Quality Improvement Health Equity Committee
5/17/2024

Committee Member Name and Title	Specialty	Present
Donna Carey MD, Interim Chief Medical Officer, Alameda Alliance for Health		X
Lao Paul Vang, Chief Health Equity Officer, Alameda Alliance for Health		X
Sanjay Bhatt, Senior Medical Director, Quality & Behavioral Health, Alameda Alliance for Health, Emergency Medicine		X
Aaron Chapman, MD, Medical Director, Alameda County Behavioral Health Care Services	Psychiatry	X
Tri Do, MD, Interim Chief Medical Officer, Community Health Center Network	Internal Medicine	X
Felicia Tornabene, MD, Chief Medical Officer, Alameda Health Systems	Internal Medicine	X
James Florey, MD, Chief Medical Officer, Children First Medical Group	Pediatrician	
Rosalia Mendoza, MD Medical Director, Utilization Management, Alameda Alliance for Health, Family Practice		
Peter Currie, Ph.D. Senior Director, Behavioral Health, Alameda Alliance for Health		
Michelle Stott, Senior Director, Quality, Alameda Alliance for Health		X

Staff Member Name and Title	Present
Ashley Asejo, Clinical Quality Programs Coordinator	X
Kalkidan Asrat, Quality Improvement Project Specialist II	X
Linda Ayala, Director of Population Health and Equity	X
James Burke, Lead Quality Improvement Project Specialist	
Rosa Carrodus, Disease Management Health Educator	X
Tiffany Cheang, Chief Analytics Officer	X
Andrea DeRochi, Behavioral Health Manager	
Gil Duran, Manager, Population, Health and Equity	X
Kathy Ebido, Senior Quality Improvement Nurse Specialist	X
Michelle Findlater, Director, Utilization Management	X
Kisha Gerena, Accreditation Manager	

Kimberly Glasby, Director, Long Term Services and Supports	X
Richard Golfin III, Chief Compliance Officer & Chief Privacy Officer	
Sanya Grewal, Healthcare Services Specialist	
Bob Hendrix, Quality Improvement Project Specialist I	X
Megan Hils, Quality Improvement Project Specialist I	X
Lily Hunter, Director, Social Determinants of Health	X
Jessica Jew, Population Health and Equity Specialist	X
Shatae Jones, Director Housing & Community Services Program	X
Beverly Juan, Medical Director Community Health	X
Jennifer Karmelich, Director, Quality Assurance	
Allison Lam, Senior Director, Health Care Services	X
Helen Lee, Senior Director Pharmacy Services	X
Daphne Lo	X
Homaira Momen, Quality Review Nurse	
Angela Moses, Quality Review Nurse	X
Fiona Quan, Quality Improvement Project Specialist I	X
Christine Rattray, Quality Improvement Supervisor	X
Tanisha Shepard	X
Sangeeta Singh, Quality Improvement Project Specialist I	X
Grace St. Clair, Director, Compliance & Special Investigations	
Yemaya Teague, Senior Analyst of Health Equity	X
Loc Tran, Manager, Access to Care	X
Matthew Woodruff, Chief Executive Officer	
Farashta Zainal, Quality Improvement Manager	X
Hellai Momen, Quality Review Nurse	
Mao Moua	X
Ami Ambu	X
Sarbjit Larb	
Sean Pepper	
Brennan Yu	X
Community Members in Attendance	
Dr.Andrea Wu – Alameda Health Systems	
Wesley Lisker	

Commented [MS1]: F.Tournabene was present also

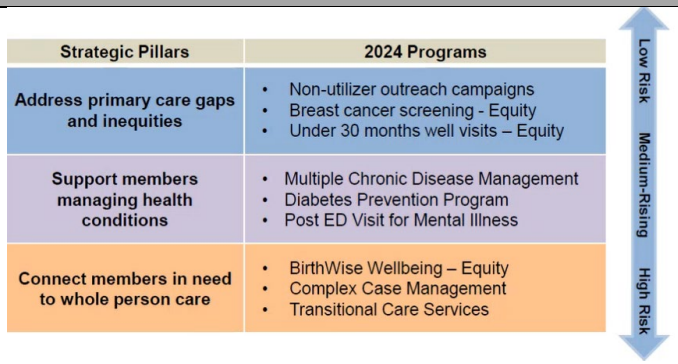
Agenda Item		Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
I.	**Call to Order**	D. Carey	The meeting was called to order at 9:02am		
II.	**Alameda Alliance Updates**	D. Carey	• DHCS Annual Audit coming in June • AAH is in preparations of becoming a D-SNP in January 2026.		
III.	**Chief of Health Equity Updates**	L. Vang	• Strategic Roadmap Committee has scheduled its first 2 meetings (May & June). • The first meeting will discuss findings from the vendor assessment on the Roadmap and next steps. • The second meeting will discuss the guiding principles and to establish a mission and vision statement. • DEI Training Curriculum is under way. First draft by end of May. Final draft by end of summer with a final submission to DHCS by September. • Completed 2 Leadership Enrichment sessions for our Senior Leadership Teams. These meetings were held in April and May to discuss the shared vision of Health Equity and DEI. • Director of Health Equity will be added to the team by end of June-early July.		
IV.	**Committee Member Presentation: Alameda Health Systems**	A.Wu	**Improving Patient Throughput** • Presentation focus is on throughput and how it impacts Quality and Health Equity. • There is a National public health issue with Hospital and Emergency Department (ED) overcrowding which leads to patients leaving the ED with incomplete care or inappropriate sites of care; thus impacting the patient's experience and quality of care. • This is a National trend and is not unique to just AHS. • Throughput Steering Committee (TSC) utilizes data driven process improvement with accountable leaders for each initiative.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• Several types of solutions were developed, we re-designed how patients are processed in the ED such as observation services and also worked on optimizing patient throughput. • Within AHS we have 3 Acute Care Hospitals. We want an integrated vison of delivering Healthcare across the system. Our goal is to function at a system capacity as opposed to a hospital floor level. • Defining Capacity: -Physical: total beds -Clinical: Aligning the right staff, equipment and level of care. • What makes inpatient throughput so challenging is the alignment of services in a timely manner. • It take an alignment for every patient that comes into the hospital to receive the Physician Specialty, Nursing special and physical environment to match their needs. • Our vision is to optimize throughput across the system to ensure that we are delivering quality care and meet time metrics for time sensitive conditions and streamlining as much as possible. • We manage and monitor many initiatives during our Throughput Steering Committees through data monitoring process and a metric dashboard that we follow. • Embedding proactive conversations about throughput early on in our bed huddles and even before then. • According to the National ED Over Crowding Scale (NEDOCS) - Highland is 50% overcrowded, severe, disaster categories. - San Leandro is 14% overcrowded. - Alameda is 2% overcrowded. • There was a problem with ED boarding causing a delay in rooming patients. We implemented a Provider in triage with a Nurse to help evaluate patients right away. This provider will determine the appropriate treatment pathway for each patient. • This completely redesigned the physical layout and front-end process. • This improved our metrics drastically.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• We improved timely care ultimately. Patients that left after triage and discharge length of stay went down significantly. **Questions/Comments:** M. Stott: When you looked at the data, did you also break it down by preventable ED and opportunities to work with Primary Care Providers or telehealth? A. Wu: That is something we are working with our ambulatory partners. I do not have that specific breakdown but I do think that is a great opportunity for access to the patients as well. S. Bhatt: My understanding of ED overcrowding is about decreasing input by using urgent care or outpatient services and improving the throughput in the ED and increasing the output. Does the throughput steering committee have an equal emphasis in all 3 processes (Input/output/ throughput)? A. Wu: Yes, there's a lot of work that we're trying to do to make those services more accessible when the patient needs it. But it can be difficult in some ways when you need the patient in different departments across the system. It is sometimes challenging when you need to focus on various patent needs.		
V. Policies & Procedures	D. Carey	Policies & Procedures packet was sent out prior to QIHEC for committee review. • CBAS-001 Initial Member Assessment and Member Reassessment for Community-Based Adult Services (CBAS) Eligibility • CBAS-002 Expedited Initial Member Assessment for Community-Based Adult Services (CBAS) Eligibility • CBAS-004 Member Assignment to a CBAS Center • CBAS-005 Provision of Unbundled CBAS Services • CBAS-006 CBAS Emergency Remote Services (ERS) • CM-034 Structure of Plan's Transitional Care • Services program • UM-001 Utilization Management Program • UM-004 Over and Under Utilization	Move to Approve: 1st: T. Do 2nd: A. Chapman	

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• UM-005 Second Opinions • UM-007 New and or Experimental Technology • Review Process • UM-008 Coordination of Care- California Children's • Services • UM-014 Identifying Abuse • UM-016 Transportation Guidelines • UM-025 Guidelines for Obstetrical Services • UM- 029 Sensitive Services • UM-063 Gender Affirmation Surgery and Services • UM- 036 Continuity of Care • UM-048 Triage and Screening Services • UM-049 Utilization Management Satisfaction • Survey • UM-050 Tracking and Monitoring of Services • Prior Authorized • UM-056 Standing Referrals • UM-057 Authorization Service Requests • UM-058 Continuity of Care for New Enrollees • Transitioned to Managed Care After Receiving • A Medical Exemption • UM-059 Continuity of Care for Medi-Cal • Beneficiaries who Transition into Medi-Cal • Managed Care • UM-015 Emergency Services and Post- • Stabilization Services • UM-003 Concurrent Review and Discharge • Planning Process • LTC-003 LTC Case Management Member • Identification and Enrollment and • Management Process		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
VI. Meeting Minutes	D. Carey	Meeting Minutes packet was sent out prior to QIHEC for committee review. • QIHEC- 4/17/2024 • A&A- 5/3/2024	Move to Approve: 1st: T. Do 2nd: A. Chapman	
VII. Population Health Management (PHM)	L. Ayala L. Hunter G. Duran F. Zainal	**PHM Evaluation** • Framework: We start with information from our members through population and member data and take that info to consider what type of continuum of care services are needed (Low/Medium/High Risk) making sure everyone had the most basic Population Health Management & Transitional Care Services. • We consider social determinants of health and health equity in every step of this process. • In 2023 we saw a number of opportunities as the program was evaluated to increase engagement and partnerships with members, community organizations and providers to better understand and address barriers to care. • Look at more member education specifically around preventative services. • Outreach to members before they leave the ED or hospital. • Connect across Alliance and County programs to promote services. • Improvement of data. • In 2024, we are utilizing the same strategic pillars as 2023. There are 9 programs across 3 pillars:	Move to Approve: 1st: F. Tornabene 2nd: T. Do	

