- At home HPV testing kit pilot program: In partnership with the vendor, Let's Get Checked, members at pilot clinics will be able to complete an at home High Risk HPV test.

Colorectal Cancer Screening

Goal 3: Increase Colorectal Cancer (COL) screening rates by 3 percentage points from MY2024 (as of April 2025) to MY2025.

- Medi-Cal: 45.27% to 48.27%
- Group Care: 57.15% to 60.15%

Target Population: Members 45 to 75 years of age.

Program or Services:

- Cologuard testing: In partnership with Exact Sciences, the manufacturer of Cologuard, members assigned to providers with low screening rates will receive test kits at their home. Exact Sciences will provide reminder calls and education to members who need assistance providing and returning the test sample.
- Educational mailer: Members ages 45 to 49 who are due for screening will receive an educational flyer explaining the lowered age recommendations and screening recommendations, with information on how to schedule a screening.

Diabetes Prevention Program (DPP) (Medi-Cal)

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

Goal: At least 25% of participants who have continued tracking their weight and completed 9 sessions between April 2025 and March 2026 will have reached and maintained at least 5% weight loss.

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

Programs or services:

- Lifestyle change program: Year-long online and app-based programs in English and Spanish with member incentives to encourage continued program engagement.
- Member outreach campaign: The Alliance helps clinics partner with DPP providers by exchanging data so clinics can identify patients for outreach. DPP

providers outreach to and gain consent for members to enroll into the program. The outreach is conducted telephonically and via text. In addition, members are informed about DPP through the Alliance member wellness form, which is distributed multiple times throughout the year, including during new member orientation, health-related mailings, and as part of the member newsletter. The form includes an option for members to request more information about DPP.

Keeping Members Healthy

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

This project monitors and improves well-child visit measures to address disparities for Black (African American) members in the first 30 months of life.

Goal: HEDIS well-child visit (W30) and immunization (CIS-10) rates will increase for Black (African American) members by 5% from MY2024 (as of April 2025) to MY2025.

- Well-Child Visits in the first 15 months of life (W30-6+): 38.57% to 40.50%
- Well-Child Visits in the first 15-30 months of life (W30-2+): 67.26% to 70.62%
- Childhood Immunization Status (CIS-10): 15.79% to 16.58% (administrative rates)

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

Programs or services:

- Outreach calls: Outreach coordinators call, educate, and help schedule well-visits for members up to 30 months of age experiencing gaps in care assigned to participating clinics.
- Well-child advertising campaign: Educate members of preventive services and how to access them by displaying a billboard and posters throughout the county. A billboard will be located near the highway in a zip code that has large gaps in completed well-visits for Black (African American) members. Posters will be placed throughout the county in train and bus stations.
- Well-child visits prenatal campaign: Send letters to members who are pregnant to inform them of the purpose, frequency, immunizations, and screenings of their child's well-visits and offer an incentive.
- Beloved Babies Centering Program incentive: The Alliance is partnering with Alameda Health System to help complete well-child visits ages 0-15 months among Black babies by providing $25 gift cards to members that complete their visits. The goal of the program is to improve access, utilization and quality of perinatal care for Black patients in Alameda County. The program also seeks to

improve system responsiveness to address the social determinants of health among Black families.

Doula Services (Medi-Cal and Group Care)

Doulas provide holistic, person-centered, and culturally affirming care to members who are pregnant or were pregnant within the past year. Services include health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum members before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion. Doulas can help with developing a birth plan, birthing techniques, and help with breastfeeding, healing, and recovery. According to Gruber KJ et. al, 2013, individuals who work with a doula during the perinatal period have better birth outcomes, are four times less likely to have a low-birth-weight baby, are two times less likely to experience a birth complication and are significantly more likely to initiate breastfeeding.

Goal 1: By March 2026, at least 2% (approximately 75) Black (African American), Hispanic (Latino), or American Indian or Alaskan Native Medi-Cal members who are or were pregnant in the last year will receive doula services.

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

Goal 2: By March 2026, at least 10% (approximately 5) Group Care members who are or were pregnant in the last year will receive doula services.

Target Population: Group Care members who are or were pregnant in the last year.

Programs or services:

- Doula services: Doulas provide development of a birth plan, health navigation, and linkages to community-based resources.
- Doula education outreach campaign: Targeted education for members in the perinatal period through member mailings that include a doula flyer and pregnancy care book. Community organizations will also inform members in target population of the availability and benefits of doula services.

Patient Safety or Outcomes Across Settings

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

This project will involve efforts to improve the timely follow-up to emergency department (ED) visits for mental illness.

Goal: Follow-up After ED Visits for Mental Illness (FUM) - 30 days HEDIS rate for Medi-Cal members will increase from 66.38% in MY2024 (as of April 2025) to 67.38% in MY2025.

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

Programs or services:

- Outreach calls: Alliance Quality Improvement staff will identify and call members with mental illness diagnoses based off claims and encounter data within 30 days of ED visit and conduct a warm handoff to the behavioral health team for assessment completion and continued care coordination.
- Member incentive: The Alliance will partner with Axis Community Health Center FQHC to offer a $25 gift card incentive to members who complete a follow-up visit at the clinic after an emergency department visit for mental illness.
- Behavioral Health ED Navigator: The Alliance is funding a Behavioral Health ED Navigator who will be working at an Alameda Health System safety net hospital. The navigator will improve follow-up care for patients discharged from the ED by conducting in-person and telephonic follow-up visits and helping members access essential health and social services, including County behavioral health resources, coaching, and medication services.

Transitional Care Services (Medi-Cal and Group Care)

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

requirements and seeking new community partners to cover the TCS program expansion.

Goal: Increase the percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7 days post-discharge by 1 percentage point from March 2025 to March 2026.

- Medi-Cal: 23.3% to 24.3%
- Group Care: 28.5% to 29.5%

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

Programs or services:

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

Other Alliance Programs and Services

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

1. Basic Population Health Management (BPHM)
2. Community Health Worker (CHW)
3. Community Supports (CS)
4. Enhanced Care Management (ECM)
5. Health Education
6. Long-Term Care (LTC) Care Management
7. Steps for Healthy Living

Basic Population Health Management (BPHM)

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

Community Health Worker (CHW) *(Medi-Cal only)*

The Alliance offers Community Health Worker (CHW) services as a preventive health benefit to members. Community health workers (CHWs) play a critical role in advancing population health by addressing health disparities, improving equitable access to care, and fostering community wellness. They promote health equity by reducing disparities through education, advocacy, and access to essential services such as screenings, nutrition counseling, and chronic disease management, while also addressing social determinants of health like housing, transportation, and food security. They educate communities on healthy lifestyle changes and support adherence to treatment plans. Additionally, CHWs empower individuals through outreach, informal counseling, advocacy, and education, fostering self-sufficiency and strengthening community care systems.

CHW services are integrated with PHM through review of the Population Needs Assessment (PNA), member underutilization reports, input from the Community Advisory Committee, HEDIS results, and trends identified in grievances and appeals. The Alliance has developed priority areas for CHW collaborations based on the PHM Strategy and Comprehensive Quality Strategy goals to support the following:

1) Chronic disease management
2) Maternal mental health
3) Quality measures focusing on behavioral health and preventive services, such as follow-up after ED visits for mental illness.

Community Supports (CS) *(Medi-Cal only)*
CS concentrates on the social determinants of health and enables the Alliance to provide medically necessary support services to members in order to maintain their health and ensure that they remain in their homes, communities, and out of emergency departments (EDs), acute hospitals, and other facilities. The Alliance currently provides asthma remediation, housing services (including housing deposits, housing navigation, and housing tenancy sustaining services), medically tailored meals/supportive food, medical respite, personal care and homemaker services, caregiver respite services, home modifications, nursing facility diversion/transition to assisted living facilities, and community transition services/nursing facility transition to a residence.

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

Health Education

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

Materials for children, adolescents, and parents cover topics such as preventive care, healthy eating, pregnancy care, parenting, safety, and more. Some of the programs available include lactation consultations, positive parenting classes, doula services, and CPR and first aid training. Members receive a wellness request form with member newsletters, prenatal and postpartum mailings, and other mailings that allow members to request more health education resources.

The Alliance Health Education Program uses PNA findings, PHM Strategy goals, HEDIS results, and other data sources to inform its annual workplan program priorities and target populations. Health Education priorities in 2025 include the development and distribution of training videos and job aids for doulas, increasing member utilization of doula services, streamlining tobacco cessation referrals to Kick It California, connecting members to CHW health education supports, and developing new health education resources for the senior population.

Long-Term Care (LTC) Care Management *(Medi-Cal only)*

The Long-Term Care program, which encompasses care management services, is administered by the LTC department.

Intensive social work care management is the process of facilitating the connection between members in long-term care facilities who are interested in returning to the community and the long-term care social workers who help manage the social determinants of health (SDOH) that may be affecting the member's ability to return to the community.

The Long-Term Care populations who are at a high risk for readmission due to complex medical conditions are the primary focus of intensive RN care management. They collaborate with nursing facilities to guarantee that all care is rendered promptly and that the member is assessed and authorized for any necessary preventative health programs or equipment.

Steps for Healthy Living

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

How Members are Informed about PHM Programs

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

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

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

How Members are Informed about PHM Programs Table

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

Program	Member Eligibility and How Informed	Utilizing Program Services	How to Opt In or Out
	eligible for Complex Case Management (CCM) and Transitional Care Services (TCS) if they meet criteria based on hospital utilization and co-morbidities. The monthly Population Health Report helps to identify members who meet CCM or high-risk member criteria, and the utilization management report on member inpatient stays is used to identify members eligible for TCS. The CM team or TCS care manager calls members to offer CCM; if the member declines, they will be offered Care Coordination services.		transferred to an RN (or scheduled for a later callback date) to complete a CCM assessment and care plan. If they consent to TCS, the care manager will complete the TCS assessment. If the member declines CCM and TCS, but consent to Care Coordination, they are transferred to a health navigator. If member declines any service, member has opted out.
Community Health Worker (CHW)	CHW services require a written recommendation submitted to the MCP by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. For CHW services rendered in the emergency department, the treating	Members receive CHW services via telehealth, clinic or hospital settings, or in the community.	If the member consents to receiving CHW services, they receive the services. If the member declines or stops engagement, the member has opted out.

Program	Member Eligibility and How Informed	Utilizing Program Services	How to Opt In or Out
	provider may verbally recommend CHWs and later document in the member's medical record. Members are informed of CHW services by the Alliance through targeted pilots to support closing care gaps, word of mouth, outreach events, or CHWs reaching out to members through phone or community-based settings.		
Community Supports (CS)	Members are identified by the Alliance, the Alliance provider network, and other county and community organizations for referral to CS services. Member eligibility and clinical criteria for CS service(s) are reviewed by the Alliance UM team.	After CS service(s) is approved by the Alliance, the CS provider will work with the member to deliver the approved service(s).	Members must consent to participate in CS. If the member declines, member has opted out.
Diabetes Prevention Program (DPP)	Members must meet the CDC guidelines for DPP eligibility. Members can be referred to a DPP provider from Health	Members participate online in health coaching, education, and nutrition and exercise tracking.	Members opt in by taking an online survey or calling to enroll and begin services. Members are also referred directly

Program	Member Eligibility and How Informed	Utilizing Program Services	How to Opt In or Out
	Education, Case Management, or Member Services staff. Clinic providers and primary care physicians are also referring directly to DPP programs. Members can also self-refer to DPP through the Alliance public website.		to a DPP provider by their physicians. Members may opt out at any time by ending program engagement.
Disease Management - BirthWise Wellbeing	Members that are at risk for perinatal depression (pregnant or have been pregnant in the past year) are eligible for BirthWise Wellbeing. Members are informed of services through a targeted mailing campaign.	Members are provided health education materials, connected to doula services and peer coaches, and/or referred to mental health services, depending on need.	Members can opt in by contacting the Alliance. Members can opt out at any time by ending engagement.
Disease Management-Chronic Conditions	Members identified with one or more chronic diseases (diabetes, hypertension, and/or asthma), are enrolled and sent an educational letter relevant to their chronic condition to inform them about the program. Members may be outreached to telephonically	Members receive health education and based on need can receive health coaching, care coordination, nurse case management services, referral to community resources, and community health workers.	Eligible members are enrolled in the program. They contact Case and Disease Management staff to receive additional services and can opt out at any time by communicating their preference to the Alliance.

Program	Member Eligibility and How Informed	Utilizing Program Services	How to Opt In or Out
	depending on their level of need and risk.		
Doula Services	Members are eligible throughout pregnancy and one year postpartum. The Alliance proactively identifies perinatal members and sends a mailer that includes information about eligibility and how to access doula services.	Members can receive doula prenatal and postpartum visits and support during labor and delivery.	Members opt in by contacting a contracted doula network provider listed in the provider directory or calling the Alliance. Members may stop services at any time.
Enhanced Care Management (ECM)	Member meets eligibility criteria for ECM. ECM providers contact the member by telephone or face to face to offer ECM.	Member works with ECM provider for services.	If the member consents, they are enrolled in the program. If member declines, member has opted out.
Health Education	All members are offered health education materials and various classes and programs. Materials and program information are available upon request via the Wellness Request Form, which is distributed to all members when they are enrolled, through the member newsletter, and in other correspondence. These are also available to	Members can refer themselves to programs and classes depending on the program or class. Community agencies or vendors offer some programs. Participation may be online, via mail, or in-person.	Members call the Alliance, mail a Wellness Request Form, or fill the form out in the Member Portal to receive program information. Depending on the program or class, members self-enroll, or the Alliance facilitates enrollment. Members may opt out at any time by ending program engagement.

Program	Member Eligibility and How Informed	Utilizing Program Services	How to Opt In or Out
	download from the Alliance website and a fillable version is available through the Member Portal.		
Long-Term Care (LTC) Care Management	Members in LTC who are interested in transitioning back to the community are eligible for intensive social worker care management. Members in LTC at high risk for readmissions are eligible for intensive nurse care management.	Depending on the member's level of function, activities are in collaboration with the member, family, and/or the facility.	Services are provided to eligible members. Care managers can coordinate with facilities if the member or their family does not participate.
Quality Improvement (QI) - Incentive Projects	Eligibility is dependent on: 1) The measure's denominator, 2) If the member has not completed the services to be in the measure's numerator, and 3) Clinic(s) that participate in this program. Members who qualify are informed by their assigned clinic.	Clinics received Gap in Care Lists of members who have not completed the services being targeted. Clinics conduct telephonic or SMS Text outreach to help schedule members.	Members opt in by scheduling and completing visits. Members can opt out by not accepting outreach, or declining scheduling the needed services.
Quality Improvement (QI) - Outreach Calls	Eligibility is dependent on: 1) The focused measure's denominator,	Members are outreached to telephonically to help	Members opt in by accepting the telephonic outreach and scheduling needed services.

Program	Member Eligibility and How Informed	Utilizing Program Services	How to Opt In or Out
	2) If the member has not completed the services to be in the measure's numerator. Members who qualify are informed by receiving a telephonic phone call.	coordinate scheduling needed services.	Members can opt out by declining participation verbally on the telephonic outreach.
Steps for Healthy Living	All members have access to evidence-based self-management tools through the member portal.	Members participate by completing a comprehensive and holistic health assessment and get access to various resources to take action.	Members choose to participate online via the member portal.
Transitional Care Services (TCS)	Member transitions from one setting to another. For high-risk members, the assigned care manager makes at least two telephonic contact attempts and sends a letter to members to offer TCS. For lower-risk members, the member receives one telephonic contact attempt and is mailed a letter offering TCS services.	Member participates via telephone after a CM team member calls the member or after the member receives a letter from the CM team. CM collaborates with inpatient UM and hospital discharge planner as needed.	Members can actively participate in TCS by contacting the Alliance. Members may also choose to opt out or limit participation. In these cases, services will be coordinated as needed for members without their participation.

How Member Programs are Coordinated

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

Case Management Programs

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

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

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

Community Health Worker Services

Community Health Worker strategies focus on aligning interdepartmental priorities to address health equity through foundational data-driven solutions. These strategies leverage key measures such as NCQA HEDIS and MCAS metrics to identify care gaps and enact qualitative and quantitative interventions targeting member wellness. Priority areas include closing care gaps, reducing health disparities, promoting client autonomy, and incorporating Persons with Lived Experience (PWLE). CHW services are deployed for priority populations through partnership building, educational initiatives, outreach efforts, and interdepartmental collaboration.

The integration of CHWs into population health efforts at Alameda Alliance involves a structured scope of work process and workflow development that encourages departments to critically assess the intended impacts and outcomes of CHW interventions. If no provider is available within the organization's repository for specific CHW-targeted strategies, the

Community Health Work Strategies team actively recruits providers through partnerships and outreach to ensure effective implementation of interventions tailored to the needs of priority populations.

Disease Management Programs

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

The BirthWise Wellbeing program identifies perinatal members at risk for depression based on claims and dates of service in the last four months that include perinatal diagnoses and/or delivery claims. Members will only be identified once every ten months. All members are notified by mail about the services available to them in the BirthWise Wellbeing program that include care coordination, doula services, peer coaching, health education, and depression screenings and referrals to mental health providers or Alameda County Acute Crisis Care and Evaluation for Systemwide Services (ACCESS) Program. The letter invites members to call the Alliance Member Services Department to utilize all perinatal resources available to them. BirthWise services are tracked in Alliance systems of record, TruCare and HealthSuite.

Enhanced Care Management (ECM)

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

Health Education

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

Long-Term Care (LTC) Care Management

The Long-Term Care (LTC) department is integrated within the Utilization Management program. The LTC department acts as the single point of contact for its members residing in a Long-Term Care facility. The LTC department also performs transitional care services (TCS) for members entering a Long-Term Care facility and Basic Population Health Management (BPHM) for its members. The program is designed to work collaboratively with internal staff, delegated entities, and safety net providers within the community directly contracted with the Alliance to coordinate the delivery of appropriate, cost effective, quality-based healthcare.

QI Projects

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

Transitional Care Services (TCS)

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

The program leverages the ADT system for timely notification of member admission and discharge and track data such as date of discharge via hospital electronic health records for admissions not requiring prior authorization or admissions where Alliance is not primary payor (i.e., Dual Medicare members). Upon receipt of the facility admission notification, the Alliance

CM team will evaluate the member for enrollment into the TCS program. Evaluation occurs by reviewing the facility record and the Alliance's internal electronic medical record, checking for other external case management programs or teams.

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

Integration of Community Resources

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

- **Care coordination for children ages 0 to 5** – In partnership with the Alliance, First 5 conducts telephonic outreach to members, care coordination, and provider assistance. Based on their outreach to members, First 5 will offer care coordination to help the member's family to schedule appointments and access identified community services.

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

- **Case Management referrals** – Alliance Case Management staff includes Nurse Case Managers, Social Workers and Health Navigators who assist members in accessing needed community resources. The Alliance maintains a listing of community resources for behavioral health; domestic violence; food, housing, and utilities assistance; LGBTQ; and older adults and people with disabilities, available to Alliance care management staff to facilitate referrals to community resources. The Alliance also utilizes the FindHelp community resource directory to connect members to new and existing resources.

- **Coalition participation** – The Alliance regularly participates in community meetings that support the wellness goals of our PHM Strategy. These include the Alameda County Breastfeeding Coalition (ACBC), the County Nutrition Action Partnership (CNAP), the Regional Asthma Management Advisory Committee, the Safe Kids Coalition, the Senior Injury Prevention Partnership, and the Perinatal Equity Initiative (PEI). Each of these meetings include various stakeholders that work together to share resources and collaborate with county-wide initiatives to address member health needs. The Alliance has collaborated with CNAP on the February Healthy Heart campaign and development of a multicultural cookbook. The Alliance continues to update the PEI on its expansion of the benefit and has incorporated feedback from the community in its efforts to stand up the doula benefit in Alameda County. Health Education staff are active participants of the ACBC by participating in steering committee meetings and contributing articles to their monthly newsletter.

- **Community Supports services** – The Alliance currently offers asthma remediation, housing services (including housing deposits, housing navigation, and housing tenancy sustaining services), medically tailored meals/supportive food, medical respite, personal care and homemaker services, caregiver respite services, home modifications, nursing facility diversion/transition to assisted living facilities, and community transition services/nursing facility transition to a residence.

  The Community Supports (CS) team collaborates with the ECM team to host a monthly learning collaborative with the providers and additional community partners. At these learning collaboratives, various community resources are discussed, including the CS services and ECM populations of focus offered by the Alliance. Community Supports providers are committed to serving members on a timely basis and consistently collaborating with the plan to ensure appropriate and coordinated services. A full list of Community Supports services and providers is below:

  Community Supports Services and Providers Table

Community Support Service	Provider
Asthma Remediation	• Alameda County Public Health - Asthma Start (<18) • Alameda County Front Door • Roots Community Health
Housing Services, including: • Deposits • Navigation • Tenancy Sustaining Services	• Alameda County Health • Abode Services • Bay Area Community Services • Insight Housing • Building Futures with Women and Children • Building Opportunities for Self-Sufficiency • East Bay Innovations • East Oakland Community Project • Fred Finch Youth and Family Services • Housing Consortium of the East Bay • Lifelong Medical Care • Cardea Health • YEAH/Covenant House • City of Fremont • East Bay Asian Local Development Corporation • La Familia Counseling Service • Five Keys Schools and Programs

	• Larkin Street Youth Services • Life Skills Training and Educational Programs, Inc. • Roots Community Health Center • Satellite Affordable Housing Associates • St. Mary's Center • Tiburcio Vasquez Health Center • Operation Dignity • Women's Daytime Drop-in Center
Medically Supportive Food	• Project Open Hand • Recipe for Health • Alameda County Food Bank
Medical Respite	• Lifelong Medical Respite • Cardea Health • BACS Medical Respite
Personal Care and Homemaker Services	• 24 Home Care • Omatochi
Caregiver Respite Services	• 24 Home Care • Omatochi
Home Modifications	• East Bay Innovations • Omatochi
Diversion Nursing Facility/Transition to Assisted Living Facilities	• East Bay Innovations • Omatochi
Community Transition Services	• East Bay Innovations • Omatochi

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

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

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

Activities That Are Not Direct Member Interventions

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

Sharing data and information with providers

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

Offering evidence-based or certified decision-making aids

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

Practice transformation support to PCPs

- Alliance Quality Improvement staff hold measure highlight webinars sharing clinical background and best practices for HEDIS measures related to well-child visits, cancer screenings, and chronic disease management and behavioral health.
- Funding and technical assistance are provided to PCP clinics to improve HEDIS measures for well-child visits, follow-up after ED visits for mental illness, and other quality improvement projects of interest to clinics. PCPs can participate in an incentive project to extend office hours for services tied to HEDIS measures.
- The Alliance Provider Recruitment Initiative provides grants to hire and retain health care professionals, including PCPs. Grant funds are also available to support training and certifications for community health workers and doulas.

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

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

Value-based payment arrangements

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

Collaborating with hospitals

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

Interacting with and integrating delivery systems

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

Conclusion

The 2025 Population Health Management Strategy summarizes the Alliance's analysis and roadmap to meet the physical and mental health needs of its diverse membership. This year's PHM Strategy outlines programs and services that care for higher risk members, such as members experiencing transitions of care and those with complex care needs as well as strategies to address the social determinants of health that exacerbate inequities through tailored outreach and connections to community health workers and doula services. The Alliance also provides programs designed to support members with multiple chronic conditions such as diabetes and hypertension, members at risk for diabetes, and pregnant and postpartum members at risk for depression. There is a continued focus on preventive care efforts with programs to improve rates of well-child visits and cancer screenings. The Alliance strives to employ creative and person-centered solutions that center equitable approaches and impact relevant clinical, utilization, and member experience measures. The Alliance aspires to partner with members, providers, and the community to achieve optimal health and wellness for all members.

Availability of Practitioners
Cultural Needs and Preferences

Analysis and Recommendations
2024

Presented to the Alliance Quality Improvement Health Equity Committee on May 9, 2025

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Alameda Alliance for Health
Availability of Practitioners
Member Cultural Needs and Preferences
Analysis and Recommendations

I. PROGRAM GOAL

Alameda Alliance for Health (Alliance) is a managed care health plan that serves eligible Medi-Cal and Group Care members in Alameda County, California. The goal of the Alliance is to offer a practitioner network that meets the cultural and linguistic needs of its membership in sufficient volume and capabilities. Our goal is to ensure that all members receive equal access to high quality health care services that are culturally and linguistically appropriate regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, creed, health status, or identification with any other persons or groups defined in Penal Code section 422.56.

The Alliance has established a Cultural and Linguistic Services program to ensure that all members receive equal access to high quality services. The Alliance:

- Hires, assesses, and monitors bilingual Alliance staff to speak with members in their language
- Provides free telephone, video, and in-person interpretation
- Provides member materials in the Alliance's threshold languages, English, Spanish, Chinese, Vietnamese, and Tagalog (2024). Alternative formats, such as large print, audio format, Braille, data CD and other auxiliary aids are also available
- Recruits, credentials, and contracts with practitioners who speak languages that reflect members' linguistic needs
- Recruits, credentials, and contracts with practitioners with similar cultural and ethnic backgrounds as members
- Provides and requires practitioners to complete cultural competency training courses based on racial/ethnic composition of the member population.

II. REPORT PURPOSE

This report provides an analysis of cultural, racial, ethnic, and linguistic needs and preferences of Alliance members and compares those needs to the composition of the Alliance practitioner network. To better understand the unique cultural and linguistic needs of our members, Alliance performs quarterly and annual assessments of our members as well as evaluates the composition of practitioners that can meet those needs within the current network. The Alliance then uses that data to adjust the practitioner network to meet the needs of the population.

The purpose of this report is to:

1. Identify ethnic, racial and linguistic needs of Alliance members from enrollment data.
2. Conduct research into the cultural needs and preferences based on characteristics of Alliance members.
3. Identify language, race/ethnicity and cultures of practitioners in the network to assess whether they meet members' needs
4. Assess whether members' CLS needs and preferences were met
5. Identify network activities to address members' language needs and cultural preferences.

Alameda Alliance for Health understands its responsibility to provide culturally and linguistically appropriate practitioner networks to our members whenever possible. Members are generally more trusting and comfortable with practitioners who speak their language and/or share their cultural/ethnic background. Additionally, members who face obstacles of understanding or access may not seek timely medical or behavioral health care services.

This report demonstrates that Alliance understands the needs of its members and the necessity of meaningful action to tailor our practitioner network towards those needs and preferences.

III. PROCESS AND FREQUENCY REPORTING

This report was created in 2025 based on data collected throughout 2024. The report was compiled by the Lead Interpreter Services Coordinator and the Manager of Cultural and Linguistic Services.