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		 • These Strategic Pillars align with NCQA and DHCS Areas of Focus. **<u>PHM Strategy</u>** **Managing Multiple Chronic Illnesses** • In alignment with NCQAs focused areas managing multiple chronic conditions, one of the goals we have is complex case management (CCM). • 2024 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. • Managing Multiple Chronic Illnesses 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. **Managing Members with Emerging Risk**		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• BirthWise Wellbeing: Utilization of doulas appears to be an effective strategy in maternal health. The Alliance launched a Doula Benefit in 2023 and invested in expanding doula services. • Depression Disease Management Program (BirthWise Wellbeing) identifies members in the perinatal period and send out a packet of multiple resources 9Maternal Mental Health, Behavioral Health, Doula Benefit) • By March 2025, our goal is to see at least 3% of African American, Hispanic, American Indian or Alaskan Native Members in the last year receive doula benefit. • Diabetes Prevention Program: Yearlong lifestyle change program designed to prevent or delay of the onset of Type II Diabetes. We want to ensure members reached and maintain 5% weight loss. • African American Breast Cancer Screening QI Project: Women are falling behind in getting breast cancer screenings so our goal is to increase the rates by 3% from MY2023 to MY2024. We will continue to work on mobile mammography and giving members incentives upon completion. **Keeping Members Healthy** • African American Well-Child Visit QI Project Between ages of 0-30 months: Our goal is to increase the rates by 5% from 2023 to 2024. We are going to work on a well-child visit prenatal campaign. Continuing care coordination with Alameda First 5. This year we are working on a well-child advertising campaign with billboards and posters around the community. • Non-Utilizer Outreach: Started in 2023. Second pilot in 2024. Working on outreaching to members 50+ and 6 and under. By June 2024, our goal is to outreach to at least 20% of members who did not utilize services from October 2022 to September 2023 and connect 2% to primary care services. **Patient Safety or Outcomes Across Settings**		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• Follow-up after ED visit for Mental Illness QI Project: Our goal is to increase the HEDIS rate from 51.10% in 2023 to 54.87 in 2024. • Transitional Care Services: Goal is to increase the percentage of transition for our high-risk members that had at least 1 interaction with their assigned care manager within 7 day post-discharge by 1 percentage point in March 2025. **Questions/Comments:** F. Tornabene: Can you say more about the ED Navigation Program and how you are working with the delivery systems? F. Zainal: We are working with AHS. Our hope is to utilize CHWs and ED navigators. We have found some codes that CHWs can use for that follow-up visit. It would be a process to notify CHWs when members are in the ED so that they can connect with the member before discharge to connect them to services. We are participating in a workgroup with AHS to set us a CHW in the ED to do those services. F. Tornabene: Are we the only one you are working with to pilot this program? F. Zainal: Yes, that is correct. W. Lisker: What's the 30 day revisit rates for patients who don't have the mental health follow up after their visit? F. Zainal: Actually I don't have this data on hand but we can definitely look into this.		Follow up on 30-day readmission rates for patient who don't have mental health follow up (low)
VIII. Availability of Practitioners to Meet the Cultural Needs and Preferences of Members	M. Moua	Mao shared the results and assessment/actions from the 2023 Availability of Practitioners to Meet Cultural Needs and Preferences of Members Report (NET 1A Report) • Completed annually to meet NET 1A Factors 1 & 2 requirements. • The goal is to make sure that the Alliance offers a practitioner network that is sufficient in volume and capabilities to meet cultural, ethnic, racial and linguistic needs of our members. • The purpose of the report is to review data, assess the characteristics of practitioners as well as whether the members' needs were met.	Move to Approve: 1st: T. Do 2nd: F. Tornabene	

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		• As we are doing the analyzing, we adjust the provider networks as needed. • The Medi-Cal population increased for the list of languages except for Spanish, Vietnamese and Arabic. The PCP and member ratio also remained within contract. **Language Capacity** • For Group Care, the member population decreased for all listed languages except for Arabic. PCP to member ratios also remain acceptable. • For Specialist Language Capacity, Spanish and Vietnamese have the highest ratio per member (Medi-Cal). Chinese and Vietnamese have the highest ratio per Group Care member. • For Behavioral Health Providers, Chinese and Vietnamese have the highest ratio per member (Medi-Cal). Chinese and Vietnamese have the highest ratio per Group Care member. We will ensure a lookback in next year's report. **Membership by Race and Ethnicity** • Medi-Cal: There were fluctuations in Medi-Cal members with less than 1 percentage point. • Hispanic (Latinx) Community represents half the membership. • For Group Care the percentage of unknown ethnicities continues to decline. **Overall Language Services for 2023** • Over 57,000 interpreter services provided in 112 languages by 3 vendors. • Telephonic services increased in 2023 from 2022 for a language thresholds. • Spanish and Mandarin having the highest increase. • There was a decrease in video interpreter services in 2023 except for Spanish. • In 2023, in-person interpreter services for Spanish doubled. **Cultural & Linguistic Related Grievances**		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• From 2022 to 2023 we saw a significant increase in grievances related to language assistance as well as discrimination. • All quality of service related to discrimination were resolved in 2023. They were either forwarded or investigated by our Grievances and Appeals team. • Our assessment is categorized by language, race/ethnicity, culture and an Intersection of Language/race/Ethnicity and culture. • In conclusion, no adjustments were needed to the provider network. • We will continue to educate providers on cultural preferences and beliefs of members via Cultural Sensitivity Trainings. • Monitor provider network as membership expands and new languages arise.		
IX. NCQA Update	J. Karmelich	• Kisha Gerena, Accreditation Manager presented the update in Jennifer's absence. • Alameda Alliance is accredited for both lines of business (Medi-Cal and Group Care). • Medi-Cal scored a 4.0/5 rating on HEDIS and CAHPS score. Group Care scored 3.0/5 rating. • NCQA Surveys are held every 3 years. Our next survey will take place in 2025. • In 2022, The Alliance scored 147 points out of 149 (98.66%) • The next re-accreditation survey will be held between 7/8/2025 – 7/29/2025 with a submission date of 6/10/2025. • The lookback period for documents is 24 months. 12 months for UM/Rx/BH/Appeal and CCM Files. 36 months for Credentialing files. **Health Equity Accreditation Status** • The 6 Standards of Health Equity are listed below.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		ALAMEDA Alliance FOR HEALTH **Health Equity Standards** ▷ HE 1: Organizational Readiness ▷ HE 2: Race/Ethnicity, Language, Gender Identity and Sexual Orientation Data ▷ HE 3: Access and Availability of Language Services ▷ HE 4: Practitioner Network Cultural Responsiveness ▷ HE 5: Culturally and Linguistically Appropriate Services Programs ▷ HE 6: Reducing Health Care Disparities • The next Health Equity Survey will be in 2025. Submission date is 6/10/2025 with a lookback period of 12 months. Mandatory Accreditation date 1/1/2026. • In order to prepare for the survey, we held a Health Equity Accreditation 101 training. • Held meeting with consultants to review accreditation documents and identified all documents we had and what is needed. Feedback will be shared once this review is completed. • Risk Assessments will be held in July after the DHCS Audit.		
X. Initial Health Appointment	F. Zainal	• In 2022 and 2023, the Health Plan was issued a corrective action plan (CAP) for Initial Health Appointments (IHA). • During the DHCS Annual Audit, they found that IHAs were not completed in the charts they reviewed. We could not show sufficient outreach evidence.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• The Health Plan started Interactive voice response (IVR) calls last year to reach out to new members reminding them to reach out to providers to make an appointment. • IHA requirements were discussed via provider communication, JOM, QI Meetings and webinars. We send out IHA reports to providers as well. • IHA Measure Highlight tool was created for providers use as well. • Members need an IHA within 120 days of enrollment to the Health Plan or when they select a provider. • It excludes members who complete an IHA in the last 12 months. Evidence must be shown. • 2 documented outreach attempts required. • Internally, we must show that we are monitoring IHAs. In early 2023 we conducted an IHA Audit. 40 charts were reviewed for IHA completed during 1/28/2023 to 10/28/2023. • 20 adults and 20 children. • 76% of all IHA Elements were completed for children 0-6 years old. • 67% of all IHA Elements were completed for adolescents 9-14 years old. • 68% of all IHA Elements were completed for adults 27-55 years old. • Elements that were missed across all age groups included health screenings (BLD, Depression, Hearing, Alcohol, Drug) **Questions/Comments:** Dr. Carey welcomed committee members to provide ideas or feedback on completing IHA and screenings.		

<table>
<tr><th>Agenda Item</th><th>Responsible Person</th><th>Discussion</th><th>Vote</th><th>Action Items (High, Medium, Low)</th></tr>
<tr><td>XI. Survey Results</td><td>L. Tran</td><td>
PAAS Survey

Provider Appointment Availability Survey (PAAS) is conducted annually to survey appointment availably for both Urgent and Non-Urgent appointments.
For measurement year 2023, DMHC required additional provider types for Specialist Physicians. Historically, specialists included Cardiology, Endocrinology and Gastroenterology.
For 2023, Dermatology, Neurology, Oncology, Ophthalmology, ENT, Pulmonology and Urology were added.
DMHCs Compliance rate is 70%
AAH Compliance rate goal in 75%
For 2023, DMHC is asking us to monitor the follow up appointment for Non-Physician Mental Health providers.

2023 PAAS Compliance Rates
<table>
<tr><th colspan="3">2023</th><th colspan="2">Year to Year % Difference</th></tr>
<tr><th>Urgent Appt</th><th>Routine Appt</th><th>Follow-up Appt</th><th>Urgent</th><th>Non-Urgent</th></tr>
<tr><td colspan="3">Ancillary</td><td></td><td></td></tr>
<tr><td>Not applicable</td><td>100%</td><td></td><td>N/A</td><td>+16.7%</td></tr>
<tr><td colspan="3">PCPs</td><td></td><td></td></tr>
<tr><td>66.6%</td><td>74.7%</td><td></td><td>+14.9%</td><td>+4.7%</td></tr>
<tr><td colspan="3">NPMH</td><td></td><td></td></tr>
<tr><td>86.7%</td><td>84.2%</td><td>87.3%</td><td>+11.4%</td><td>-3.4%</td></tr>
<tr><td colspan="3">Psychiatrists</td><td></td><td></td></tr>
<tr><td>76.9%</td><td>92.3%</td><td></td><td>+19.1%</td><td>+7.1%</td></tr>
<tr><td colspan="3">Specialists</td><td></td><td></td></tr>
<tr><td>55.5%</td><td>56.7%</td><td></td><td>+9.2%</td><td>-0.4%</td></tr>
</table>
DHCS QMRT Timely Access Study

Held on a quarterly bases to monitor Urgent and Non-Urgent appointments.
From Q4 2022 to Q3 2023, we saw a slight decrease in the past 4 quarters. This is due to low response rates.
We will continue to educate providers on this study. Providers are thinking these surveys are scam calls.

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Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		Q1 2023 to Q4 2023 Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) • Conducted on a quarterly basis and measures member experiences with providers and staff. • 3 areas of measurement: In-Office Wait Time, Call Return Time and Time to Answer Call. **CG-CAHPS Survey Results**		

In-Office Wait Time			
See provider within 60 minutes at an 80% compliance threshold goal			
Q1 2023	Q2 2023	Q3 2023	Q4 2023
92.0%	91.1%	94.0%	92.0%

Call Return Time			
Return calls within 1 Business Day at an 70% compliance threshold goal			
Q1 2023	Q2 2023	Q3 2023	Q4 2023
74.3%	74.5%	75.8%	75.2%

Time to Answer Call			
Answer calls within 10 minutes at an 70% compliance threshold goal			
Q1 2023	Q2 2023	Q3 2023	Q4 2023
70.0%	71.4%	75.3%	72.2%

- Our next steps include provider education/orientation and sending out biweekly fax blasts up to 2 month prior to survey period.
- Virtual and on-site provider visits not meeting Timely Access year over year.
- CAPs for non-compliant and non-responsive providers.
- Provider incentive and extended office hours to improve access to care.

After Hours Survey

- Survey designed to ensure that providers are compliant with after hours access and standard after hours instructions.
- Providers surveyed included PCPs, Specialists and Behavioral Health totaling 325 surveys. Compliance goal is 80%
- For PCP, there was a 1.3% increase in compliance from 2022 to 2023 (98.6% Compliant)

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• For Specialists, there was a 0.5% increase in compliance from 2022 to 2023 (93.3 Compliant) • For BH, there was a 7% Decrease in compliance from 2022 to 2023 (83.3% Compliant) • For non-responsive providers, we will continue to meet and educate them around the requirement for After Hours standards. 25 provides were non-compliant. CAPS will be sent.		
XII. Public Comment	D. Carey	None		
XIII. Meeting Adjournment	D. Carey	Meeting Adjourned at 10:40am		

X_____ <click to insert a date>
Dr. Donna Carey
Interim Chief Medical Officer
Chair

Minutes prepared by: Ashley Asejo - Clinical Quality Programs Coordinator

Utilization Management Committee Meeting Minutes
May 31, 2024, 1:30 PM – 3:00 PM
Teams

Member Name and Title	Present	Member Name and Title	Present
Donna Carey, Interim Chief Medical Officer		Jorge Rosales, Manager, Case & Disease Management	
Richard Golfin, Chief Compliance Officer		Judy Rosas, Sr. Manager, Member Services	X
Tiffany Cheang, Chief Analytics Officer	X	Karen Marin, Manager, Long Term Care	
Allison Lam, Senior Director, Health Care Services	X	Katherine Goodwin, Supervisor, Health Plan Audits	X
Alma Pena, Sr. Manager, G&A		Kimberly Glasby, Director, Long Term Services & Supports	X
Amani Sattar, Executive Assistant	X	Kisha Gerena, Manager, Grievances & Appeals	
Andrea DeRochi, Manager, Behavioral Health	X	Laura Grossman-Hicks, Sr. Director, BH Services	X
Annie Lam, Manager, Provider Services Call Center		Lily Hunter, Director, Social Determinants of Health	X
Benita Ochoa, Lead Pharmacy Technician		Linda Ayala, Director, Population Health & Equity	X
Beverly Juan, Medical Director, Community Health		Lisha Reamer-Robinson, Manager, Compliance Audits & Investigation	X
Brittany Nielsen, Executive Assistant		Loc Tran, Manager, Access to Care	
Carla Healy-London, Manager, Inpatient UM	X	Marie Broadnax, Manager, Regulatory Affairs & Compliance	
Cecilia Gomez, Sr. Manager, Provider Services		Michelle Findlater, Director, Utilization Management	X
Darryl Crowder, Director, Provider Relations and Contracting		Michelle Stott, Senior Director, Quality	X
Daphne Lo, Medical Director, LTSS	X	Nancy Pun, Sr. Director, Analytics	
Farashta Zainal, Manager, Quality Improvement		Peter Currie, Senior Director, Behavioral Health	
Gia Degrano, Senior Director, Member Services	X	Rahel Negash, Pharmacy Supervisor	X
Gil Duran, Manager, Population Health & Equity		Rosalia Mendoza, Medical Director, Utilization Management	X
Heather Wanket, Clinical Manager, ECM		Sanjay Bhatt, Senior Medical Director	
Helen Lee, Senior Director, Pharmacy Services	X	Sanya Grewal, Healthcare Services Specialist	X
Hope Desrochers, Manager, Outpatient UM	X	Stephen Williams, Supervisor, OP UM	X
Jennifer Karmelich, Director, Quality Assurance	X		

Utilization Management Committee Meeting Minutes
May 31, 2024, 1:30 PM – 3:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
I. Call to Order/ Introductions	A. Lam R. Mendoza	The meeting was called to order by Allison Lam at **1:31 pm**		
II. Review and Approval of minutes	A. Lam R. Mendoza	The UM Committee Minutes from **April 26th, 2024** were approved electronically by a quorum of the committee prior to the meeting.		**Approved via e-vote:** 5/9/24
III. Policies and Procedures	All	• UM-016	PP Summary of Changes_5.31.24.pdf	**Vote to Approve:** None opposed: The policies will be finalized as approved and moved forward to QIHEC

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Utilization Management Committee Meeting Minutes
May 31, 2024, 1:30 PM – 3:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
IV. Monitoring of UM Operational Activities **A. TAT: OP, IP, BH, Rx**	H. Desrochers C. Healy-London A. DeRochi H. Lee	• **Inpatient** ○ Authorizations = 8,046 ○ TATs = 98% • **Outpatient** ○ Authorizations = 12,726 ○ TATs ▪ Routine Pre-Service = 100% ▪ Routine Pre-Service, Extension Needed = 100% ▪ Urgent Pre-Service = 99% ▪ Urgent Pre-Service, Extension Needed = 100% • **Behavioral Health** ○ Authorizations = 1,417 ○ TAT ▪ Routine Pre-Service = 97% ▪ Routine Pre-Service, Deferral/Pended = 67% ▪ Urgent Pre-Service = n/a ▪ Post-Service/Retrospective = 100% • **Rx** ○ Authorizations - 431 ○ TAT ▪ Routine Pre-Service = 100% ▪ Routine Pre-Service, Extension Needed = 100% ▪ Urgent Pre-Service = 100% ▪ Post-Service/Retrospective = 100%	TAT_IP_5.31.24.pdf OP & BH TAT - 5.31.24.pdf TAT_Rx_5.31.24.pdf Rx.pdf	

Utilization Management Committee Meeting Minutes
May 31, 2024, 1:30 PM – 3:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date

B. Long Term Care	Kimberly Glasby	• LTC Membership up 38.2% from Q4 2023
		• TAT increased 139.52% from Q4 2023
		  ○ Total = 3,370
		  ○ Met = 3,225
		  ○ % = 95.7%
		• Admits per 1000 decreased from January to March
		• ER Visits have decreased 33% from Q4 2023
			LTC_5.31.24.pdf	

C. OON Utilization	R. Mendoza	• CHCN OON Utilization = 1,228 (highest)
		• Highest contribution urgent level of urgency
		  ○ General Acute Care Hospital = 60%
		  ○ Specialty NOS = 30%
		• Highest contribution OON referrals by specialty type
		  ○ General Acute Care Hospital = 25%
		  ○ Specialty NOS = 17%
		  ○ Acute Skilled Nursing Facility = 4%
		• Total number of approved authorizations = 3,098
		• OON ER Utilization = 415
		  ○ Top 3 ER Diagnosis were: Encounter Full Term Uncomplicated Del, Sepsis, Cellulitis
		• OON General Acute Care = 791
			OON_5.31.24.pdf	

Utilization Management Committee Meeting Minutes
May 31, 2024, 1:30 PM – 3:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
		• Sutter OON Hospital Utilization = 336 ○ Sutter is the number one OON facility and replaces previously OON Kaiser hospital utilization • Kaiser OON Hospital Utilization = 178 • Specialty NOS OON Utilization = 539 • PCP OON Utilization = 90		

V. Activities to Improve Member Experience
A. Case Management Report
	J. Rosales	• **Patient Volume**
		  ○ Complex cases and care coordination at baseline
		  ○ Increase in Transitional Care Services Cases
		  ▪ Cases re-stratified as high risk may be open longer for high risk TCS interventions.
		• **Internal Audit**
		  ○ Q4 Audit Results
		  ▪ Reviewed Complex cases from Q4 2023, using NCQA auditing tool
		  ▪ Assessment Factors – 95%, from 98% previous quarter
		  ▪ Care Plan Factors – 87%, from 78% previous quarter
		  ▪ CM leadership to increase auditing CCM cases now that supervisor roles full staffed
		• **Quarterly Evaluation Update**
		  ○ Increase in Self referrals into CMDM
		  ○ Referrals being automated from ADT feed
			CM_5.31.24.pdf	

Utilization Management Committee Meeting Minutes
May 31, 2024, 1:30 PM – 3:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date

		• **Behavioral Health**
		  ○ BHT / ABA Case Coordination Referrals
		  ▪ January = 199
		  ▪ February = 162
		  ▪ March = 175
		  ○ BHT / ABA Cases Closed = 89
		  ○ MH Case Coordination Referrals
		  ▪ January = 198
		  ▪ February = 169
		  ▪ March = 176
		  ○ MH Cases Closed = 418		

VI. Adjournment	A. Lam	The meeting was adjourned at **2:18 pm**		**Next Meeting:** July 26th, 2024 at 1:30 PM

Utilization Management Committee Meeting Minutes
May 31, 2024, 1:30 PM – 3:00 PM
Teams

Meeting Minutes submitted by: DocuSigned by: Amani Sattar 1515265B2F7F4DC... **Date:** 06/03/2024 | 10:34 AM PDT

Amani Sattar,
EA to the CMO

Approved by: DocuSigned by: Allison Lam 8E7713C4669F403... **Date:** 06/03/2024 | 10:42 AM PDT

Allison Lam,
Sr. Director, Health Care Services

Approved by: DocuSigned by: Rosalia Allan Mendoza, MD 39B79088420042E... **Date:** 06/03/2024 | 1:24 PM PDT

Rosalia Mendoza, MD
Medical Director, Utilization Management

Utilization Management Committee Meeting Minutes
July 26, 2024, 1:30 PM – 3:00 PM
Teams

Member Name and Title	Present	Member Name and Title	Present
Donna Carey, Interim Chief Medical Officer	X	Jorge Rosales, Manager, Case & Disease Management	X
Richard Golfin, Chief Compliance Officer		Judy Rosas, Sr. Manager, Member Services	
Tiffany Cheang, Chief Analytics Officer		Karen Marin, Manager, Long Term Care	
Allison Lam, Senior Director, Health Care Services	X	Katherine Goodwin, Supervisor, Health Plan Audits	X
Alma Pena, Sr. Manager, G&A		Kimberly Glasby, Director, Long Term Services & Supports	X
Amani Sattar, Executive Assistant	X	Kisha Gerena, Manager, Grievances & Appeals	
Andrea DeRochi, Manager, Behavioral Health	X	Laura Grossman-Hicks, Sr. Director, BH Services	
Annie Lam, Manager, Provider Services Call Center		Lily Hunter, Director, Social Determinants of Health	
Benita Ochoa, Lead Pharmacy Tech		Linda Ayala, Director, Population Health & Equity	X
Beverly Juan, Medical Director, Community Health	X	Lisha Reamer-Robinson, Manager, Compliance Audits & Investigation	
Brittany Nielsen, Executive Assistant		Loc Tran, Manager, Access to Care	
Carla Healy-London, Manager, Inpatient UM		Marie Broadnax, Manager, Regulatory Affairs & Compliance	
Cecilia Gomez, Sr. Manager, Provider Services		Michelle Findlater, Director, Utilization Management	X
Darryl Crowder, Director, Provider Relations and Contracting		Michelle Stott, Senior Director, Quality	X
Daphne Lo, Medical Director, LTSS	X	Nancy Pun, Sr. Director, Analytics	
Farashta Zainal, Manager, Quality Improvement		Peter Currie, Senior Director, Behavioral Health	X
Gia Degrano, Senior Director, Member Services	X	Rahel Negash, Pharmacy Supervisor	X
Gil Duran, Manager, Population Health & Equity		Rosalia Mendoza, Medical Director, Utilization Management	X
Heather Wanket, Clinical Manager, ECM	X	Sanjay Bhatt, Senior Medical Director	X
Hope Desrochers, Manager, Outpatient UM	X	Sanya Grewal, Healthcare Services Specialist	X
Jennifer Karmelich, Director, Quality Assurance	X	Stephen Williams, Supervisor, OP UM	X

Utilization Management Committee Meeting Minutes
July 26, 2024, 1:30 PM – 3:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
I. Call to Order/ Introductions	A. Lam R. Mendoza	The meeting was called to order by Allison Lam at **1:30 pm**		
II. Review and Approval of minutes	A. Lam R. Mendoza	The UM Committee Minutes from **May 31, 2024** were approved electronically by a quorum of the committee prior to the meeting.		**Approved via e-vote:** 6/3/24 – 6/7/24
III. Policies and Procedures	All	• CM-004 • CM-005 • CM-008 • CM-020 • CM-021 • CM-022 • CM-023 • CM-024 • CM-025 • CM-026 • CM-027 • CM-029 • CM-033	UMC PP Summary of Changes 7.26.24.pdf	**Vote to Approve:** None opposed: The policies will be finalized as approved and moved forward to QIHEC

Utilization Management Committee Meeting Minutes
July 26, 2024, 1:30 PM – 3:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
		• CM-035 • CM-036 • CM-037 • CM-038 • CM-039 • CM-040 • HCS-015 • HCS-020 • UM-001 • UM-046		
IV. Monitoring of UM Operational Activities **A. Internal Audit: NOA's, Quality Audits**	H. Desrochers	• Overall Scores ○ UM Overall Score = 98% ○ Expedited Timeliness = 100% ○ Routine Timeliness = 100% ○ Review Elements = 97% ○ NOW Review Score = 100%	OP UM NOA Audit_Q2_7.26.24.pdf	
B. UM Metrics	M. Findlater R. Mendoza	• Admits/1000 decreased 69.5 (-0.2) • Decrease in ALOS 5.3 days (-0.1) • Decrease in Paid Days/1000 368.5 (-25.5) • Readmission Rate from 2023-2024 remain unchanged despite TCS and PHM interventions, with an average 20.6% readmission rate • Rising IP denials, with greatest contribution from Fully Denials vs Partial Denials ○ Highest rate of 2024 IP Denials: Subacute 4.3% (+2.9) > Med/ Surg 3.1% (+1.1) > SNF 1.6% (+1.0)	UM Metrics_7.26.24.pdf	