The process for the development of this report is:

1. The Lead Interpreter Services Coordinator is responsible for the collection of data and development of the summary report.
2. The Director of Population Health and Equity and the Manager of Cultural and Linguistic Services analyze the data and drafts the recommendations for submission to the Alliance Cultural and Linguistic Services Subcommittee of the Quality Improvement and Health Equity Committee (QIHEC).
3. The Director of Population Health and Equity presents significant results, recommendations, and actions to the Alliance QIHEC.

IV. DEFINITIONS

Alliance –Alameda Alliance for Health

Group Care – Commercial plan of Alameda Alliance for Health

Cultural and Linguistic Services Subcommittee (CLSS) is a subcommittee of the Quality Improvement and Health Equity Committee (QIHEC). It reports demographic changes in the Alliance membership, language services offered, grievances related to discrimination, sensitivity and language services and overall execution of the Alliance's Cultural and Linguistic Services Program to QIHEC. Its primary role is to ensure members receive culturally and linguistically appropriate health care services regardless of language, ethnicity, gender identity, sexual orientation, age, or disability.

V. DATA SOURCE AND METHODOLOGY

The sources, population and information collected are summarized in Table A – Data Sources and Characteristics below.

Table A. Data Sources and Characteristics

Data Source	Frequency	Population
Alliance Member Enrollment Database Report by Business Line	Quarterly	All Alliance Members active during calendar year

Data Source	Frequency	Population
Alliance Practitioner Credentialing Database	Annually	All Alliance Network credentialed during calendar year
Alliance Interpreter Services Report	Quarterly	Alliance Interpreter Services Provided
Alliance Member Satisfaction Survey: Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS)	Quarterly	Random Sample of Alliance members seen by Primary Care Physician
Alliance Grievances and Appeals Reports	Quarterly	Members who express any form of dissatisfaction of Alliance benefits and services
Alliance Discrimination Cases Report	Annually	All Alliance member grievance cases related to discrimination
Pew Research Center Religious Landscape Study	2014 Report	Religious preferences by region

VI. INDICATORS / METRICS

The specific metrics tracked by the Alliance from the data sources are listed in Table B – Indicators and Metrics below. The Alliance selected these metrics to best understand the cultural and linguistic needs of our membership and determine how those needs are currently met by the existing practitioner network.

Table B. Indicators and Metrics

Indicators/ Metrics Tracked	
Data Source	**Metric**
Alliance Member Enrollment Database Report by Business Line	• Language Spoken (% of all members) • Member Race/ Ethnicity (% of all members)
Alliance Practitioner Credentialing Data	• Providers' Race/Ethnicity and Language Information
Alliance Interpreter Services Report	• Number of on-demand and scheduled interpreter services provided by language

Alliance Member Satisfaction Survey: CG-CAHPS	• Ability to communicate with doctors in their preferred language, by Adult and Child • Use of Family and Friends as interpreters
Alliance Grievances and Appeals Report	• Grievances related to cultural and linguistic and discrimination by provider type • Grievances related to discrimination/sensitivity by provider type
Grievance-based discrimination cases, categorized as substantiated or non-substantiated	• Grievance-based discrimination cases, categorized as substantiated or non-substantiated
Pew Religious Landscape Study	• % of individuals in regions identify with specific religious beliefs

VII. RESULTS

The Alliance collects and compiles results of surveys, census, enrollment, and practitioner data on an ongoing basis which are then evaluated routinely to determine areas for improvement. The Alliance summarizes the data and compares the member profiles to the network practitioner characteristics to identify opportunities to improve alignment of the practitioner network with member needs and preferences with regards to race/ethnicity and language.

The results of these analyses are then used to focus network development and education efforts for the coming year. The sections below outline and summarize the annual findings for each tracked metric.

1. Assessing Language, Ethnic, and Racial needs of Alliance Members

A. Member Preferred Language

Alliance tracks and examines quarterly the spoken languages of membership. See Table C below for threshold languages in 2024 by line of business, Medi-Cal and Group Care.

Table C. Alliance Membership Threshold Languages, December 2024
By Membership Count and Percent*

Total by Plan	Threshold Languages		
Medi-Cal 407,721	English	245,480	60.21%
	Spanish	105,231	25.81%
	Chinese	29,441	7.22%
	Vietnamese	8,064	1.98%

	Tagalog	1,967	0.48%
Group Care 5,788	English	3,362	58.09%
	Chinese	1,462	25.26%
	Spanish	307	5.30%
	Vietnamese	230	3.97%
	Tagalog	25	0.43%

Source: Alliance Monthly Health Education Membership Report, December 2024
*Not all members indicate their language preferences

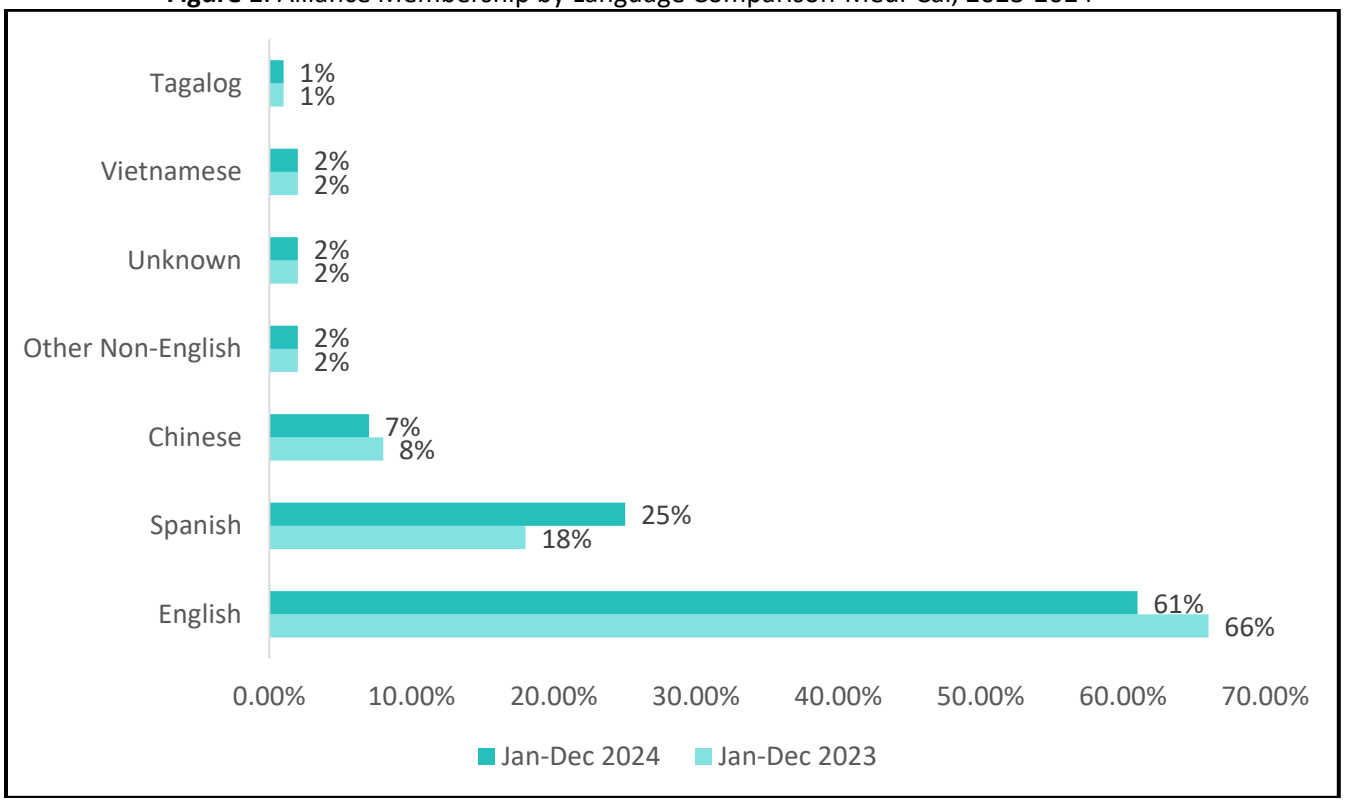
The threshold languages are defined as languages spoken by either 3,000 or 5% of eligible beneficiaries residing in the Alliance's service area who indicate their primary language as other than English, whichever is less. A more detailed look at languages spoken by the Alliance membership by lines of business, Medi-Cal and Group Care, is provided in Membership by Language Comparison in the tables and figures below.

Table D. Alliance Membership by Language Comparison-Medi-Cal, 2023-2024

MEDI-CAL	Prior Year	YTD	% Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY LANGUAGE	Jan - Dec 2023	Jan - Dec 2024	% YTD Membership in Jan - Dec 2024 (minus) % of Membership in Jan - Dec 2023	Dec 2024	Dec 2024 %
English	66.25%	61.00%	-5.25%	245,480	60.21%
Spanish	18.40%	24.95%	6.55%	105,231	25.81%
Chinese	8.32%	7.30%	-1.02%	29,441	7.22%
Other non-English	2.13%	2.20%	0.07%	9,051	2.22%
Unknown	1.93%	2.02%	0.09%	8,487	2.08%
Vietnamese	2.36%	2.02%	-0.34%	8,064	1.98%
Tagalog	0.61%	0.50%	-0.10%	1,967	0.48%
Total Members				**407,721**	

Source: Alliance Monthly Health Education Membership Report, December 2024

Figure 1. Alliance Membership by Language Comparison-Medi-Cal, 2023-2024



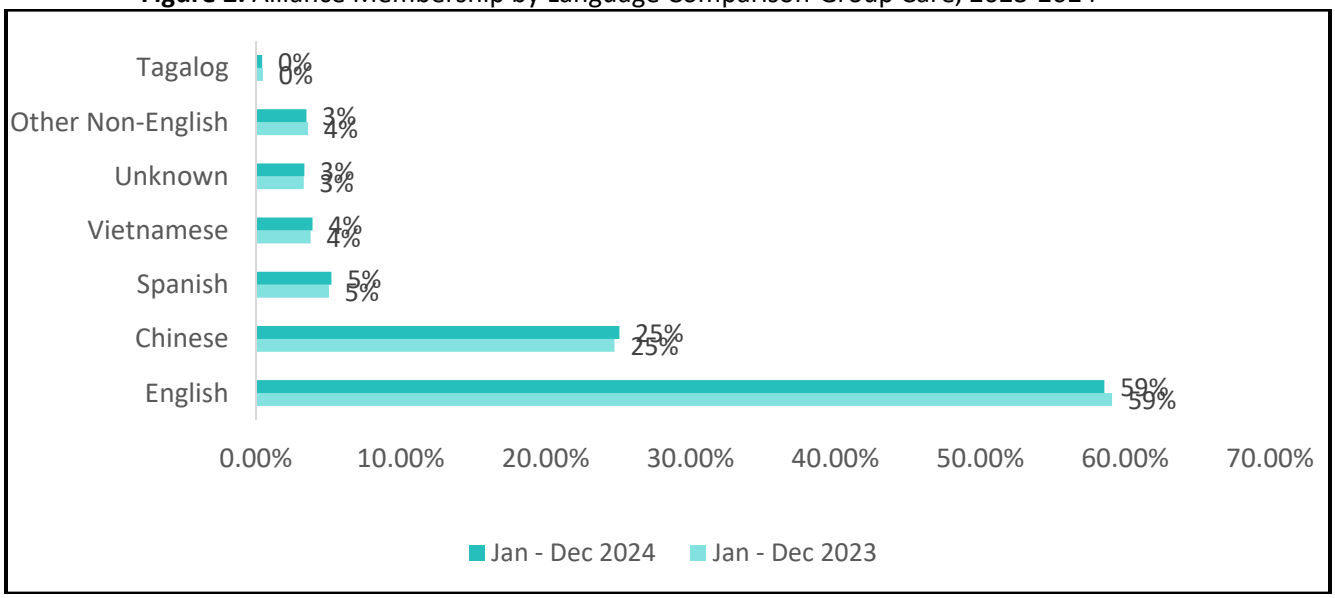
Source: Alliance Monthly Health Education Membership Report, December 2024

Table E. Alliance Membership by Language Comparison-Group Care, 2023-2024

GROUP CARE	Prior Year	YTD	% Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY LANGUAGE	Jan - Dec 2023	Jan - Dec 2024	% YTD Membership in Jan - Dec 2024 (minus) % of Membership in Jan - Dec 2023	Dec 2024	Dec 2024 %
English	59.10%	58.57%	-0.53%	3,362	58.09%
Chinese	24.74%	25.08%	0.34%	1,462	25.26%
Spanish	5.04%	5.21%	0.17%	307	5.30%
Vietnamese	3.77%	3.90%	0.13%	230	3.97%
Unknown	3.29%	3.33%	0.04%	202	3.49%
Other non-English	3.59%	3.48%	-0.11%	200	3.46%
Tagalog	0.48%	0.43%	-0.05%	25	0.43%
Total Members				**5,788**	

Source: Alliance Monthly Health Education Membership Report, December 2024

Figure 2. Alliance Membership by Language Comparison-Group Care, 2023-2024



Source: Alliance Monthly Health Education Membership Report, December 2024

Notable Findings:

- Medi-Cal continues to be predominantly English and Spanish-speaking, with Spanish seeing the highest increase (6.55%) in 2024.
- Group Care remains predominately English and Chinese-speaking, with percentages unchanged between 2023 to 2024, except for a slight decrease in English.