Utilization Management Committee Meeting Minutes
July 26, 2024, 1:30 PM – 3:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
		• Stable OP Denial Rates in 2024 ○ Highest rate of 2024 IP Denials: Subacute 4.3% (+2.9) > Med/ Surg 3.1% (+1.1) > SNF 1.6% (+1.0) • Total ED rates are decreasing, but individual networks have increased since 1/1/2024		
C. TAT: Rx	R. Negash	• TAT Q2 2024 is at 100%	TAT_Rx_Q2_7.26.24.pdf	

D. CBAS Metrics	H. Desrochers	• CBAS Q2 2024
		  ○ Total members provided CBAS across 6 centers = 375
		  ○ TAT remains at 100% at average of 1 day
		  ○ IPC Renewals for Q2 have gone up 12% (total of 180)
		  ○ There are 22 new Emergency Remote Services for Q2, and 12 members who stopped
			CBAS_Q2_7.26.24.pdf	

E. Compliance Report	S. Pepper	• Q2 2024 HIPAA/Privacy Incidents
		  ○ Total Referrals = 37
		  ▪ One referral required reporting to DHCS. It was closed as a non-breach
		• Internal Referrals to Compliance Q2-2024
		  ○ 65% of the referrals to Compliance were made within 24 hours. Removing cases without a privacy component, 84% of referrals were made within 24 hours
			Compliance Report_7.26.24.pdf	

Utilization Management Committee Meeting Minutes
July 26, 2024, 1:30 PM – 3:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
		• Total HIPAA Cases by Type ○ Email = 45 ○ Paper = 14 ○ Other Electronic = 21 ○ Other = 60 ○ No Privacy Issue = 25 • Discrimination Cases are within the normal range for this quarter • Compliance Audit Updates ○ 2024 DHCS Routine Medical Survey ▪ During the two (2) week engagement, the Plan received 311 on-site end of day document requests and an additional twelve (12) post-audit requests. This represents a significant increase in document requests ▪ The Plan expects the DHCS to distribute a draft report in the coming weeks. Once received, the Plan will have fifteen (15) days to respond to the draft report. ○ 2023 DHCS Routine Medical Survey ▪ The Preliminary Report outlined nine (9) findings: four (4) findings under Behavioral Health Services; and five (5) findings under Transportation Services, Non-Medical and Non-Emergent Medical Transportation (NMT/NEMT). ▪ The Plan's response to the draft report was submitted on July 19th, 2024		
F. 2024 – 2026 Audit Calendar	K. Goodwin	• See Attachment	2024-2026 Audit Calendar.pdf	

Utilization Management Committee Meeting Minutes
July 26, 2024, 1:30 PM – 3:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
V. Activities to Improve Member Experience **A. DUR Report**	R. Negash	• Q2 ○ April = 350 ○ May = 348 ○ June = 375	DUR_Q2_7.26.24.pdf DUR_7.26.24.pdf	
B. Community Advisory Committee Report	L. Ayala	• CEO Update ○ There was a concern about increase in population and lower budget impacting access to needed services in which Matt Woodruff (CEO) assured CAC members that we are not cutting services.	CAC_7.26.24.pdf	
VI. Delegation Oversight	M. Findlater R. Mendoza	• CHCN HICE Report ○ Medical Necessity Denials (IP & OP) Q1 2024 ▪ Commercial = 0.34% ▪ Medi-Cal = 0.8% ○ CHCN Denial rate goal for ≤ 1.0% was met in 2024 • All areas met the 98% Tat Metrics for Medi-Cal & Group Care • Over & Under Utilization ○ TOC (30 day readmission rate) = 18.9% ○ TOC (primary care follow up within 30 days) = 59.8% ○ Preventative Care (BP control) = 58.3% ○ Preventative Care (improve diabetes control) = 74.1%	Delegation Oversight_7.26.24.pdf	

Utilization Management Committee Meeting Minutes
July 26, 2024, 1:30 PM – 3:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
		• CFMG HICE Report ○ Denial rate goal for ≤ 5.0% was met ○ All areas met the Tat Metrics for Medi-Cal		
A. Delegates Finding Denial of Auths DHCS 1.5.1, 1.5.2	M. Findlater R. Mendoza	• CHCN NOA Audit ○ CHCN – Outpatient ▪ 1/30 (3%) had an untimely provider notification sent ○ CHCN – Inpatient ▪ 7/60 (12%) files had untimely initial review and untimely notification ▪ 1 case missing UM Nure review notes ▪ 1 case did not have LVN/RN oversight in notes ▪ 546 total failed faxed due to unexpected disconnect (247), provider entering wrong number in auth submission (96), fail line being busy (44) and no fax number (87) • CFMG NOA Audit ○ CFMG have yet to schedule to review NOA oversight process before determining if CAP is needed	Delegates Finding Denial of Auths_7.26.2	
VII. Adjournment	A. Lam	The meeting was adjourned at **3:00 pm**		**Next Meeting:** August 30, 2024 at 1:30 PM

Utilization Management Committee Meeting Minutes
July 26, 2024, 1:30 PM – 3:00 PM
Teams

Meeting Minutes submitted by: DocuSigned by: Amani Sattar 1515265B2F7F4DC... **Date:** 07/31/2024 | 10:29 AM PDT
Amani Sattar,
EA to the CMO

Approved by: DocuSigned by: Allison Lam 8E7713C4669F403... **Date:** 07/31/2024 | 12:12 PM PDT
Allison Lam,
Sr. Director, Health Care Services

Approved by: DocuSigned by: Rosalia Allan Mendoza, MD 39B79088420042E... **Date:** 07/31/2024 | 1:14 PM PDT
Rosalia Mendoza, MD
Medical Director, Utilization Management

COMMUNITY ADVISORY COMMITTEE (CAC)
Thursday, March 14, 2024, 10:00 AM – 12:00 PM

Committee Member Name	Role	Present
Natalie Williams	Alliance Member	x
Valeria Brabata Gonzalez	Alliance Member	x
Cecelia Wynn	Alliance Member	x
Tandra DeBose	Alliance Member	x
Irene Garcia	Alliance Member	x
Erika Garner	Alliance Member	x
Melinda Mello	Alliance Member	x
Jody Moore	Parent of Alliance Member	x
Sonya Richardson	Alliance Member	
MiMi Le	Alliance Member	x
Mayra Matias Pablo	Parent of Alliance Member	
Amy Sholinbeck, LCSW	Asthma Coordinator, Alameda County Asthma Start	
Jody Moore	Parent of Alliance Member	x
Irene Garcia		x
Roxanne Furr		x

Other Attendees	Organization	Present
Bernie Zimmer	CHME/ Visitor	
Melodie Shubat	CHME/ Visitor	
Christina Pandolfo	Community Liaison, CHME	
Yael Martinez	ACPH	
Jesus Verduzco	Family Services, ACPH	x
Lori Kabangu	Kaiser Permanente, Community Advisory Committee	x
Melinda Yanonis	Kaiser Permanente, Community Advisory Committee	x

Alliance Staff Member	Title	Present
Matt Woodruff	Chief Executive Officer	x
Michelle Lewis	Senior Manager, Communications & Outreach	x
Alejandro Alvarez	Community Outreach Supervisor	x
Thomas Dinh	Outreach Coordinator	x

Linda Ayala	Director, Population Health and Equity	x
Peter Currie	Senior Director, Behavioral Health	x
Rachel Marchetti	Supervisor, Case Management	x
Mao Moua	Manager, Cultural and Linguistic Services	x
Jennifer Karmelich	Director, Quality Assurance	x
Steve Le	Outreach Coordinator	x
Lena Lee	Health Education Coordinator	x
Isaac Liang	Outreach Coordinator	x
Rosa Carrodus	Disease Management Health Educator	x
Lao Paul Vang	Chief Health Equity Officer	x
Monique Rubalcava	Health Education Specialist	x
Gil Duran	Manager, Population Health and Equity	x
Emily Erhardt	Population Health and Equity Specialist	x
Gabriela Perez-Pablo	Outreach coordinator	x
Anne Maragret Villareal	Outreach coordinator	x
Trevor Green	Communications Initiative Specialist	x
Sylvia Guzman	Interpreter Services Coordinator	x
Michelle Stott	Senior Director of Quality	x

Agenda Item	Responsible Person	Discussion	Action	Follow-Up
Welcome and Introductions	Tandra DeBose Linda Ayala	• Member Roll Call • Alliance Staff • Visitors • On-line visitors		
Approval of Minutes	Tandra DeBose	M. Mello and C. Wynn made a motion to approve the Minutes.	Minutes approved by consensus.	
Approval of Agenda	Tandra DeBose	M. Mello and C. Wynn made a motion to approve the agenda. L. Ayala- Asked for permission to record the meeting. No concerns with recording.	Agenda approved by consensus.	

CEO Update	Matt Woodruff	M. Woodruff presented an update on Alliance financials:
		• The Alliance did well for the first 6 months of the fiscal year
		• In January, the Alliance did not do as well and lost 8 million dollars.
		  ○ This was due to many members in the hospital and the Alliance inherited members who were in the hospital.
		  ○ The state recovered 23 million dollars because Alliance members were healthier than they thought.
		  ▪ The last 12 million dollars will hit in the last 6 months of the fiscal year.
		  ▪ The rest was made up in hospital costs.
		• Questions/Comments from CAC members:
		  ○ T. DeBose- Were there any significant changes in members coming in or leaving the Alliance?
		  M. Woodruff- The Alliance gained 101,000 members during the single-plan transition. Yet, we lost our 51,000 Kaiser members.
		• Regulatory: The Alliance reached most metrics in February.
		  ○ The Alliance missed some Member Services metrics due to how fast we could answer our phones.
		  ▪ January was the highest ever call volume at 30,000 calls.
		  ▪ The second largest call volume was 23,000 calls in February.
		• Single Plan Model: The Alliance's current membership is 400,500 members.		

		○ In February, we expected membership to go down, but instead the Alliance gained 2,000 members. ○ We will know our March numbers around the 25th of the month. ○ We had our second highest number of walk-ins member visits in February at 64 walk-ins. ▪ Our highest walk-in for members was in January at 119 walk-ins. • Healthcare Services: In December 2023, there were 2,700 requests for care. ○ Authorizations for care were over 8,500 in January and 7,000 in February. • Questions/Comments from CAC members: ○ T. DeBose: But they're healthier since the state is taking money away from us. • Pay equity staff salary review is in process. A report should be available by the next CAC meeting. ○ The pay equity project started with looking at pay for both men and women. ○ Now we're looking at pay by race and ethnicity. • Provider Recruiting Incentives: are in the budget for this next fiscal year along with our Community Investment Program. ○ The Alliance will start these incentives this year, but the state does not require a start date until 2026. ○ Members of the CAC and regular board committees will be able to look at investments. ○ The state will come out with criteria April – June 2024. ▪ The criteria will define access and equity.		

		• Medicare D-Special Needs Population (SNP) Readiness: The Alliance started going through our portfolio and financials last June 2023.
		  ○ The Alliance has offered D-SNP training programs online for staff.
		  ○ The Alliance has also included timelines for D-SNP.
		
		• Questions/Comments:
		  ○ L. Ayala- When is the launch?
		  M. Woodruff- By October 2025 we have to be fully implemented.		

Follow up Items
12/14/23 Meeting
	Mao Moua	M. Moua provided a summary of follow-up items from the last two (2) meetings in Q4 2023.
		• There was a follow-up correction to the 09/14/2023 meeting minutes.
		  ○ Completed. Corrections/updates to the meeting minutes were made.
		• CAC role and Community Investment Program.
		  ○ Completed. Presented during the CEO Update of today's meeting.
		• CAC topic list: request for ABA services and detailed information on provider services.
		  ○ Resolved. The Behavioral health team will present at the June of December CAC meeting.
		• Create emergency contacts list for CAC members
		  ○ Completed. All contacts were collected in December 2023.
		• Share presenter from Medi-Pal, Zia Li's email address with CAC members.
		  ○ Completed. Email sent to CAC members on 12/21/2023.
		• Add non-diagnosed members as future CAC meeting agenda item.		

		○ Resolved. Alliance Staff added to CAC topic list for future agendas to present at CAC meetings.		
New Business				
1. Health Education	**Health Education Presenters** Gil Duran Monique Rubalcava	The Health Education team presented the Health Education 2023 Workplan Update. • Health Education handouts, like the Wellness Programs and Materials Request Form and the Care Books were passed out. • Materials, classes, and program referrals: A Wellness Programs and Materials Request Form (Wellness Form) is one way members may request more information about specific health topics. • The Wellness Form is sent out to new Alliance members and then once a year at least. • Members can request brochures, handouts, and care books. ○ Care books are more detailed and include guides and tools for members to adapt into their lives. ○ The Health Education team asked CAC member for feedback on how they could get members interested to request these materials more, and how to best promote among members? • A handout was also passed out to CAC members to share their feedback. • Questions/Comments from CAC members: ○ M. Mello- Are these in doctor's offices, that way they know there is a book? M. Rubalcava- That's great feedback. I know providers can request materials but I'm not sure if they are stocked in their offices.		Alliance Staff to check and see if providers offer disease management materials in their clinics and offices.

		○ M. Mello- If a doctor says "Oh, you have diabetes and there's a book you can review it would be helpful". But if they don't have it, they may not know there is a book. M. Lewis- We give them out at community events and outreach programs, and they have been popular. At the Black Joy Parade in Oakland the Care books and the and the coloring books were the first things we ran out of. They help improve health literacy. M. Rubalcava- Care books topic include diabetes, asthma, and perinatal health. ○ M. Mello- If a friend is an Alliance member and has diabetes, I tell them they can call member services to get materials, or a bracelet. You just have to call and see what's available. M. Rubalcava- We also have materials on asthma, child - live healthy, adult - eat well be active, heart care, kidney failure, preventative care book includes vaccinations, screenings, well child visits. ○ T. DeBose- As CAC members could we get copies of each of these books? M. Rubalcava- Absolutely! T. DeBose- Thank you. I think it's important if we are going to share and advocate that we should know what all the different materials are. ○ M. Rubalcava- What would be another way to share this to members? M. Mello- Send a newsletter. • CAC members provided feedback on the Multi-Cultural Flavors Cookbook. The cookbook is in the		Alliance Staff to share Care books with CAC members. Alliance Staff to include information about handouts, Care books and other materials in Member Newsletter.

		final stages of development, then will be translated and ready for distribution.
		• Questions/Comments from CAC members:
		  ○ M. Mello- Can we get a copy of that too? M. Rubalcava- Absolutely.
		
		• Members and providers can find more health education materials and program information on the Alliance website.
		  ○ For members, visit the Live Healthy Library.
		  ○ For providers, visit the Provider Health Education Resource Directory.
		
		• The Alliance Member Newsletter goes out twice per year.
		  ○ Important information and materials are included in the newsletter. Care books can also be promoted through the newsletter.
		  ○ Fall/Winter newsletter issue included blood pressure monitoring, hookah smoking, and preterm births.
		• Questions/Comments from CAC members:
		  ○ M. Rubalcava-What else should we include in the newsletter?
		  ○ M. Mello- Preventative care, like the signs and symptoms of illness and cancer screenings.
		  ○ V. Brabata Gonzalez- A "Did you know…" section, like coverage when traveling to other countries; things that are not well known by all members. Or, if your service is not working, here's how you can file a complaint. There are concerns within the community regarding adults to enroll in Medi-Cal without the need for documents. How do they do that? Health
				Alliance Staff to share Multi-Cultural Flavors Cookbook with CAC members when available.
				
				Suggested future Newsletter topics include preventative care, "Did You Know…", member spotlights

		education materials is also a good addition. ○ M. Lewis- I want to highlight Trevor, who is leading the charge to make our newsletters more interactive. Like benefit spotlights, transportation, behavioral health, etc. We want members to access care, and the newsletter is an important vehicle for that. We also want to continue provider spotlights or add in member spotlights and expanding it to have a community partner focus. Knowledge and information can improve access. ▪ T. Green- Please contact me with any feedback. ▪ T. DeBose- I really like the idea of a member spotlight. Hearing other members stories that directs them to seek help or preventative medicine leads them to accessing care. Sometimes people need that guidance and it would help increase understanding. It would be really beneficial. ○ L. Ayala- If there are other ideas or something comes up for you later on, please use the handouts we distributed today for other comments. We will collect these at the end of the meeting. • Health Education Workplan for 2023- Areas of focus include Diabetes Prevention Program (DPP), Disease Management (DM), Doulas, and Maternal Mental Health (MMH).		

		• DPP- is a yearlong, lifestyle change program for at risk members, or those without diabetes. The goal is to reduce the risk of development.
		• Eligibility factors:
		  ○ There are two (2) programs: Yumlish and HabitNu. Under these programs:
		  ▪ Members will receive the same services, including member incentives.
		  ▪ Currently offered online only.
		  ▪ HabitNu can be self-referral or by an Alliance staff member.
		  ▪ Yumlish requires a provider or clinic referral.
		• YumLive!/YumVivo!: are live virtual classes and each week there is a new health/nutrition topic.
		  ○ These classes are only offered in Spanish only.
		  ▪ Topics include: introduction to exercise and planning food on a budget
		  ○ Starting in April/May classes will also be in English.
		• Questions/Comments from CAC members:
		  ○ V. Brabata Gonzalez- In that program, is there information on other services, like cooked meals to your home? Because nobody knows about that benefit.
		M. Woodruff- It is not just a benefit, it must be for a medical reason. Like, being discharged from the hospitals, or in some cases you can go through a community support program. The way it is set up, it is only for medical reasons right now, and not for food insecurity. So, it is not widely available. But we do have over 3,500 members who did receive the benefit.		

		○ V. Brabata Gonzalez- Is food insecurity due to not being able to cook because of their medical condition? M. Woodruff- They would go through the community support programs to see if they are eligible to receive services. ○ V. Brabata Gonzalez- How can we integrate the services? Seems like programs are sometimes siloed, so how can we make it more encompassing? M. Woodruff- Referrals goes through our Case Management program. Case Management oversees these different programs and can help link members to services or support those members that are eligible for services. L. Ayala- Globally, we are working on how we ensure that members know about all the programs we offer, and I appreciate your comment. ○ M. Rubalcava- How could we promote YumLive!/ YumVivo! to Alliance members and in Alameda County? The only requirement for the program is that you need to be older than 18 years of age. ○ D. Carey- Case Management is always a great place to begin and can direct you to the benefits that we offer through the Alliance or through the county. • DM- include a few different programs that help with disease management. ○ Living Your Best Life is for adult members with asthma, diabetes, and high blood pressure. ○ Happy Lungs is for pediatric members with asthma.		Alliance Staff to reach out to CAC members who have had previous experiences with doulas for input.

		○ BirthWise Wellbeing is a maternal mental health program that helps members during their perinatal period with or at risk for depression (pregnant or postpartum). ○ Members can refer through the following ways: ▪ Self-referral through Alliance Case Management/Disease Management (CM/DM) line ▪ Through a provider or community partner ▪ Alliance staff. • Questions/Comments from CAC members: ○ J. Moore- I suggest reaching out to the Regional Centers, social workers or In-Home Support Services (IHSS) social workers, who support the application process for when they approve a client to let them know about this program and share this information with their clients. M. Rubalcava– Thank you. • When members have a diagnosis for diabetes, asthma, high-blood pressure, or depression, they will be enrolled in one of these DM programs. • Members will receive a letter and/or a phone call to inform them that they have been enrolled into a program. It is a member's choice to participate in the program, and it doesn't affect a member's benefits. It's a resource for members. • Doulas- are trained birth workers that provide support during the perinatal period. • Questions/Comments from CAC members: ○ J. Moore- I had a doula for both of my children. ○ M. Rubalcava- We are going reach out to you after the call to learn more about your experience.		Alliance Staff to connect with community-based organizations

		• Alliance provides doula services. If you are pregnant or have been pregnant in the past year, you are eligible for services.
		• Alliance contracts with doulas to provide services in health education, lactation support, and if a member had a miscarriage, abortion, or stillborn birth.
		• Questions/Comments from CAC members:
		  ○ J. Moore- The Alliance is really advanced for offering this program. It makes me tear up, thank you so much!
		  ○ V. Brabata Gonzalez- When did the doula services start?
		  M. Rubalcava- Doula services started in January 2023.
		• Members can call the Alliance Member Services Department or call the doula directly by looking in the Alliance Provider Directory.
		• Maternal Mental Health Program- Designed to promote quality outcomes among pregnant and postpartum members.
		  ○ A focus of the program is to provide guidance to our community provider network on resources, best practices, treatment, and referrals.
		  ○ Under this program, the following services are offered:
		  ▪ Outpatient behavioral health care services
		  ▪ Substance use disorder (SUD)
		  ▪ Doulas
		  ▪ Care coordination
		  ▪ Breastfeeding
		  ▪ Health education materials
		  ○ Members can ask about more information through the Member Services Department or be referred to this program by their provider.
				and community providers to help promote the doula benefit.
				
				Alliance Staff to educate providers on the doula benefit.

		○ M. Rubalcava asked members to complete the question on the feedback worksheet about their doula experience if they have any and/or if members have ideas about how to promote services. • Questions/Comments from CAC members: ○ C. Wynn- Thank you for that. ○ T. DeBose- This is important to promote within the African American community. M. Woodruff- I was in Sacramento and the state announced plans to focus on maternal and infant health outcomes and the impact of doulas and behavioral health services. California has some of the lowest birth equity rates in the country, and the state really wants plans to focus on improving this. We don't know what it means, but if plans can't do better there will be fines coming out. We need to figure out how to affect these rates. T. DeBose- An organization called Black Infant Health is finding that there are so many families that have children with special needs because of the lack of appropriate care. I appreciate you doing this work and targeting my community. M. Woodruff- If you have ideas of how to get the service out, please let us know. ○ J. Moore- Have you guys heard of the La Leche League? They help and supports women to breastfeed. It's like we're going back to grassroots programs. When a woman is pregnant and has high cortisol level or high level of stress occurs, it increases the chances of producing a child with auto-immune disease. It's such a stressful time for pregnant individuals. I would also recommend reaching out to		

		the psychiatrist within in the area. There's also another organization in San Francisco that helps women who are incarcerated and who are pregnant. ○ A. Alvarez- We handle social media platforms as well. On our Instagram, we highlighted doula services through our spotlights. ○ V. Brabata Gonzalez- OBGYNs and PCPs are key in telling members about this benefit. I had a great doctor, but they never said I should have a doula. And then I learned about birth in the US, and I wish I had. Because no one ever tells you, and you don't really have one doctor, they go in and out. ○ J. Moore- The doula concept is an elitist concept and people had to pay out of pocket. People who are low income, or receiving county benefits, having a doula may not be something they have even considered before. I had to pay out of pocket for my doulas. And this helps people who are the most in need of this service, it's groundbreaking. M. Rubalcava- Thank you, you'll be hearing from me. Please send any feedback you may have. L. Ayala- If you have any ideas, please put it on that worksheet. We appreciate your feedback.		
Alliance Reports				
Grievances and Appeals Report	**G&A Presenter** Jennifer Karmelich	J. Karmelich presented the Medi-Cal Grievance and Appeals report for Q4 2023 (October, November, December) . • 7,384 Total Cases		

		• 2,845 standard grievances with a 99.9% compliance rate • 0 expedited cases • 4,467 exempt grievance with a 99.8% compliance rate • 71 standard appeals with a 100% compliance rate • 1 expedited appeal with a 100% compliance rate Appeal Data and Analysis • CHCN: 22 appeals • Plan: 50 appeals • Overall overturn rate: 18.1% Overturn is when we reverse the original decision and approve those services. • Overturn rate goal of 25% present. We want to make sure we stay below this rate as it means we are making the original decision beforehand and not deny services that should have been approved. ▪ The highest number of complaints are in access. Usually, the member asks for timely appointments and we refer them to Teledoc, urgent care or change their PCP. ▪ Grievances against Networks/Vendors- Highest for Kaiser of 186, if a member were not enrolled then members called in and reported a grievance. Those numbers now are close to zero, because we transitioned to a Single Plan Model, and our members no longer use Kaiser. • ModivCare- Our transportation vendor had 331 grievances filed against them. We meet with them regularly to ensure our members are getting the transportation they need.		