B. Member Race/Ethnicity

Table F. Membership by Race/Ethnicity Comparison-Medi-Cal, 2023-2024

MEDI-CAL	Prior Year	YTD	% Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY ETHNICITY	Jan - Dec 2023	Jan - Dec 2024	% YTD Membership in Jan - Dec 2024 (minus) % of Membership in Jan - Dec 2023	Dec 2024	Dec 2024 %
HISPANIC (LATINX)	30.35%	34.54%	4.20%	136,303	33.43%
OTHER	23.22%	18.86%	-4.35%	71,529	17.54%
BLACK (AFRICAN AMERICAN)	13.48%	13.10%	-0.38%	50,829	12.47%
UNKNOWN	0.81%	4.73%	3.91%	37,850	9.28%
CHINESE	10.11%	8.68%	-1.43%	33,824	8.30%
WHITE	8.79%	8.09%	-0.70%	30,854	7.57%
ASIAN INDIAN	3.14%	2.98%	-0.16%	11,725	2.88%
VIETNAMESE	3.47%	2.91%	-0.56%	11,183	2.74%
FILIPINO	2.93%	2.47%	-0.46%	9,336	2.29%
ASIAN OR PACIFIC ISLANDER	1.97%	2.06%	0.09%	8,299	2.04%

KOREAN	0.51%	0.46%	-0.05%	1,714	0.42%
CAMBODIAN	0.47%	0.39%	-0.07%	1,522	0.37%
AMERICAN INDIAN OR ALASKAN NATIVE	0.19%	0.20%	0.00%	763	0.19%
SAMOAN	0.18%	0.17%	-0.00%	663	0.16%
JAPANESE	0.15%	0.14%	-0.01%	512	0.13%
LAOTIAN	0.14%	0.13%	-0.01%	477	0.12%
HAWAIIAN	0.06%	0.05%	-0.01%	209	0.05%
GUAMANIAN	0.04%	0.03%	-0.01%	108	0.03%
HMONG	0.00%	0.01%	0.00%	21	0.01%
Total Members				**407,721**	

Source: Alliance Monthly Health Education Membership Report, December 2024

**The "Other" category represents members who self-reported their ethnicity as "Other". It is not a compilation of multiple ethnicity categories.*

Table G. Membership by Race/Ethnicity Comparison-Group Care, 2023-2024

GROUP CARE	Prior Year	YTD	% Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY ETHNICITY	Jan - Dec 2023	Jan - Dec 2024	% YTD Membership in Jan - Dec 2024 (minus) % of Membership in Jan - Dec 2023	Dec 2024	Dec 2024 %
ASIAN INDIAN	28.01%	28.68%	0.68%	1,605	27.73%
UNKNOWN	22.69%	22.22%	-0.47%	1,445	24.97%
CHINESE	15.20%	15.46%	0.26%	867	14.98%
BLACK (AFRICAN AMERICAN)	11.31%	10.62%	-0.69%	573	9.90%
OTHER	8.63%	9.05%	0.42%	521	9.00%
HISPANIC (LATINX)	4.52%	4.62%	0.10%	262	4.53%
VIETNAMESE	3.17%	3.25%	0.08%	186	3.21%
WHITE	2.12%	2.03%	-0.09%	109	1.88%
FILIPINO	1.27%	1.19%	-0.08%	66	1.14%
ASIAN OR PACIFIC ISLANDER	1.20%	1.14%	-0.06%	65	1.12%
CAMBODIAN	0.91%	0.88%	-0.03%	47	0.81%
KOREAN	0.52%	0.48%	-0.05%	24	0.41%
AMERASIAN	0.14%	0.14%	-0.00%	7	0.12%
LAOTIAN	0.13%	0.09%	-0.04%	5	0.09%
AMERICAN INDIAN OR ALASKAN NATIVE	0.14%	0.10%	-0.04%	4	0.07%

JAPANESE	0.02%	0.02%	-0.00%	1	0.02%
SAMOAN	0.02%	0.02%	-0.00%	1	0.02%
Total Members				**5,788**	

Source: Alliance Monthly Health Education Membership Report, December 2024

**The "Other" category represents members who self-reported their ethnicity as "Other". It is not a compilation of multiple ethnicity categories.*

Notable Findings:

- Hispanic (Latinx) members make up 33 % of Medi-Cal membership, followed by 17% categorized as "Other" and 12% Black (African American).
- The ethnic distribution within the Medi-Cal membership showed modest changes from 2023, with the largest decrease in the "Other" category and the largest increase among Hispanic (Latinx. 4.2%) in 2024.
- For Group Care members, the proportion of those with "Unknown" ethnicity continues to decline, though it remains higher than Medi-Cal. Asian Indian members are the largest identified group, making up nearly 28% of Group Care membership.
- Changes in ethnicity percentages within the Group Care membership from 2023 were minimal.

2. Identify Language, Race, Ethnicity and Culture of Practitioners in the Network to Assess Whether They Meet Member Cultural and Linguistic Needs

A. Meeting Member Language Needs

The Alliance conducts quarterly monitoring of Provider Language Capacity to ensure that our provider network meets the diverse language needs of our membership. The analysis for 2024 compares provider language capacity across Primary Care Physicians (PCPs), Specialists, Behavioral Health (BH) and Applied Behavior Analysis (ABA) providers (only for Medi-Cal child members). In addition to our threshold languages, we evaluate provider availability for Arabic and Farisi, two (2) of the most common languages among our members categorized as "Other Non-English".

Multilingual providers are counted for each language they speak, however, it is important to note that several providers do not report their ethnicity or designate a primary language in the data we receive. To better understand our members' language needs, we used the third quartile (Q3) benchmark for the member to provider ratio for each provider category. The Q3 benchmark represents the point below which 75% of the data falls. Member ratios above this benchmark fall into the top 25% of all ratios, which may indicate limited provider availability for that language group.

PCP Language Capacity – Medi-Cal

Table H. PCP Language Capacity Comparison-Medi-Cal, 2024 Q1 and Q2

	2024 Q1			2024 Q2		
Language	**PCPs**	**Members**	**Ratio PCPs: Members**	**PCPs**	**Members**	**Ratio PCPs: Members**
English	735	244,569	1:332	699	242,083	1:346
Spanish	189	97,166	1:514	175	100,218	1:572
Chinese	79	29,342	1:371	76	29,230	1:384
Vietnamese	19	8,312	1:437	18	8,139	1:452
Unknown	3	7,784	1:2,594	3	7,920	1:2,640

Other non-English	226	3,350	1:14	231	3,363	1:14
Farsi	9	2,783	1:309	10	2,791	1:279
Arabic	10	2,528	1:252	9	2,488	1:276
Tagalog	21	2,064	1:98	20	1,980	1:99
Total	**1,291**	**397,898**		**1,241**	**398,212**	

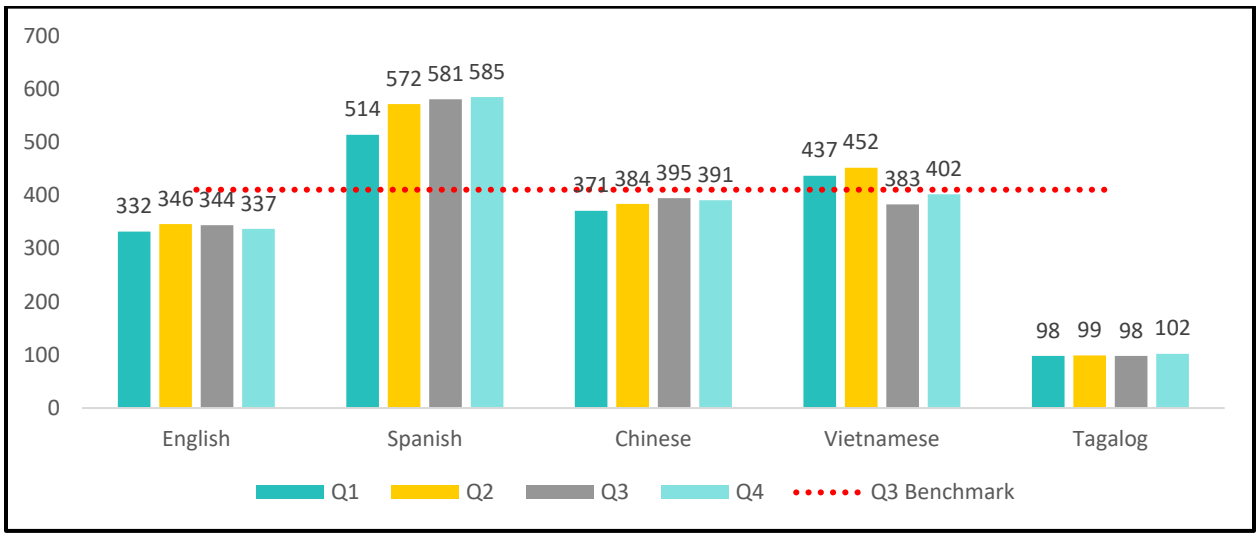
Source: Alliance Provider Language Access Report 2024

Table I. PCP Language Capacity Comparison-Medi-Cal, 2024 Q3 and Q4

	2024 Q3			2024 Q4		
Language	**PCPs**	**Members**	**Ratio PCPs: Members**	**PCPs**	**Members**	**Ratio PCPs: Members**
English	701	241,673	1:344	727	245,035	1:337
Spanish	176	102,365	1:581	179	104,871	1:585
Chinese	74	29,289	1:395	75	29,353	1:391
Vietnamese	21	8,051	1:383	20	8,053	1:402
Unknown	3	8,057	1:2,685	4	8,275	1:2,068
Other non-English	235	3,388	1:14	252	3,393	1:13
Farsi	10	2,837	1:283	10	2,941	1:294
Arabic	8	2,514	1:314	8	2,580	1:322
Tagalog	20	1,972	1:98	19	1,950	1:102
Total	**1,248**	**400,146**		**1,294**	**406,451**	

Source: Alliance Provider Language Access Report 2024

Figure 3. Medi-Cal Member Per PCP by Threshold Language, 2024 with Third Quartile (Q3) Benchmark of 410



Source: Alliance Provider Language Access Report, 2024

PCP Language Capacity – Group Care

Table J. PCP Language Capacity Comparison-Group Care, 2024 Q1 and Q2

	2024 Q1			2024 Q2		
Language	**PCPs**	**Members**	**Ratio PCPs: Members**	**PCPs**	**Members**	**Ratio PCPs: Members**
English	603	3,336	1:5	574	3,351	1:5
Chinese	68	1,391	1:20	64	1,398	1:21
Spanish	159	278	1:1	147	283	1:1
Vietnamese	16	228	1:14	15	235	1:15
Unknown	1	174	1:174	1	177	1:177
Other non-English	193	102	1:0	196	102	1:0
Farsi	8	80	1:10	9	83	1:9
Tagalog	20	25	1:1	18	23	1:1
Arabic	10	6	1:0	9	7	1:0
Total	**1,078**	**5,620**		**1,033**	**5,659**	

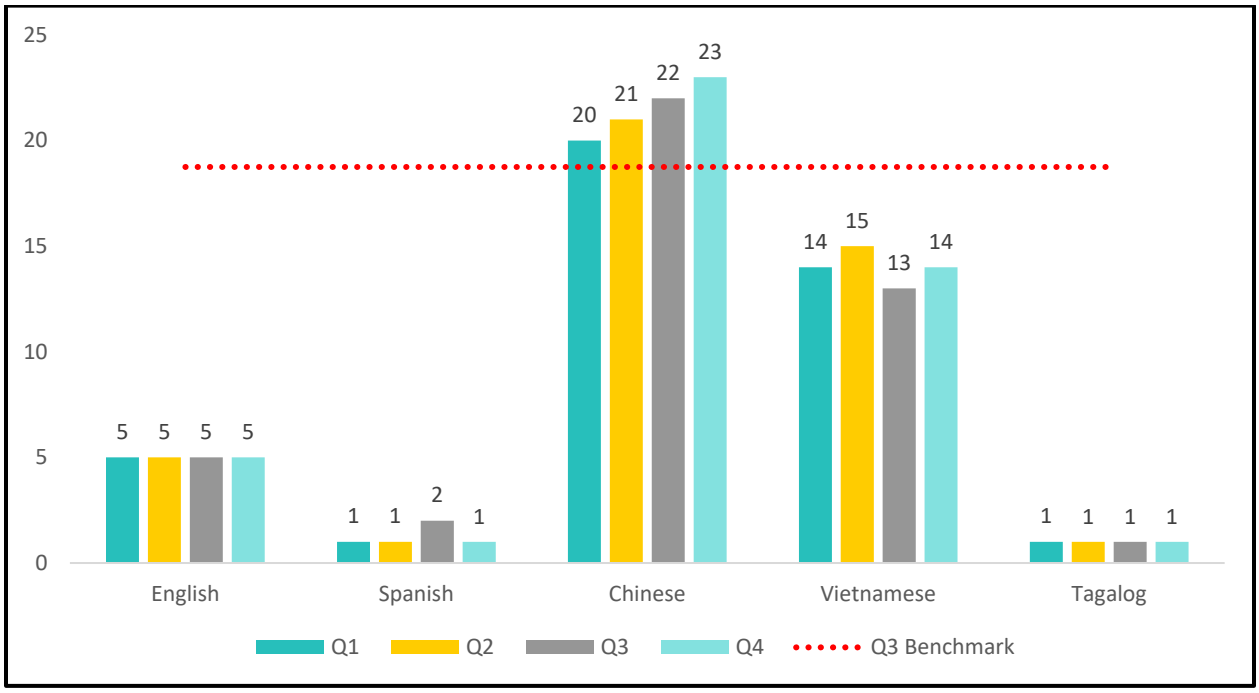
Source: Alliance Provider Language Access Report 2024