		Tracking and Trending • Kaiser has diminished from Q1 and Q2. • We will always have grievances with ModivCare because if a member is waiting for a ride and they don't have one, they will call us. • Grievance decisions resolve in the members favor 75% of the time. • Questions/Comments from CAC members: o T. DeBose- In the member Spotlight, feature why people like using ModivCare instead of always hearing about complaints about this vendor. J. Karmelich- That is a great idea. We want to be better. o V. Brabata Gonzalez- In going through grievance presentations in the past, I have feelings about the indicators used to measure effectiveness. You could reduce the number of grievances if you make it harder for people to complain, it appears as though we are being very efficient. Which is not what you are necessarily doing. But if you also highlight how easy it is for people to make a complaint, you'll show that you are trying to improve the program. Like, 30% of our members think it is easy to file an appeal, up to 40-50%. If we are showing that we are getting less complaints, it is hard to say that we are doing better. o R. Furr- I use ModivCare and I have been late to my dialysis appointments by an hour in the last two (2) weeks, and then I hear it from my doctor. In the beginning they were doing a really good job, but now they are starting to slack. o N. Williams- There has been an increased use of the service, and they did not		

		prepare correctly for the surplus of people using the service. They will pick up and get better. ○ V. Brabata Gonzalez- We really need to understand how the grievance process is working, and if the services we are providing are getting better. I had a personal experience, where I had to appeal and re-appeal, because my case would be closed due to missing due dates. The process from the Alliance side was delayed and I did get an apology from the Alliance when discovered that the Alliance's mailing system was not working. But if we go just by the numbers then it looks like you are doing better than you think and that's not ethical. The grievance process needs to improve. ○ M. Woodruff- If you are not making it to appointments on time please call us. If a service is not happening, we want to know about that. Also, the measure of 1 per 1000 is regulated by the state. It is easy to file a complaint because you can call Member Services, go directly to the Grievance Department, or go online. We've tried to make it easier over the years. There was a fluke with our mailing vendor when we completed an internal audit on them, and we have since addressed it. The system broke, and we did not know about it until after the audit. V. Brabata Gonzalez- Thank you for your answer. I understand that these indicators are statewide. You could have an internal measure that the Alliance tracks to share with the community.		

		○ M. Woodruff- We have our member surveys that go out and on the provider side too. The problem with the member results, is that we get confused with Alameda Health Systems (like Highland Hospital, Highland Clinic, Eastmont, and San Leandro Hospital). ○ V. Brabata Gonzalez- It's a work in progress, but it's an important part of the story to include and share with the community. Otherwise, it's a partial picture. In theory it is easy to call, but the actual process is not easy. I needed to gather letters from doctors from other countries, receipts within a week. And I emailed all this and then later found out the Alliance could not open the file. Why did they not tell me about that? I do not want to be all negative because there were good things about that process. I learned that I could file a grievance. ○ R. Furr- The doctor's office makes the complaints on my behalf. Because there's not much I can do. ○ D. Carey- I want to provide information on two (2) services. If you have called ModivCare for a ride and waited for more than 15 mins, you can call them back and they will send you a Lyft/Uber. Also, if you have standing appointments, like with the dialysis center, contact our Case Management and we can put you in a special program where your rides are scheduled for you in advance according to your dialysis schedule. ○ L. Ayala- Due to timing, are there any significant highlights to share.		

Outreach Report	**Outreach Presenter** Alejandro Alvarez	J. Karmelich - Grievance and appeals is highly regulated and audited due to Department of Health Care Services (DHCS)requirements. If you're not receiving a grievance resolution letter, or not getting what you need from Grievance and Appeals, please let us know. A. Alvarez presented the Outreach Report. • Communication and Outreach (C&O) conducted 8,000-member orientation phone calls since the start of the pandemic in March 2020. Kudos to our team. • Questions/Comments from CAC members: o T. Debose- Wow, 8,000. o M. Lewis- I want to highlight that 8,000 may seem small, but that is 8,000 more members who know where to call when they need help, and have an increased awareness, in their threshold languages and beyond through our interpreter services. Thank you to Alex and the team. Thank you to the CAC for making this program a success. Having that knowledge and information improves access to care. o A. Alvarez- We will start implementing in our orientations how to use and navigate the website, like how to create an account, request for a new ID, how to look up doctors. This will help redirect those calls away from Member Services. o T. DeBose- Do you ever do campaigns for radio or television? Our communities also utilize those platforms so it may help with putting your message out there to reach a large group of people at the same time.		Alliance Staff to recommend other forms of media for campaigns, including radio advertisements.

		N. Williams- With the internet, I think people tend to use their phones more. So, focusing on the internet may be more helpful. If we could use face recognition in the portal that would helpful instead of putting a password. If I don't feel well, or I forget my password, it becomes a pain to login. M. Lewis- That is good feedback. For this meeting, we only report out on the outreach activities, but we do have ad campaigns. Right now, we are running a Keep Your Coverage campaign that features Dr. Carey. We also have bus and billboard campaigns running. V. Brabata Gonzalez- The challenge with outreach is that it depends on the population you are trying to reach. For example, in the Latinx community, for newcomers and the older population, radio is the most important media to reach, which is different from the younger population. Are you doing outreach regarding the Medi-Cal adult expansion? M. Lewis- We are doing outreach in all our social media channel, but we could make enhancements and add in radio and public service announcements to expand and inform members on how to keep your coverage campaign and include the expansion. Currently, we have a Keep Your Coverage campaign. Social media is more accessible, and we can implement more readily. V. Brabata Gonzalez- There is so much fear and anxiety around coverage, such as, if it will affect my immigration status.		

		There's a great opportunity to improve our health.		
CAC Business				
2024 Medi-Cal Contract – New CAC Requirements Update	**Requirements Presenter** Linda Ayala	• The new contract with DHCS asks us to create a committee called the Selection Subcommittee to select who will be on this committee. • This subcommittee will include representatives from our Board of Governors, member representatives, safety net providers, behavioral health providers, regional centers, local education agencies, dental providers, Indian Health Care providers, home and community-based program providers. • We will hold meetings as needed to bring new CAC members on. • Before our next CAC meeting, we will hold a meeting at least once to make sure that our current CAC members are presented to the Selection Subcommittee. • The Selection Subcommittee will support us to make sure this group is diverse and reflective of our members. • We will be connecting Selection Subcommittee to a current meeting, the Quality Improvement and Health Equity Committee (QIHEC) meeting, that already includes some of our providers, doctors in the community, and Alliance staff. • The meeting does not have to follow the Brown Act Requirements. • Our Legal Team is guiding us in this process. • Questions/Comments from CAC members: ○ N. Williams- What is the role for these subcommittee members? Will one of the members take one of these sites?		

		○ L. Ayala- The only role for this subcommittee is to select CAC members to participate on this Committee, and we will send that list over to the Board of Governors for their final approval. The state's perspective is to make sure it's not just staff at the Alliance, but it also includes community and agencies we are partnering with. ○ C. Wynn- Like a liaison! Give this stuff to the community. ○ L. Ayala- Yes, sharing of power and decision-making. • Timeline ○ From March to April 2024, committee recruitment. ○ On 04/16/2024, we will present on the Selection Subcommittee at the QIHEC meeting and ask members from the QIHEC if want to be members. ○ On 05/17/2024, we will hold our first Selection Subcommittee meeting to present our current CAC members. ○ On 06/14/2024, we will present CAC members to our Board of Governors. ○ By the June CAC meeting, all members will have been voted on. ○ You will all be newly recognized CAC members. • Questions/Comments from CAC members: ○ T. DeBose- I think chair and vice chair should be on the committee. You want a balance of power, where your committee shouldn't outweigh your members. ○ N. Williams- Who can volunteer to be on subcommittee. M. Moua- We are in the beginning stages to make sure we are recruiting the right		

Confidentiality Statement Updates	**Statement Presenter** Lena Lee	members from the community and members. We have created an internal selection criteria that are being reviewed by stakeholders. We can share that. Again, we must follow contract language because it is a regulatory requirement to create a Selection Subcommittee to vote in CAC members. We want to ensure it is equitable and the selection criteria will help us create the right representation. o N. Williams- How do we submit our name to be selected? L. Ayala- We haven't figured it out yet, so that will be a takeaway for us. M. Moua- Send me an email me if you are interested in being a part of the Selection Committee. • Each year in March, we ask for CAC members to sign the confidentiality agreement. o CAC members were asked to complete and sign the confidentiality agreement. • Questions/Comments from CAC members: o L. Ayala- If you have any questions please ask one of us. o M. Mello- I noticed a discrepancy. Next to the chair and co-chair, it just says Alliance members. o L. Ayala- We'll fix that for next meeting. o V. Brabata Gonzalez- If we have questions, we ask you, Mao or Lena? L. Ayala- Yes. This meeting is regulated for any public meeting and follows the Brown Act so there needs to be a confidentiality agreement.		CAC members interested in being on the subcommittee to email Mao. Alliance Staff to add Chair and Vice-Chair titles to CAC members on future agendas.

CAC Recognitions	**Recognitions Presenter** Linda Ayala	○ N. Williams- We talk a lot about doing an appreciation recognition for CAC members, when is that going happen? L. Ayala- We're going do it today! Perfect segway. • L. Ayala and A. Alavarez passed out CAC recognition awards to the CAC members.		
Open Forum	Tandra DeBose	• M. Moua- Today will be Lena's last meeting. She is not leaving the Alliance but getting a promotion to another team. I will be at your service for now, until Lena's position is filled. I want to ensure the good communication you have experienced with Lena.		
Adjournment	Tandra DeBose	• M. Mello- Motion to adjourn the meeting, C. Wynn seconds. Next meeting: June 13, 2024	M. Mello adjourned the meeting.	