Table K. PCP Language Capacity Comparison-Group Care, 2024 Q3 and Q4

	2024 Q3			2024 Q4		
Language	**PCPs**	**Members**	**Ratio PCPs: Members**	**PCPs**	**Members**	**Ratio PCPs: Members**
English	580	3,361	1:5	599	3,391	1:5
Chinese	64	1,425	1:22	63	1,455	1:23
Spanish	151	302	1:2	154	304	1:1
Vietnamese	17	229	1:13	16	238	1:14
Unknown	1	170	1:170	2	187	1:93
Other non-English	202	101	1:0	219	97	1:0
Farsi	9	87	1:9	9	86	1:9
Tagalog	18	23	1:1	17	23	1:1
Arabic	8	11	1:1	8	8	1:1
Total	**1,050**	**5,709**		**1,087**	**5,789**	

Source: Alliance Provider Language Access Report 2024

Figure 4. Group Care Member Per PCP by Threshold Language, 2024 with Third Quartile (Q3) Benchmark of 18



Source: Alliance Provider Language Access Report 2024

Specialist Language Capacity – Medi-Cal

Table L. Specialists Language Capacity Comparison-Medi-Cal 2024, Q1 and Q2

	2024 Q1			2024 Q2		
Language	**Specialists**	**Members**	**Ratio Specialists: Members**	**Specialists**	**Members**	**Ratio Specialists: Members**
English	8,268	244,569	1:29	8,315	242,083	1:29
Spanish	903	97,166	1:107	906	100,218	1:110
Chinese	439	29,342	1:66	438	29,230	1:66
Vietnamese	75	8,312	1:110	75	8,139	1:108
Unknown	814	7,784	1:9	801	7,920	1:9
Other non-English	1,199	3,350	1:2	1,228	3,363	1:2
Farsi	90	2,783	1:30	94	2,791	1:29
Arabic	62	2,528	1:40	62	2,488	1:40
Tagalog	78	2,064	1:26	75	1,980	1:26
Total	**11,928**	**397,898**		**11,994**	**398,212**	

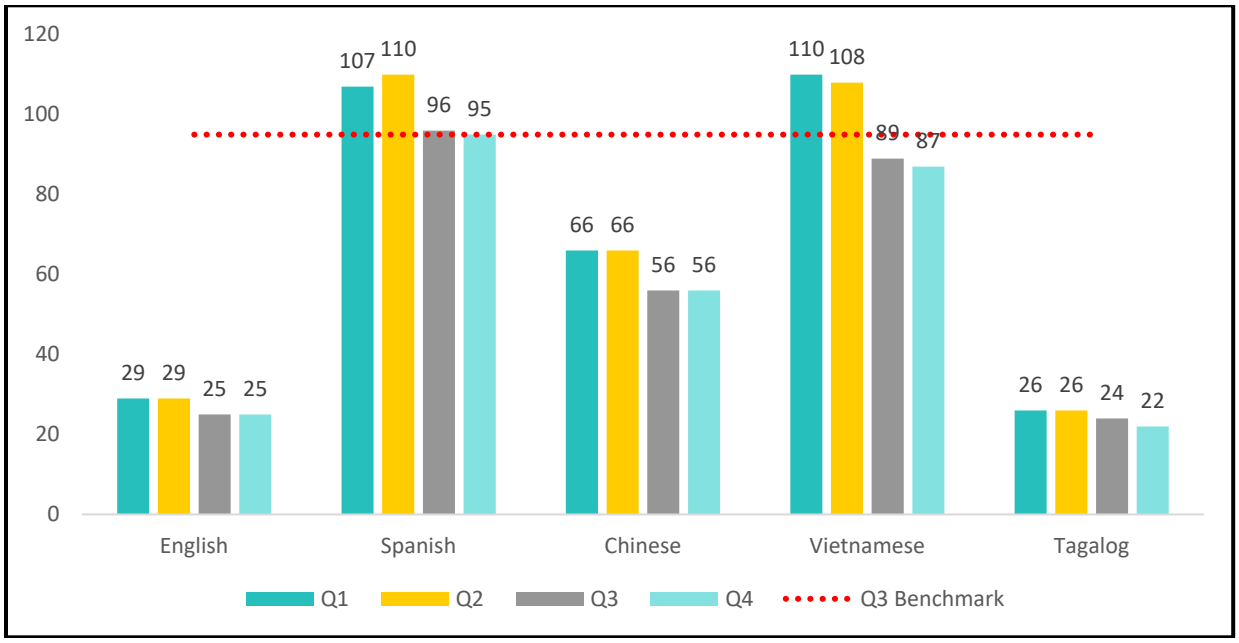
Source: Alliance Provider Language Access Report 2024

Table M. Specialists Language Capacity Comparison-Medi-Cal, 2024 Q3 and Q4

	2024 Q3			2024 Q4		
Language	**Specialists**	**Members**	**Ratio Specialists: Members**	**Specialists**	**Members**	**Ratio Specialists: Members**
English	9,378	241,673	1:25	9,502	245,035	1:25
Spanish	1,059	102,365	1:96	1,101	104,871	1:95
Chinese	516	29,289	1:56	518	29,353	1:56
Vietnamese	90	8,051	1:89	92	8,053	1:87
Unknown	793	8,057	1:10	803	8,275	1:10
Other non-English	1,443	3,388	1:2	1,467	3,393	1:2
Farsi	106	2,837	1:26	109	2,941	1:26
Arabic	68	2,514	1:36	70	2,580	1:36
Tagalog	80	1,972	1:24	85	1,950	1:22
Total	**13,533**	**400,146**		**13,747**	**406,451**	

Source: Alliance Provider Language Access Report 2024

Figure 5. Medi-Cal Per Specialist by Threshold Language, 2024 with Third Quartile (Q3) Benchmark of 95



Source: Alliance Provider Language Access Report 2024

Specialist Language Capacity – Group Care

Table N. Specialists Language Capacity Comparison-Group Care, 2024 Q1 and Q2

	2024 Q1	2024 Q2

Language	Specialists	Members	Ratio Specialists: Members	Specialists	Members	Ratio Specialists: Members
English	8,132	3,336	1:0.41	8,176	3,351	1:0.41
Chinese	435	1,391	1:3	434	1,398	1:3
Spanish	888	278	1:0.31	891	283	1:0.32
Vietnamese	75	228	1:3	75	235	1:3
Unknown	793	174	1:0	780	177	1:0
Other non-English	1,186	102	1:0	1,215	102	1:0
Farsi	89	80	1:0	93	83	1:0
Tagalog	76	25	1:0.33	73	23	1:0.32
Arabic	61	6	1:0	61	7	1:0
Total	**11,735**	**5,620**		**11,798**	**5,659**	

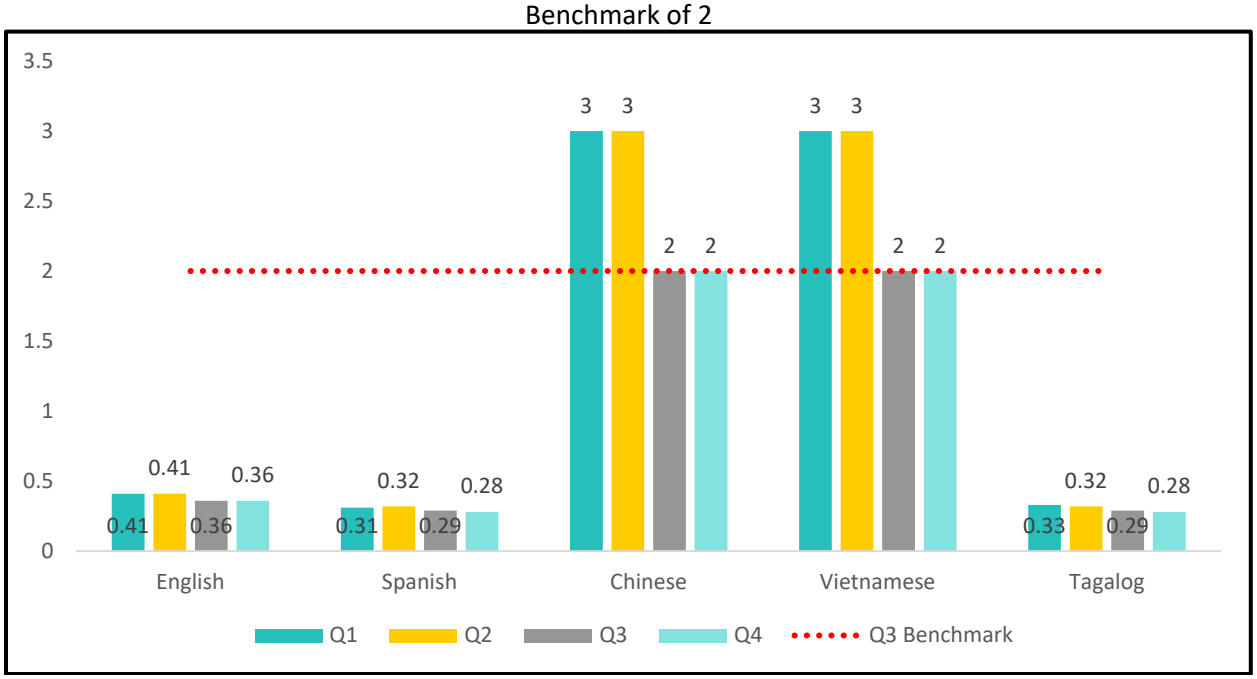
Source: Alliance Provider Language Access Report 2024

Table O. Specialists Language Capacity Comparison-Group Care, 2024 Q3 and Q4

	2024 Q3			2024 Q4		
Language	Specialists	Members	Ratio Specialists: Members	Specialists	Members	Ratio Specialists: Members
English	9,240	3,361	1:0.36	9,362	3,391	1:0.36
Chinese	513	1,425	1:2	515	1,455	1:2
Spanish	1,044	302	1:0.29	1,086	304	1:0.28
Vietnamese	90	229	1:2	92	238	1:2
Unknown	772	170	1:0	782	187	1:0
Other non-English	1,432	101	1:0	1,454	97	1:0
Farsi	105	87	1:0	108	86	1:0
Tagalog	78	23	1:0.29	83	23	1:0.28
Arabic	67	11	1:0	69	8	1:0
Total	**13,341**	**5,709**		**13,551**	**5,789**	

Source: Alliance Provider Language Access Report 2024

Figure 6. Group Care Per Specialist by Threshold Language, 2024 with Third Quartile (Q3) Benchmark of 2



Source: Alliance Provider Language Access Report 2024

Behavioral Health Providers Language Capacity – Medi-Cal

Table P. Behavioral Health Providers Language Capacity Comparison-Medi-Cal, 2024 Q1 and Q2

	2024 Q1			2024 Q2		
Language	**Behavioral Health Providers**	**Members**	**Ratio BH: Members**	**Behavioral Health Providers**	**Members**	**Ratio BH: Members**
English	911	244,569	1:268	1,214	242,083	1:199
Spanish	137	97,166	1:709	168	100,218	1:596
Chinese	23	29,342	1:1,275	31	29,230	1:942
Vietnamese	7	8,312	1:1,187	9	8,139	1:904
Unknown	14	7,784	1:556	14	7,920	1:565
Other non-English	154	3,350	1:21	187	3,363	1:17
Farsi	14	2,783	1:198	24	2,791	1:116
Arabic	7	2,528	1:361	10	2,488	1:248
Tagalog	5	2,064	1:412	6	1,980	1:330
Total	**1,272**	**397,898**		**1,663**	**398,212**	

Source: Provider Language Access Report 2024

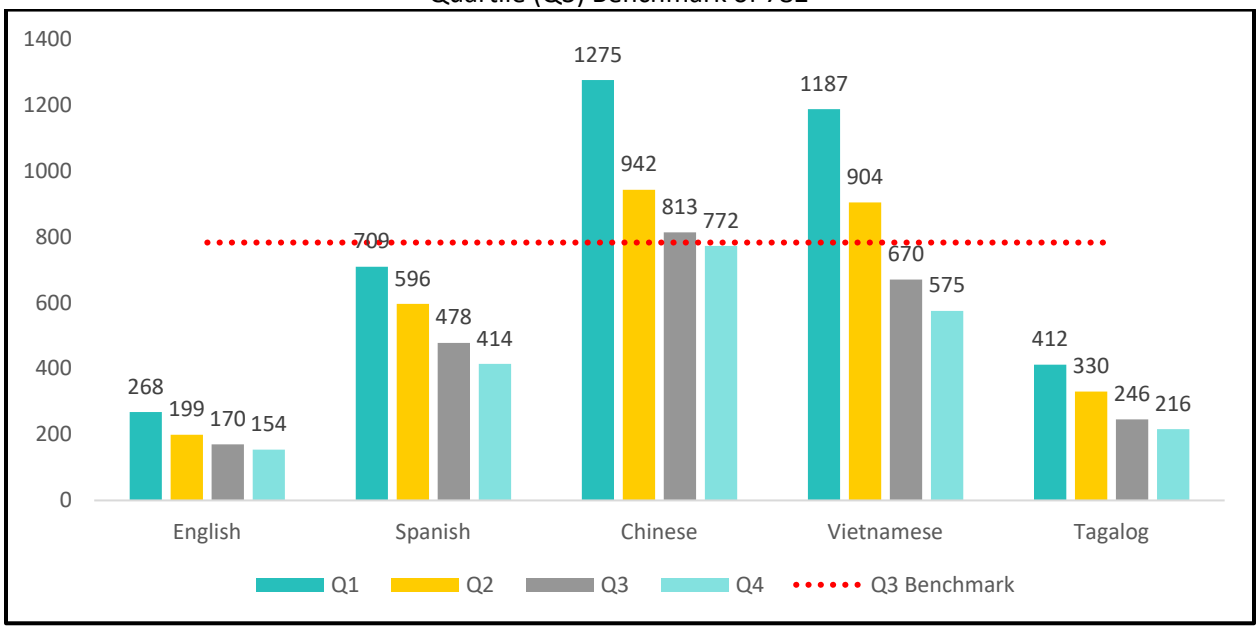
Table Q. Behavioral Health Providers Language Capacity Comparison-Medi-Cal, 2024 Q3 and Q4