Meeting Minutes Submitted by: Emily Erhardt – Population Health and Equity Specialist Date: 3/14/24

Approved By: DocuSigned by: Melinda Mello 5AB6F41B39C5449... Date: 06/27/2024 | 11:32 AM PDT

Cultural and Linguistic Services Subcommittee (CLSS) Meeting
April 24, 2024

Committee Member Name	Title	Present
Linda Ayala, MPH	Director, Population Health and Equity	X
Sanjay Bhatt, MD	Medical Director of Quality Improvement	
Farashta Zainal, MBA, PHP	Quality Improvement Manager	X
Tran Loc	Manager, Access to Care	X
Donna Carey, MD	Medical Director of Case Management	
Darryl Crowder	Director, Provider Services	
Gia DeGrano	Director, Member Services	X
Carlos Lopez	Quality Assurance and Regulatory Reporting Manager	
Cecilia Gomez	Sr. Manager, Provider Services	
Beverly Juan, MD	Medical Director, Medical Services	X
Jennifer Karmelich	Director, Quality Assurance	X
Michelle Lewis, MPH	Manager, Communications and Outreach	X
Alma Pena	Manager, Grievances and Appeals Manager	X
Mao Moua, MPA	Manager, Cultural and Linguistic Services	X
Gil Duran, MPH	Manager, Population Health and Equity	X
Lao Vang	Chief Health Equity Officer	X
Michelle Stott	Senior Director of Quality	X
Anastacia Swift	Chief Human Resource Officer	
Taumaoe Gaoteote	Director, Diversity, Equity, Inclusion	X
Allison Lam	Senior Director, Health Care Services	X

Staff Member Name	Title	Present
Cindy Brazil	Interpreter Services Coordinator	X
Sylvia Guzman	Interpreter Services Coordinator	X
Mara Macabinguil	Interpreter Services Coordinator	X
Berenice Sanchez	Lead Interpreter Services Coordinator	X
Debbie Spray	Supervisor, Health Plan Privacy	X
Sophia Noplis	TEMP Regulatory Compliance Specialist	X
Mandy Gutierrez	Senior Communications & Media Specialist	X
Rosa Carrodus	Disease Management Health Educator	X
Dani Staub	Director, Incentives & Reporting	X

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
1. Call to Order/Introductions	Mao M.	Meeting called to order.	
2. Minutes from 1/24/2024	Mao M.	Minutes from last meeting reviewed by presenters with no additional changes and attached to the meeting invite for reference.	
3. Agenda review	Mao M.	Agenda reviewed with attendees with no further comments.	
4. Follow-up item review	Mao M.	Follow up items from last meeting: • Develop strategies targeted for non-favorable responses in CG-CAHPs (In-Progress): Results for all quarters in 2023 will be presented today which meet the Alliance metrics. As for the next steps, the CLS manager will identify provider sites that had a high non-favorable responses rate to discuss opportunities on how to access interpreter services with the Alliance. • Follow-up with Member Services regarding PQI guidelines (In-Progress): Meeting internally with G&A and PQI teams to map out current PQI workflow as well as identifying gaps within the Quality Suite application. • Update Bilingual Staff Report to a Multilingual Staff Report (Completed): Updated by Carlos L. and included in meeting packet. • Update on Mandarin language in Alliance phone tree system (Completed): Carlos L. is presenting information today.	Mao M. to update committee at the next meeting. Mao M. to update committee at the next meeting.
5. New Business			
5a. 2024 CLS Workplan Q1 Update	Mao M.	• Member Cultural and Linguistic Assessment: Completed Q4 2023 evaluation on 1/24/2024 to assess the cultural and linguistic needs of plan enrollees. • Language Assistance Services: The Alliance met and exceeded our metric with a 97% fulfillment rate in Q1 2024 for all modalities of interpreter services. • Utilization of interpreter services for Behavioral Health services: CLS manager met with our vendor to discuss options to track behavioral health encounters accurately. • Timely Access Requirement (TAR) Survey: This is a new survey as part of the Annual Timely Access and Network Reporting requirement for the Department of Managed Health Care	Mao M. to follow up on the TAR implementation for Q2 2024.

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		(DMHC). The goal is to evaluate members' satisfaction with interpreter services. • Provider Language Capacity (Member Satisfaction): Results from 2023 CG-CAHPS survey reported an 86.6% for adults and 95.7% for children who reported receiving a non-family qualified interpreter through their doctor's office or health plan. • NCQA Net 1 A Report (Provider Language Capacity): Presenting information today. • Community Advisory Committee (CAC): In order to ensure implementation of DHCS 2024 contract updates, the Alliance developed a CAC selection committee proposal as well as a CAC selection committee recruitment process. Recruitment efforts have already started in Q1. The CAC Demographic Survey report was completed, and the organization continues to work on other requirements within the Medical contract for 2024. • Potential Quality Issues-Quality of Language (PQI-QOL): Reported a 96% closure rate for Q1 2024.	

5b. Availability of Practitioners Cultural Needs and Preferences Report Update	Mao M.	Also known as the NCQA Net 1A Factors 1&2 requirements:
		• Is completed annually to:
		  ○ Assess the cultural, ethnic, racial, and linguistic needs of the members.
		  ○ Adjust the availability of practitioners within the network if necessary.
		• The Alliance has included for the first-time information on provider race/ethnicity (self-reported via credentialing process) and member cultural preferences and beliefs by race/ethnicity. In terms of the timeline, a draft report was already submitted to a consultant for feedback, which is also attached to the meeting invite for those who would like to get a head start on this document. Report and actions will be shared with the Cultural and Linguistic Services Subcommittee (CLSS) for input via email before presentation at the Quality Improvement Health Equity Committee (QIHEC) meeting for approval on May 17th.
			Mao M. to share final report with CLSS at the next meeting.

6. Standard Reports			

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
6a. C&L Grievances and Discrimination-based grievances	Alma P.	Presented the Q1 2024 G&A report for C&L: For Medi-Cal, the Alliance received a total of 138 cases which all of them were closed within the internal timeframe. The goal is to have less than 1 complaint per 1,000 members, this metric was achieved with 0.08 complaints per 1,000 members. AAH Plan: • There were (24) complaints against the Plan regarding Language Access. The majority of the complaints consisted of the members having difficulty reaching representatives who speak their preferred threshold language. PCP/Clinic: • (6) Asian Health Services - Frank Kiang Medical Center o (5) Lack of PCPs who speak Spanish. o (1) Member complained that the clinic does not have providers who speak Tagalog or Portuguese. • (2) Dr. Rajiv Ahuja: o (2) The member is dissatisfied because the provider does not speak Spanish. • (3) Eastmont Wellness Center: o (2) The members were dissatisfied that the doctor does not speak Spanish. o (1) Member dissatisfied that the clinic provider her forms in English instead of Spanish. • (2) Newark Health Center: o (1) Member dissatisfied that they were unable to connect with a Chinese speaking staff member at the clinic. o (1) Member dissatisfied that the doctor did not speak Chinese. • (3) Roots Community Health Center o (1) Member dissatisfied that the clinic did not provide her registration forms in Spanish.	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		○ (1) Member dissatisfied that the clinic's phone tree does not have options to select Spanish to make an appointment. ○ (1) Member dissatisfied because the clinic staff does not speak Spanish. • (2) Tiburcio Vasquez Health Center – Hayward: ○ (1) The member was dissatisfied their PCP does not speak Spanish. ○ (1) Member was frustrated with the language barrier because their provider only speaks English. • (2) Dr. Floyd Huen: • (1) The office staff does not speak Cantonese. • (1) The member had difficulty with the office in obtaining an interpreter. • (2) Dr. San Myint: • (1) The member is experiencing a language barrier with the doctor. • (1) The member is dissatisfied because Dr. Myint does not speak Chinese. • (2) Dr. Najibrulrahman Saifulrahman: • (1) The member is dissatisfied that the doctor does not speak English. • (1) The member is dissatisfied that the doctor does not speak Spanish. Specialist: *There was not enough data for Q1 2024. Vendor: • (6) complaints consist of: ○ (3) Hanna: • (1) An interpreter had not yet been assigned for an upcoming appointment.	

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

		• (1) The interpreter was canceled before an appointment.
		• (1) The member could not connect with a Mam interpreter.
		  ○ (2) ModivCare:
		  ▪ (1) The member had a difficult time speaking to a Spanish-speaking representative.
		  ▪ (1) The member is dissatisfied ModivCare's Cantonese phone queue does not have representatives who speak Cantonese.
		  ○ (1) CHME:
		• The member experienced a language barrier when calling CHME.
		
		There was a total of 21 grievances related to discrimination that were resolved during the reporting period and were forwarded to the Compliance Department for further investigation.
		
		There were 97 unique grievance cases resolved during Q1 2024, pertaining to lack of language access and discrimination/sensitivity, with a total of 138 grievances including all shadow cases.
		
		For IHSS (Group Care), the Alliance received a total of 5 cases which all of them were closed within the internal timeframe. The goal is to have less than 1 complaint per 1,000 members, this metric was achieved with 0.029 complaints per 1,000 members.
		AAH Plan:
		• (1) The member was dissatisfied there were no PCPs who speaks Chinese in the San Leandro area.
		PCP/Clinic:
		(2) The members were dissatisfied that the doctors at their PCP clinics do not speak Chinese.
		Specialist:
		(1) The member was dissatisfied that the specialist did not offer to get her an interpreter for her appointment.	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		There was a total of 1 grievance related to discrimination during the reporting period of Q1 2024, and it was reviewed by our Compliance Department.	

6b. Quality of Language PQI Report	Mao M.	Presented the Potential Quality Issue-Quality of Language (PQI-QOL) Report for Q1 2024:
		• There is an overlap in the number of cases that were registered as both PQIs and grievances (G&A) as the CLS team also follows up on any QOL related issue.
		• The following is a breakdown by against type closed referrals in the first quarter of this year:
		  ○ (3) Ancillary Provider
		  ○ (35) Clinic
		  ○ (2) Delegate
		  ○ (1) Hospital
		  ○ (3) Mental Health Facility
		  ○ (1) Mental Health Professional
		  ○ (3) Out of Network
		  ○ (16) PCP
		  ○ (20) Plan
		  ○ (19) Specialist
		  ○ (14) Vendor
		• March was a very busy month with a total of 117 closed cases and only 4 opened cases, although the closure time frame remains within 120 days requirement.
		• The majority of the PQIs received (47) are related to provider language where members would like for provider to speak their preferred language.
		• There were 35 cases associated with providers who did not request interpreter services on behalf of the member.
		• There were 16 cases related to “Other” issues such as member received correspondence and/or a phone call not on their preferred language.
		• There were 10 cases related to the quality of the interpreter provided by our vendors.	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		• In case the member's preferred language is not listed accurately in our system, the CLS team and/or Member Services staff advise members to update their preferred language with the Social Services Agency (SSA). Michelle S. – Are we seeing any language trends from members who transitioned from Anthem this year? Mao M. – Most of the cases are related to members who would like to be assigned to a bilingual PCP that speaks their preferred language. Also, some of the members who transitioned from Anthem this year were not aware that they needed to select a PCP within the first 30 days of enrollment. • There were no providers who had 2 (or more) QOL PQIs in 2023 Q4 and 2024 Q1; therefore, no Correction Action Plan (CAP) was issued. • There was a total of 15 referrals in 2023 Q4 and a total of 20 referrals in 2024 Q1 against the Alliance. Details on 20 PQIs for AAH are: ○ (7) Non-exempt cases related to mailing in non-preferred language (deferred to G&A). ○ (1) Case for no Mandarin option in the phone tree system (deferred to G&A). ○ (2) Not enough Cantonese speaking staff on phone tree system. ○ (1) Connectivity time to Cantonese speaking staff. ○ (2) Connectivity time to language services through AAH. ○ (1) Availability of Punjabi speaking provider in Hayward area. ○ (1) No Cantonese or Mandarin speaking AAH providers in the Bayside Medical Group (Fremont area). ○ (1) Received call in non-preferred spoken language by AAH (deferred to G&A). ○ (1) Interpreter request cancelled by AAH. ○ (2) Non-exempt cases related to dissatisfaction with AAH interpreter service request (deferred to G&A).	