	2024 Q3			2024 Q4		
Language	**Behavioral Health Providers**	**Members**	**Ratio BH: Members**	**Behavioral Health Providers**	**Members**	**Ratio BH: Members**
English	1,417	241,673	1:170	1,587	245,035	1:154
Spanish	214	102,365	1:478	253	104,871	1:414

Chinese	36	29,289	1:813	38	29,353	1:772
Vietnamese	12	8,051	1:670	14	8,053	1:575
Unknown	13	8,057	1:619	14	8,275	1:591
Other non-English	215	3,388	1:15	230	3,393	1:14
Farsi	30	2,837	1:94	32	2,941	1:91
Arabic	12	2,514	1:209	13	2,580	1:198
Tagalog	8	1,972	1:246	9	1,950	1:216
Total	**1,957**	**400,146**		**2,190**	**406,451**	

Source: Provider Language Access Report 2024

Figure 7. Medi-Cal Members Per Behavioral Health Providers by Threshold Language, 2024 with Third Quartile (Q3) Benchmark of 782



Source: Provider Language Access Report 2024

Behavioral Health Providers Language Capacity – Group Care

Table R. Behavioral Health Providers Language Capacity Comparison-Group Care, 2024 Q1 and Q2

	2024 Q1			2024 Q2		
Language	**Behavioral Health Providers**	**Members**	**Ratio BH: Members**	**Behavioral Health Providers**	**Members**	**Ratio BH: Members**
English	894	3,336	1:3	1,197	3,351	1:2
Chinese	23	1,391	1:60	31	1,398	1:45
Spanish	136	278	1:2	167	283	1:1
Vietnamese	7	228	1:32	9	235	1:26
Unknown	14	174	1:12	14	177	1:12
Other non-English	154	102	1:0	187	102	1:0
Farsi	14	80	1:5	24	83	1:3
Tagalog	5	25	1:5	6	23	1:3
Arabic	7	6	1:0	10	7	1:0

Total	**1,254**	**5,620**		**1,645**	**5,659**	

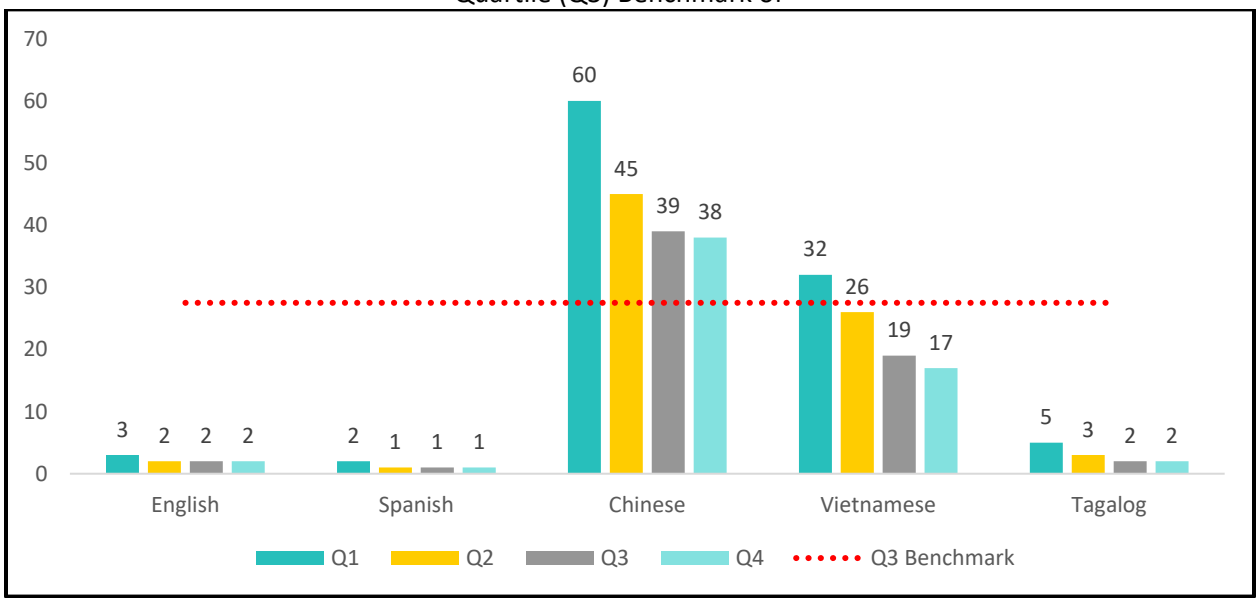
Source: Provider Language Access Report 2024

Table S. Behavioral Health Providers Language Capacity Comparison-Group Care, 2024 Q3 and Q4

	2024 Q3			2024 Q4		
Language	**Behavioral Health Providers**	**Members**	**Ratio BH: Members**	**Behavioral Health Providers**	**Members**	**Ratio BH: Members**
English	1,400	3,361	1:2	1,571	3,391	1:2
Chinese	36	1,425	1:39	38	1,455	1:38
Spanish	213	302	1:1	253	304	1:1
Vietnamese	12	229	1:19	14	238	1:17
Unknown	13	170	1:13	14	187	1:13
Other non-English	215	101	1:0	230	97	1:0
Farsi	30	87	1:2	32	86	1:2
Tagalog	8	23	1:2	9	23	1:2
Arabic	12	11	1:0	13	8	1:0
Total	**1,939**	**5,709**		**2,174**	**5,789**	

Source: Alliance Provider Language Access Report 2024

Figure 8. Group Care Members Per Behavioral Health Provider by Threshold Language, 2024 with Third Quartile (Q3) Benchmark of



Source: Alliance Provider Language Access Report 2024

Notable Findings:

- Member to PCP Ratio:
  Spanish and Vietnamese languages showed the highest for Medi-Cal member to PCP ratios, reflecting a 6.55% membership increase among the Latino ethnicity in 2024. Spanish, Vietnamese, and Chinese languages either exceeded or were close to the third quartile benchmark, however overall, member to PCP Ratio did not show concerning variations. In Group Care, the member population remained stable, with a slight decrease in English-

speaking members. Chinese and Vietnamese languages had the highest member to PCP ratios in Group Care, with Chinese exceeding the third quartile benchmark.

- Member to Specialists Ratios:
  For Medi-Cal, Spanish and Vietnamese languages had the highest ratios per member in Q1 and Q2, however, both declined below the third quartile benchmark in Q3 and Q4, indicating improvement in capacity. In Group Care, Chinese and Vietnamese languages remained the highest but dropped below the benchmark in later quarters.
- Member to Behavioral Health (BH) Provider Ratios:
  Chinese and Vietnamese languages had the highest member to BH provider ratios in both Medi-Cal and Group Care. While ratios declined over time, Chinese remained above the third quartile benchmark in Group Care.

B. Meeting Member Ethnic/Racial Needs

The Alliance tracks and monitors the Provider race/ethnicity using self-reported data collected during the credentialing process. Alliance Providers are categorized by Primary Care Physician (PCP), Specialists, Ancillary, and Behavioral Health (BH) along with their race/ethnicity.

Table T. Provider by Race/Ethnicity Comparison-Medi-Cal and Group Care Members, 2024

Race/Ethnicity	% Members	% PCP	% Specialists	% Behavioral Health
Hispanic (Latinx)	33%	6%	3%	20%
Asian *	13%	43%	46%	19%
Black (African American)	12%	13%	4%	11%
White	7%	34%	41%	48%
Asian Indian	0%	2%	3%	0%
Pacific Islander **	7%	1%	1%	0%
American Indian or Alaskan Native	0%	1%	0%	1%
Other ***	17%	1%	1%	0%
Unknown	10%	0%	0%	0%
Total	**100%**	**100%**	**100%**	**100%**

Source: Provider Race/Ethnicity and Language Report, 2024 and Alliance Monthly Health Education Report, December 2024

** Includes Chinese, Vietnamese, Korean, Cambodian, Japanese, Filipino and Laotian*
*** Includes Hawaiian*
**** Includes Samoan, Guamanian, Amerasian, and Other self-reported ethnicities*

Notable Findings:

- The most notable difference between member and provider race/ethnicity was for Hispanic (Latinx) members, who were underrepresented among PCPs and Specialists. Whereas White and Asian race/ethnicity are overrepresented in all provider categories.
- The "Other" race/ethnicity category showed lower percentages among PCP, BH providers, and Specialists when compared to membership. While this category includes a broad range of diverse racial and ethnic identities, the corresponding diversity is not proportionately reflected in provider demographics.

C. Meeting Member Cultural Needs

Cultural Traits for Ethnic Groups

External studies completed in Alameda County were used to assess the cultural traits of the top four (4) ethnic groups identified, which are Hispanic, African American, Chinese and Pacific Islander. The following is a summary of the cultural traits of the identified groups.

Hispanic: The value placed on human life is paramount in the Hispanic culture. Research shows that especially the elder generation, prefer seeing a male physician because male doctors are considered more knowledgeable than that of their female counterparts. Practitioners are respected and viewed as authority figures. Additionally, Hispanic women are generally very shy when it comes to discussing medical information with providers. Hispanics also want a personal relationship with practitioners. Faith and church remain powerful sources of hope and strength in the Hispanic community, especially in times of sickness.

Source: San Francisco Bay Area Hispanic Chamber of Commerce - Home (sfbayhcc.com)

African American: African American adolescent males are affected by physical and emotional stressors that include "adverse experiences such as racism, poverty, incarceration, and the lack of positive emotional attachments". African American males must be engaged in ways that honor how they experience life as an African American. In Alameda County, one in three African American residents live in a high poverty neighborhood compared to one in fifteen white residents.

Source: African American Adolescent Males: Living Stressfully in Alameda County - Policy Forum at Mills College (millspolicyforum.com)

Chinese: The concept of "saving face" is deep in Chinese culture. It means maintaining dignity and a good reputation. Family plays a huge role in the Chinese culture. The Chinese practice both Western medicines, as well as traditional folk medicine. The elderly may find it very hard to ask for help from individuals or agencies, such as case management. Language barriers may prevent access to health care information.

Sources: Elaine Peng - Mental Health Services Act - Alameda County Behavioral Health Care Services (acmhsa.org)

Pacific Islander: A study by the Stanford School of Medicine reported that Pacific Islanders are a very diverse group and that it is important to avoid stereotyping. The study showed that for the clinical interaction to be meaningful, Pacific Islanders need to develop a sense of trust with their healthcare providers. Pacific Islanders have the second highest infant death rate and some of the overall worst health outcomes in Alameda County, yet their vulnerability is too often overlooked. The pandemic heavily affected Pacific Islander communities. Life in multigenerational households, common among communities of Pacific Islanders, complicates the challenge to maintain distance. Not only did coronavirus threaten the health of the Pacific Islanders, but it also impacted their customs.

Source: 'The disease is ripping through': why coronavirus is devastating California's Pacific Islanders | California | The Guardian

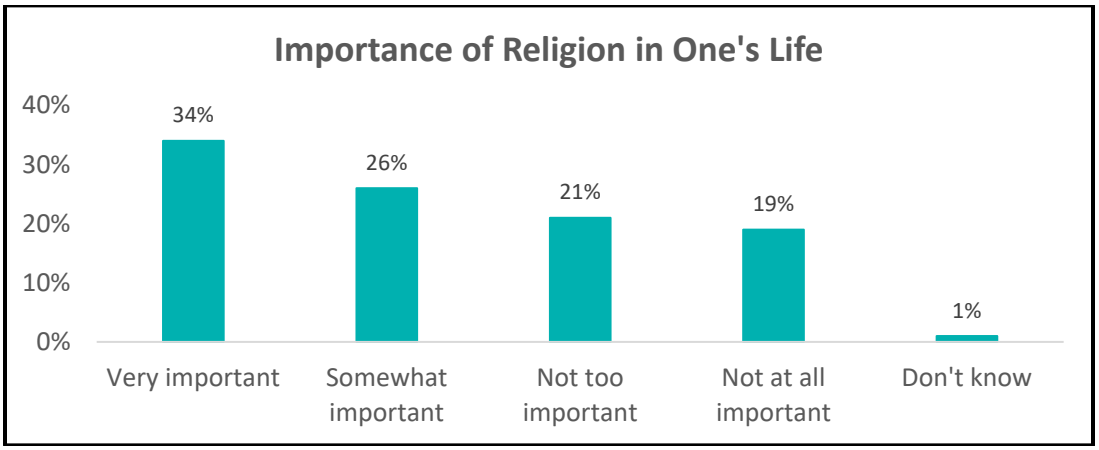
Religion

The Pew Research Center Religious Landscape Study from 2014 was used to understand the religious beliefs of adults in the San Francisco metro area.

Table U. Religious Composition of Adults in the San Francisco Metro Area, 2014

Religion	Percent
Christian	**48%**
Evangelical Protestant	10%
Mainline Protestant	6%
Historically Black Protestant	4%
Catholic	25%
Mormon	1%
Orthodox Christian	1%
Jehovah's Witness	<1%
Other Christian	1%
Non-Christian Faiths	**15%**
Jewish	3%
Muslim	1%
Buddhist	2%
Hindu	5%
Other World Religions	1%
Other Faiths	3%
Unaffiliated	**35%**
Atheist	5%
Agnostic	10%
Nothing in particular	20%
Don't know	**2%**

Figure 9. Importance of Religion in One's Life Among Adults in the San Francisco Metro Area, 2014



Notable Findings:

- Almost two-thirds (63%) of adults in the San Francisco metro area were affiliated with a Christian (48%) or non-Christian (15%) religion in 2014.
- About one-third (35%) were unaffiliated and 2% didn't know.
- Of the Christian faiths, the most common were Catholic, Evangelical Protestant, and Mainline Protestant. Of the non-Christian faiths, the most common were Hindu and Jewish.
- Over half (60%) of adults said religion was very or somewhat important, and 40% said it was not too important, not at all important, or they didn't know.
- Data on religion on Alliance members and providers is not available, but this information for the San Francisco metro area shows that religious beliefs are an important cultural

consideration for members and providers.

3. Analysis of Member Language Services, Survey Feedback and Member Grievance Data

A. Language Services Provided

To support culturally competent care across all points of services, the Alliance supplements internal multilingual capacity as well as provider bilingual capacity by offering telephonic, in-person, and video interpreter services at no cost. The following services were offered in 2024.

Table V. Telephonic Interpreter Services-All Lines of Business Comparison, 2023-2024

Language	2023	2024	% Change
Spanish*	**10,516**	**30,635**	**191%**
Cantonese*	**11,895**	**13,144**	**11%**
Vietnamese*	**7,855**	**8,864**	**13%**
Mandarin*	**3,504**	**6,480**	**85%**
Mam	1,405	2,780	98%
Arabic	1,440	2,188	52%
Dari	817	1,420	74%
Khmer	754	949	26%
Farsi	662	911	38%
Mien	722	824	14%
Korean	743	766	3%
Punjabi	563	685	22%
Russian	401	617	54%
Mongolian	355	548	54%
Tigrinya	374	498	33%
Hindi	255	455	78%
Pashto	290	425	47%
Tagalog*	**277**	**412**	**49%**
Burmese	255	293	15%
Amharic	153	290	90%
Urdu	94	195	107%
French	94	186	98%
Portuguese	83	183	120%
Tamil	56	124	121%
Nepali	101	123	22%
Lao	56	113	102%
Taishanese	99	108	9%
Turkish	13	105	708%
Japanese	33	96	191%
Telugu	37	77	108%
Ukrainian	36	66	83%
Igbo	34	59	74%
Thai	36	52	44%

Karen	58	49	-16%
Tongan	29	49	69%
Gujarati	26	39	50%
Bengali	12	35	192%
Haitian	23	32	39%
Hmong	29	32	10%
Romanian	10	27	170%
Bosnian	7	19	171%
Wolof	1	15	1400%
Tibetan	3	14	367%
Hungarian	0	13	New
Indonesian	11	13	18%
Other languages of lesser diffusion	114	186	63%

Source: Alliance Interpretive Services Summaries (Power BI Dashboard), 2023-2024

**Threshold language*

Table W. In-Person Interpreter Services-All Lines of Business Comparison, 2023-2024

Language	2023	2024	% Change
Spanish*	**2,154**	**7,062**	**228%**
Cantonese*	**2,432**	**4,104**	**69%**
Vietnamese*	**1,515**	**2,069**	**37%**
Mandarin*	**910**	**1,649**	**81%**
Mam	54	677	1154%
Arabic	258	480	86%
American Sign Language	386	412	7%
Russian	202	321	59%
Dari	201	270	34%
Farsi	87	286	229%
Hindi	63	190	202%
Punjabi	128	171	34%
Korean	89	154	73%
Khmer	37	115	211%
Tagalog*	**15**	**93**	**520%**
Pashto	41	85	107%
Taishanese	53	85	60%
Tigrinya	72	73	1%
Mongolian	16	54	238%
Burmese	94	45	-52%
Tamil	8	35	338%
Mien	24	32	33%
Lao	4	28	600%
Portuguese	7	26	271%
Urdu	9	23	156%
Amharic	17	22	29%

Thai	10	12	20%
French	3	11	267%
Deaf Blind: tactile	4	10	150%
Ukrainian	2	8	300%
Bengali	1	7	600%
Nepali	6	5	-17%
Other languages of lesser diffusion	5	16	220%

Source: Alliance Interpretive Services Summaries (Power BI Dashboard), 2023-2024

**Threshold language*

Table X. Video Interpreter Services-All Lines of Business Comparison, 2023-2024

Language	2023	2024	% Change
Spanish*	**419**	**550**	**31.26%**
Cantonese*	**474**	**155**	**-67.30%**
Vietnamese*	**119**	**127**	**6.72%**
American Sign Language	33	60	81.82%
Arabic	36	34	-5.56%
Mandarin*	**91**	**28**	**-69.23%**
Hindi	8	26	225.00%
Russian	15	17	13.33%
Mam	7	13	85.71%
Farsi	23	10	-56.52%
Korean	13	9	-30.77%
Amharic	2	7	250.00%
Khmer	12	7	-41.67%
Punjabi	8	7	-12.50%
Dari	19	5	-73.68%
Pashto	6	5	-16.67%
Mongolian	8	4	-50.00%
Urdu	11	4	-63.64%
Tigrinya	3	3	0.00%
Burmese	5	2	-60.00%
French-based creoles and pidgins	0	2	New
Portuguese	15	2	-86.67%
Igbo	0	1	New
Karen	0	1	New
Mien	6	1	-83.33%
Taishanese	11	1	-90.91%
Tamil	0	1	New
Telugu	2	1	-50.00%
Thai	0	1	New
Turkish	0	1	New
French	2	0	-100.00%

Indonesian	1	0	-100.00%
Japanese	1	0	-100.00%
Lao	1	0	-100.00%
Nepali	6	0	-100.00%
Tagalog*	**4**	**0**	**-100.00%**
Tongan	1	0	-100.00%

Source: Alliance Interpretive Services Summaries (Power BI Dashboard), 2023-2024

**Threshold language*

Notable Findings:

- Telephonic interpreter services saw an increase across all threshold languages in 2024, with Spanish and Mandarin languages showing the highest increase.
- Utilization of video interpreter services decreased for most threshold languages in 2024, except for Spanish and Vietnamese, as clinics resumed in-person visits after the Covid-19 pandemic.
- For in-person interpreter services, Spanish language utilization doubled in 2024.
- Overall, utilization for all interpreter services modalities increased in 2024.

B. Member Satisfaction Survey

Alameda Alliance for Health conducts a member satisfaction survey using the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey tool once per quarter. The goal of the survey is to better understand our members' level of satisfaction with the Plan and its providers. Members are asked about five (5) topics related to individual provider encounters, one of which is language services.

For language services, we asked adults and parents of children who need language services: "Were you able to communicate with your child's doctor and clinic staff in your preferred language?"

Response options included:

- No
- Yes, my health plan provided one for me.
- Yes, my doctor's office gave me an interpreter or spoke my language.
- Yes, I used family or a friend as my interpreter.

A favorable response was defined as either:

- "Yes, my health plan provided one for me."
- "Yes, my doctor's office gave me an interpreter or spoke my language."

These results are evaluated to assess and identify disparities in availability and effectiveness of languages services, with a focus on communication between healthcare providers and both adults and children over time. Green highlights indicate an increase in favorable or decrease in unfavorable results, while red indicates an increase in unfavorable or decrease in favorable results. Yellow indicates a change of less than 1%. Note that Tagalog response rate was low, resulting in more volatile results.

Table Y. Member Satisfaction Survey-CG-CAHPS-Adult Comparison, 2023-2024

ADULT: Able to communicate with doctor and clinic staff in preferred language?	Favorable % 2023	Favorable % 2024	Family and Friends % 2023	Family and Friends % 2024	No % 2023	No % 2024
Total	85.20%	87.3%	12.19%	9.73%	2.60%	2.98%
Chinese	91.81%	89.57%	7.17%	8.29%	1.02%	2.13%
Spanish	91.47%	92.76%	6.71%	5.10%	1.82%	2.13%
Vietnamese	85.71%	93.50%	9.82%	5.42%	4.46%	1.08%
English	61.84%	64.84%	29.61%	27.85%	8.55%	7.31%
Tagalog	40.00%	41.38%	60%	44.83%	0.00%	13.79%
Other Languages	71.10%	71.24%	25.58%	22.57%	3.32%	6.19%

Source: CG-CAHPS-Adult Report 2024

Table Z. Member Satisfaction Survey-CG-CAHPS-Child Comparison, 2023-2024

CHILD: Able to communicate with doctor and clinic staff in preferred language?	Favorable % 2023	Favorable% 2024	Family and Friends % 2023	Family and Friends % 2024	No % 2023	No % 2024
Total	95.40%	92.5%	3.04%	4.19%	1.59%	3.30%
Chinese	97.87%	96.20%	0.53%	1.27%	1.22%	2.53%
Spanish	95.58%	94.21%	3.02%	3.39%	1.40%	2.40%
Vietnamese	100%	95.35%	0%	0%	0.00%	4.65%
English	90.41%	85.05%	8.22%	8.25%	1.36%	6.70%
Tagalog (n=0, 2024)	0%	0%	0%	0%	0%	100%
Other Languages	90.53%	74%	5.26%	16%	4.21%	10%

Source: CG-CAHPS-Child Report 2024

[1] Eligible response excludes any skipped or not answered responses

[2] Favorable response is based on question category -
**** Either doctor's office or health plan provided interpreter or spoke my language*

Notable Findings:

- In 2024, the percentage of individuals who needed an interpreter and received one through their doctor's office or health plan (a favorable response) was 87.3% for adults and 92.50% for children. Favorable responses increased for adults compared to 2023, while there was a slight decrease for children in 2024.
- The use of family or friends to communicate with their doctor decreased slightly for adults in 2024 across all languages except Chinese, compared to 2023. For children, all languages showed slight increase in use of family or friends to communicate with their doctors. This trend may be attributed to cultural preferences for family members to interpret.
- Favorable responses for children, all languages, continue to be higher than adult favorable responses.
- Overall, there was an increase in total survey responses from 2023 to 2024 for both adults and children. For adults, responses increased from N=1,993 in 2023 to N=2,486 in 2024. For children, responses increased from N=1,315 in 2023 to N=1,576 in 2024.

C. Cultural & Linguistic Related Grievances

The Alliance tracks and examines member Cultural and Linguistic Grievances as well as Exempt Grievances, which address complaints related to language accessibility and discrimination/sensitivity.

Table AA. Cultural and Linguistic Grievances and Exempt Grievances Medi-Cal and Group Care Combined, 2024

Grievance Type	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Total
Access to Care	**121**	**115**	**146**	**137**	**519**
Language Assistance Plan	25	19	27	31	**102**
Language Assistance Provider	96	96	119	106	**417**
Quality of Service	**22**	**25**	**31**	**31**	**109**
Discrimination	18	24	30	31	**98**
Disability Discrimination	4	1	1	0	**6**
Grand Total	**143**	**140**	**177**	**168**	**628**

Source: Alliance Grievances and Appeals Report-Medi-Cal and Group Care, 2024

In 2024, a total of 104 quality of service grievances related to **discrimination** were reported for Medi-Cal membership and 5 grievances were reported for Group Care. All cases were resolved and forwarded to the Alliance Compliance Department for further investigation as well as the Alliance Grievance and Appeals team for a follow-up/resolution.

For substantiated discrimination grievance cases, findings are shared with the provider and member, and appropriate action, such as education or corrective action plans are implemented as needed.

Of the total discrimination grievance cases reported across both lines of business in 2024, a total of 1 case was found to be substantiated. Refer to Table BB below for details.

Table BB. Substantiated vs. Non-Substantiated Discrimination Cases-Medi-Cal and Group Care, 2024

Discrimination Cases	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Total

Substantiated	**0**	**1**	**0**	**0**	**1**
Non-Substantiated	**22**	**24**	**31**	**31**	**108**
Total	**22**	**25**	**31**	**31**	**109**

Source: Alliance Discrimination Cases Report, 2024

In 2024, there were a total of 503 grievances related to **access to care** for language assistance for Medi-Cal membership and 16 grievances for Group Care. The most common grievances included:

- Requests to change PCPs to providers who spoke the members' preferred language (despite education being provided about available language assistance services).
- Providers not scheduling interpreting services.
- Quality issues with interpreter services during appointments.

Tracking and trending: Grievances filed against Delegates/Interpreter Service Vendors are reported and reviewed during quarterly Interpreter Service Vendor Joint Operation Meetings and Cultural and Linguistic Services Subcommittee meetings. All grievances are tracked, and providers or vendors with patterns of grievances are analyzed for potential corrective action plans.

In 2024, no formal corrective action plans were implemented, however all grievances were addressed with the provider and/or interpreter service vendor, and member education was provided as needed.

Notable Findings:

- In 2024, no significant patterns of concern were identified for individual providers or interpreter service vendors regarding access to language services, indicating consistent compliance and service delivery.
- Overall, language assistance grievances increased significantly by 75% from 2023 to 2024, compared to a 17.5% increase in membership, while discrimination cases saw a notable decrease of 41%.

VIII. ASSESSMENT

The data included in this report is presented quarterly to the Alliance's Cultural and Linguistics Services Subcommittee (CLSS), which reports to the Quality Improvement Health Equity Committee (QIHEC) of the Alliance Board of Governors. Participants include management and director-level staff from the Health Care Services division, including the following departments: Quality Improvement, Member Services, Health Equity, Compliance, Provider Services, Behavioral Health, and Communications and Outreach.

When deficiencies are identified, committee members recommend actions to address the concerns and identify areas of opportunity to collaborate to improve services.

Assessment by Language:

In 2024, the Alliance experienced an over 17% increase in membership, which led to a higher demand for language services. Notably, the proportion of Spanish-speaking members grew from 18% in 2023 to 25% in 2024, representing a relative increase of 39% in this language group. There were fluctuations in the overall availability of PCPs across threshold languages. The number of PCPs increased for Farsi and Other non-English-speaking PCPs, while the availability for other threshold languages either remained unchanged or experienced slight decreases. However, no significant barriers were identified in the ratio of members to PCPs for both Medi-Cal and Group Care lines of business. All remained well below the 1 PCP to 2000 member to PCP ratio Alliance Provider Services Department uses to measure network

adequacy.

For Specialists, there were improvements in availability for English, Spanish, Vietnamese, and Other Non-English languages across both lines of business. Additionally, availability for Chinese, Farsi, Arabic, and Unknown languages remained stable or improved.

For BH providers, availability increased for English, Chinese, Farsi, and Arabic languages, while it remained stable for Unknown language. Most notably, there was improved availability for Spanish-speaking BH providers across both lines of business.

Overall, the ratios of members to PCP, Specialists, BH, and ABA by threshold language remained favorable, showing improvements despite some fluctuations throughout 2024.

Assessment by Race/Ethnicity

Since provider race/ethnicity data is self-reported, accurate comparisons with membership across both lines of business are challenging due to the limited available data. Within the provider network, Hispanic (Latinx) members are underrepresented among PCPs and Specialists.

Although PCP and Specialist networks show underrepresentation of Hispanic (Latinx) providers, many provider offices employ non-clinical Hispanic (Latinx) staff who serve essential links between Alliance members and their non-Hispanic (Latinx) providers. Furthermore, within the Alliance provider network, we have safety net providers who specialize in serving our diverse populations, including Tiburcio Vasquez Health Center and La Clinica, who offer culturally tailored services for our Hispanic (Latinx) members. To further support these members, the Alliance continues to provide qualified Spanish interpreters and in 2024. We observed a 70% increase in utilization for interpreter services compared to 2023.

Assessment by Culture

The ability to communicate effectively across cultural barriers greatly influences the overall healthcare experience, from service accessibility to patient satisfaction and health outcomes. Recognizing the diversity within our membership, the Alliance emphasizes the importance of integrating cultural influences, including religious beliefs and practices, into provider education and training. This ensures that delivery of care is culturally sensitive, respectful, and tailored to meet individual needs.

To achieve this, the Alliance will continue leveraging the PHM Strategy Population Assessment and Evaluation as a tool to identify and address the evolving needs of our membership. This comprehensive strategy helps enhance health outcomes and supports an improved quality of life for all members. Additionally, the Alliance's diversity, equity, and inclusion (DEI) training for providers prioritize cultural sensitivity and competence, equipping providers and staff with the knowledge and skills to serve our diverse membership effectively.

Furthermore, the Alliance is committed to fostering collaboration with the community, community-based organizations, and advocates to ensure healthcare delivery is informed by and responsive to the unique cultural and linguistic needs of our members.

Intersection of Language/Race-Ethnicity and Culture

The intersections between language, race/ethnicity, and culture play a pivotal role in shaping access to healthcare services and the overall quality of care members receive. These interconnected factors influence how individuals navigate healthcare systems, communicate their needs, and experience equitable care. To ensure all members are adequately served, it is important to consider all dimensions of culturally and linguistically appropriate services.

Interpreter Use and Cultural Preferences:
The utilization of language assistance services can be shaped by cultural norms and preferences. According to the 2024 CG-CAHPS member satisfaction survey, a subset of members from both adult and child populations continue to rely on family and friends for interpretation, despite the availability of no cost interpreter services through the Alliance. We continue to see this trend even with ongoing education for both members and providers about the importance of using qualified interpreters and availability of these services.

In 2024, the reliance on family and friends was highest among members who speak "Other" Languages, followed by English and Spanish for child. Among adults, the Chinese-speaking population showed the greatest use of family and friends for interpretation. These findings highlight the importance of the availability of interpreter services for both threshold and non-threshold languages and continuation of member education on their right to qualified interpreters.

Overall, the Alliance saw increased interpreter needs for non-threshold languages. In 2024, interpreter services were provided in 134 non-threshold languages, including Mam, Arabic, Dari, Farsi, and Khmer, representing a 26% increase in non-threshold language interpretation compared to 2023.

These trends not only reflect the growing linguistic diversity but also point to broader shifts in the member population that may be influencing the overall care experiences and satisfaction.

The overall decline in member satisfaction scores observed in 2024 may be partially attributed to the significant changes in membership demographics, including the integration of Adult Expansion members and those transitioning from Anthem. These newly enrolled populations brought increased needs, particularly in language access, which is reflected in the notable growth in interpreter service utilization. The 70% increase in interpreter use underscores the importance of meeting the communication needs of a linguistically diverse membership and reinforces the Alliance's commitment to delivering culturally and linguistically appropriate services across all populations.

Cultural Preferences and Practice:
Insights gathered from our ongoing conversations with clinics showed a multifaceted issue. For some members, cultural preferences for trusted family or friends to interpret play a significant role. For others, changes in clinic practices may be needed to ensure the consistent provision of bilingual providers and staff or qualified interpreters. The Alliance will continue to address these challenges by monitoring trends, identifying deficiencies, and providing targeted education to providers where gaps are found.

Language Access Grievances and Responses:
Grievances regarding language access increased significantly from 2023 to 2024, while discrimination cases saw a notable decrease. Changes to Alliance internal workflows and the influx of members new to the plan may have resulted in this increase in grievances. The Alliance addresses each grievance involving a potential quality issue through targeted education for both providers and members about the availability of language services and how to access them.

Efforts to Improve Language Access:
To further address these challenges, the Alliance works closely with the Provider Services team to identify and mitigate network deficiencies. Additionally, collaborative efforts with other provider-facing teams aim to ensure that providers are well-informed about available language assistance services and are equipped to meet the diverse language needs of our membership.

Assessment Conclusions

Overall, the Alliance continues to maintain a practitioner network that is culturally and linguistically appropriate for its members. At this time, no adjustments are needed to the network, however, the Alliance will continue to promote and monitor our Cultural and Linguistic Services Program to ensure all members receive culturally and linguistically appropriate services.

As the Alliance continues to serve an increasingly diverse membership, the intersection of language, culture, and healthcare access remains central to our mission. The evolving needs of newly enrolled members highlight the importance of ongoing investment in culturally and linguistically appropriate services. By expanding interpreter services, addressing clinic practice-level gaps, and reinforcing member and provider education, the Alliance is actively working to reduce barriers and promote health equity.

Our county is experiencing growth in residents who speak non-threshold languages, including Arabic, Farsi, Mam, Dari, Punjabi, and Russian. Despite a high demand for qualified interpreters in these languages, recruiting and retaining practitioners who speak these languages remains a challenge. While the Alliance strives to close the cultural and linguistic gaps in its network, the immediate necessity to meet geographic network access requirements often means prioritizing the inclusion of highly qualified practitioners, regardless of language capabilities into our network.

The Alliance will continue addressing the intersection of language, race/ethnicity, and culture through proactive measures. This includes efforts to reduce barriers, promote inclusivity, and ensure equitable access to quality healthcare services for our diverse membership. By closely monitoring demographic changes and working collaboratively with our community partners, the Alliance remains committed to identifying and meeting the emerging needs of our membership, while continuing to provide the highest standards of delivery of care.

IX. ACTIONS

The monitoring and analysis of member characteristics and preferences indicated slight adjustments in the demographic mix compared to the previous year, though no significant changes were observed. The Alliance network continues to be diverse and well-equipped to address the cultural and linguistic needs of our membership.

As the Alliance's membership continues to grow, we remain committed to expanding our provider network to meet emerging needs. Based on the analysis of data received from this annual assessment, the Alliance Manager Cultural and Linguistic Services, Director of Population Health and Equity, Senior Director of Quality Improvement, Senior Director of Members Services, and Director of Provider Services will continue to collaborate on an action plan that may include, but is not limited to the following initiatives:

1. Member - Cultural and linguistic Services Program

The Alliance has a Culture and Linguistic Services Program with components that address the language race/ethnicity, cultural needs of our membership. Included in this program are the following efforts that support members.

- **CBO Partnerships -** Partner with community organizations with cultural and linguistic capacity, and whose personnel reflect the racial/ethnic diversity of our membership for wellness and prevention and care management services.

- **Culturally and Linguistically Appropriate Materials -** Translate plan materials into our five (5) threshold languages (English, Spanish, Chinese, Vietnamese, and Tagalog), review for cultural appropriateness and relevance, consider respect for religion and other cultural preferences, and ensure images reflect the racial and ethnic diversity of our members. Also, continue to offer plan materials translation into other foreign languages and alternative formats upon request.
- **Responding to Member Grievances -** Respond to member grievances against our interpreter service vendors through increased monitoring, communication, and addressed process improvement during monthly and/or quarterly interpreter service meetings. This includes, addressing exempt grievances, focusing on one-on-one provider education/coaching about availability/accessing interpreter services, provider language access responsibilities, and how the Alliance can support providers in meeting their patient's linguistic needs.
- **Non-Clinical Cultural Liaisons -** Expand member services and programs offered by non-clinical practitioners with lived experience and that are culturally and linguistically aligned with our members, including services such as community health workers and doula services.
- **Population Assessments -** Through our Population Health Management Program, monitor member health status, preventative services and program engagement data for inequities based on language, race/ethnicity, and other cultural factors.

2. Practitioners - Cultural and Linguistic Services Program

- **DEI Training -** Ensure that our contracted health care providers, subcontractors, and downstream subcontractors participate in DEI Training that covers the language access, including availability of interpreter services, best practices for working with interpreters, and how to access interpreters for patients, as well as information on working with the diverse cultures represented in the Alliance membership.
- **Data Sharing -** Make available to providers up-to-date information on the language needs of members through PCP member roster available on the Provider Portal and Alliance Provider Website.
- **Network Recruitment -** Make efforts to recruit, credential, and contract with a diverse network of providers whose cultures, race/ethnicity, and languages spoken reflect our membership. Alliance will focus specifically on Spanish, Chinese, Vietnamese, Tagalog, Arabic and Farsi speaking practitioners or speaking providers or staff who are qualified to interpret in communities with higher concentrations of members speaking these languages, as well as practitioners whose race/ethnicity reflects the Alliance membership, such as Hispanic (Latinx) providers.
- **Provider Assignment -** Collect and maintain information on provider race/ethnicity and make available to Alliance staff to assist in matching providers to member preferences.
- **Provider Education -** Regularly inform providers of Alliance interpreter services and the importance of culturally competent services through regular updates in various Alliance provider communication, such as the New Provider Orientation, Provider Quarterly Packets, Provider Manual, provider information on the Alliance website, and the Alliance Interpreter Services Guide for Providers, which describes access to on-demand telephonic interpreters, and the Interpreter Services Request Form for requesting prescheduled interpreters.
- **Provider Language Monitoring -** Maintain information on provider language capacity and

update regularly in both online and printed provider directory. Verify and correct when needed the provider language listing.

- **Provider Race/Ethnicity Data Collection –** Send reminders to all providers about the importance of updating their provider profile, including information on race/ethnicity, and spoken languages.

3. Ongoing Monitoring and Continuous Improvement

The Alliance monitors and continuously improves Alliance activities aimed at achieving cultural competence and reducing health care disparities.

- **Language Services -** Monitoring requests for language services and language services fulfillment metrics. Identifying language trends that show a need for language access improvement.
- **Language Access Grievances and Potential Quality Issues** – Monitoring of grievances and appeals and potential quality issues related to quality of language, and cultural and linguistic services to identify areas of improvement as well as report on trends/data to appropriate department(s).
- **Network Composition** - Monitoring of the provider network's language capacity and race/ethnic diversity.
- **Member Satisfaction** – Monitoring of member satisfaction with availability and quality of language services.
- **Provider Medical Record Review (MRR)** - Conduct facility site reviews for compliance with Cultural and Linguistic services requirements including: 24-hour interpreter services and capacity and training of bilingual medical and interpreter staff.

The Alliance presents results of all monitoring activities of the CLS program to the CLSS, QIHEC, and Community Advisory Committee (CAC) for input and opportunities for areas of improvements.