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		Jennifer K. – For those cases show as "deferred to G&A", can that be removed from the PQI report? -these cases were not PQIs deferred to G&A, these are grievances referred from G&A (looks confusing). Mao M. – Yes, we can remove those cases from the PQI report and continue to review/update the current PQI referral workflow internally. Linda L. – Just to clarify that even when the G&A team has taken the lead of the investigation and resolution for these cases, the CLS team also follows up as part of their process to track and trend QOL related issues. Jennifer K. – Correct, and these are two separate processes as the PQI is not investigated as part of G&A process. Once the G&A process is closed, then the case is referred as PQI for further investigation. Mao M. – Thank you, Jennifer! I appreciate the feedback. Farashta Z. – We recently did a survey for the pediatric population and received a negative response from a member who stated that they were not able to get interpreter services via phone from Children's Hospital in Oakland to due phone tree/staff continued to hang up the call. Mao M. – Happy to follow up (offline) on member's feedback to determine whether was an isolated event or a language access issue on provider's site.	Mao M. to update PQI QOL report without grievances "deferred to G&A" moving forward. Mao M. to follow up with Farashta Z. regarding possible language access issue at Children's Hospital in Oakland.
6c. Membership Reports	Mao M.	Presented the following highlights of the Membership Report: • Alliance membership increased due to the Anthem transition as well as the adult expansion that occurred this year. • From Medi-Cal threshold languages, Spanish language had the largest increase since January 2023 with 5.61%	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
6d. Utilization of Language Services	Mao M.	• For Group Care, threshold languages percentages have remained stable. • For more details on members' demographics, please see CLS Subcommittee Report (attached to the meeting invite). Informed that: • The goal is to meet a fulfilment rate of at least 95% for all modalities: in-person, video, and telephonic interpreter services. The Alliance met an average fulfillment rate of 97% in Q1 2024. There was also a considerable increase in volume of interpreter services requests for both on-demand and scheduled services from Q4 2023 to Q1 2024. • The top 5 languages requested in Q1 were Spanish (34%), Cantonese (21%), Vietnamese (12%), Mandarin (9%), and Mam (4%). The most common requested languages remained stable except for Spanish language with an 8% increase from Q4 2023. As for the Anthem transition related impact, there was a considerably increase in Spanish telephonic services in January. • The CLS team is working on implementing efficiencies with providers and vendors as the utilization of interpreter services continues to steadily grow from month to month in 2024. Gia D. – Are we tracking the new dialects for Spanish language? Mao M. – Yes, we are. Mam is one of those dialects that we are seeing more often, although this dialect may vary depending on the region. We work closely with providers to properly document interpreter requests as well as with our vendors to review their language capacity for the new dialects. Gia D. – Can we get updated "Point to your language" cards with new dialects for our walk-in members? Mao M. – Absolutely. I'll take this as a follow-up item for the CLS team. Linda A. – Propose reviewing our current language cards to see if new dialects and other languages of lesser diffusion are included.	Mao M. to follow up with Gia D. regarding new language cards that include most common dialects for Spanish language.
6e. Translation Services	Mandy G.	Presented translation services report highlights:	

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

		• Detailed translation services report for Q1 2024 can be found on the intranet page: http://allianceconnect/Intranet/Main.aspx?tid=248&mtid=224
		• Translation requests are divided into 7 departments as follows:
		  ○ Community and Outreach (C&O) - related to member facing materials.
		  ○ Grievances and Appeals (G&A) – letters.
		  ○ HRA & HIF MIT – back translation from other language to English
		  ○ Notice of Action (NOA)
		  ○ Enhanced Care Management (ECM)
		  ○ Community Support (CS)
		  ○ Pharmacy Services (PS)
		
		Lao V. – A couple of months back, Richard was trying to get a few documents translated within 2 weeks and vendor was not able to meet our TAT. Was this issue resolved?
		Mandy G. – We worked with Compliance to resolve that issue and it seems that now we are getting the translations back within 24 to 48 hrs. Debbie, can you provide a little more insight?
		Debbie S. – Of course. The processing time is working out great as we send out requests and receive translations back within 48 hrs. If needed sooner, please inform Mandy when an expedited service within 24 hrs. is required.
		Mandy G. – Yes, we can let our vendor know which documents are high priority items -such as legal documents- that require a shorter TAT.
		• Some of the most common member facing materials translated in Q1 were Authorized of Representative (AOR) forms, audio transcript back translations, flyers, and handouts.	

6f. Member Services Reps Multilingual Staff Monitoring	Carlos L.	Presented Member Services multilingual services report: • There are thirty-eight (38) qualified multilingual staff that have completed a non-medical evaluation. At least one (1) non-English threshold language call per month is monitored for each threshold language spoken by the Member Services Representative. No linguistic issues were reported in Q1.	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
6g. Provider Access by Language	Mao M.	○ (27) Spanish ○ (2) Vietnamese ○ (6) Cantonese ○ (3) Tagalog • There is currently one (1) open position for Behavioral Health Member Liaison Specialist – Bilingual Spanish, four (4) open positions for Member Services Representative I - Bilingual Spanish, one (1) open position for Member Services Representative II - Bilingual Spanish, one (1) open position for Member Services Representative I – Bilingual Cantonese/Mandarin, one (1) open position for Member Services Representative I - Bilingual Cantonese, and two (2) open positions for Member Services Representative I – Bilingual – Vietnamese. The Alliance has extended an offer to candidates from 2 (out of 10) positions which are expected to be filled soon. • A new queue for Mandarin language is currently in development and is expected to go live in June. Present Member Services Representatives (MSR) who speak Cantonese are also bilingual in Mandarin. However, the Alliance will hire MSRs who are at least bilingual in Mandarin starting in 2025. Mao M. – That's great news, Carlos, as we continue to receive PQIs regarding not having a Mandarin option on the phone tree system. Thank you to Gia and Judy for making that happen and ensuring the proper staffing to accommodate our members' linguistics needs. Informed that the Provider Access by Language Capacity report has been updated to include data for Behavioral Health (BH) providers, Applied Behavioral Analysis (ABA) providers, and specialists. • For Medi-Cal plan: ○ PCPS: Number of unique PCPs in Q1 2024 is 741. There was an improvement from Q4 2023 for Chinese and unknown languages due to a decrease in membership. Spanish and Unknown languages have the highest ratio per member.	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		○ Specialists: Number of unique specialists in Q1 2024 is 9,113. There was an improvement from Q4 2023 for Chinese language due to an increase in specialists. For Spanish language, there was an increase in both members and specialists. Spanish and Vietnamese languages have the highest ratio per member. ○ BH providers: Number of unique BH providers in Q1 2024 is 925. There was an improvement from Q4 2023 for English, Chinese, Spanish, and Other Non-English languages due to an increase in BH providers. Chinese and Vietnamese languages have the highest ratio per member. ○ ABA providers: Number of unique ABA providers in Q1 2024 is 725. There was an improvement from Q4 2023 for Chinese, Vietnamese, Unknown, and Tagalog languages due to a decrease in membership. Spanish, Chinese, and Unknown languages have the highest ratio per member. • For Group Care plan: ○ PCPS: Number of unique PCPs in Q1 2024 is 606. There was an improvement from Q4 2023 for Chinese and Unknown languages due to a decrease in membership and an increase in PCPs. ○ Specialists: Number of unique specialists in Q1 2024 is 8,956. There was an improvement from Q4 2023 for English and Unknown languages due to an increase in specialists. ○ BH providers: Number of unique BH providers in Q1 2024 is 908. There was an improvement from Q4 2023 for Chinese language due to a decrease in membership. Chinese and Vietnamese languages have the highest ratio per member. ○ ABA providers: Number of unique ABA providers in Q1 2024 is 725. There was an improvement from Q4 2023 for Chinese and Spanish languages due to a decrease in	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
6h. CG-CAHPS	Mao M.	membership. Vietnamese, Chinese, and Unknown languages have the highest ratio per member. • More granulated and detailed data about the Alliance provider network is included in the Net 1 A Report (draft is attached to the meeting invite. Linda A. – This is the first time that we have included data for specialists, BH providers, and ABA providers (in addition to PCPs); however, it's challenging without benchmarks to know what an appropriate ratio would be. I did observe that for Chinese and Vietnamese languages the ratio for BH and ABA providers is very high so our members will have to utilize interpreter services for these types of services which may not be ideal. I just wanted to point out that I do see a need there. Mao M. – Thank for your feedback, Linda. We will continue to report on Provider Language Capacity with this new breakdown and welcome any feedback from the Net 1 A report as well. Presented the 2023 CG-CAHPS results: • This is a quarterly survey for members to answer the following questions: "Were you able to communicate with your child's doctor and clinic staff in your preferred language?" • Response options are: ○ "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 a family or a friend as my interpreter". • Favorable response rate for 2023 was: ○ Q1: Adult 84.4%, Child 95.9% ○ Q2: Adult 87.1%, Child 94.3% ○ Q3: Adult 81.8%, Child 96.1 % ○ Q4: Adult 86.6%, Child 95.7% • Overall, the favorable response rate in 2023 was higher than 2022 for both Adults and Child. • 2023 Adult Responses:	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		○ 85% Favorable responses ○ 12% Family/friend as interpreter ○ 3% No • 2023 Child Responses: ○ 95% Favorable responses ○ 3% Family/friend as interpreter ○ 2% No • We continue to see a higher preference for adults to have a family member and/or friend to interpret for them which could be related to cultural preferences.	
Adjournment	Mao M.	Next meeting on August 28 at 1:00 pm.	

Meeting Minutes Submitted by: Berenice Sanchez, Lead Interpreter Services Coordinator Date: 5/9/2024

Approved By: Mao Moua, Manager, Cultural Linguistic Services Date: 06/14/2024

ALAMEDA Alliance FOR HEALTH
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POLICY AND PROCEDURE

Policy Number	PH-003
Policy Name	Risk Stratification & Segmentation (RSS) Process
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Cal, IHSS
Effective Date	~~TBD~~9/19/2023
Subcommittee Name	~~Health Care Quality~~Quality Improvement and Health Equity Committee
Subcommittee Approval Date	~~8/18/2023~~TBD
Compliance Committee Approval Date	~~9/19/2023~~TBD

POLICY STATEMENT

1. Alameda Alliance for Health (AAH) is responsible for the development, implementation, and distribution of requirements for the Population Health Management (PHM) services and related activities to contracted entities, including risk stratification and segmentation grouping.
   1.1. Risk Stratification and Segmentation (RSS): AAH has developed an RSS methodology to separate all eligible members into risk groups or tiers based on all data sets currently available, including their clinical and behavioral health utilization, risk, and social needs characteristics and 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.
      1.1.1. Members will be stratified at least annually into one the following risk tiers: 1. High Risk, 2. ~~Emerging~~ Medium-Rising Risk or 3. Low Risk
      1.1.2. The risk tiering logic will be assessed by AAH for validity and modified as needed to maximize efficacy, avoid and reduce biases, and prevent exacerbation of health disparities.
      1.1.3. Until the DHCS PHM Service and RSS Methodology have been implemented, AAH will utilize the RSS methodology it has developed to meet the requirements of the DHCS PHM Policy Guide, specifically using all ~~of the~~ data sources possible prior to the launch of the PHM service.
      1.1.4. RSS approach will comply with National Committee for Quality Assurance

(NCQA) PHM standards, including integrating data sources to ensure the ability to the Alliance to assess the needs and characteristics of all members and including at least 3 of the 7 NCQA data sources, and integrate data sources as defined in the 2023 MCP Contract.

1.1.5. AAH considers findings from the Population Needs Assessment (PNA) and all members' behavioral, developmental, physical, oral health, and Long-Term Services and Supports (LTSS) needs, as well as health risks, rising-risks, and health-related social needs due to SDOH.

PROCEDURE

1. Risk Stratification and Segmentation prior to Service launch: AAH categorizes eligible members into risk tiers through the following mechanisms:
   1.1. AAH's RSS methodology includes utilizing predictive and status metrics from the Johns Hopkins ACG model to stratify members. Metrics may include probabilities for persistent high utilizers, high cost, and Inpatient/ED utilization. ~~In addition, c~~Criteria utilized for Enhanced Case Management (ECM) and Complex Case Management (CCM) identification is also incorporated into the methodology. Additionally, utilization, care management, and eligibility information are included in capturing members who qualify as high risk.
   1.2. AAH Analytics team consolidates the data sources into their reporting databases and runs the algorithm to assign a risk tier to each eligible member.
   1.3. As new member populations are implemented and/or new data sources are identified, AAH Analytics team will review and evaluate each data source to determine their impact on the methodology. Any potential impacts to the methodology will be reviewed with AAH Health Care Services (HCS) team. Any new data sources deemed to have an impact will be incorporated into the existing methodology logic.
   1.4. Any exclusion and/or non-duplication criteria as outlined in the DHCS PHM Policy Guide will be incorporated into the RSS logic, when applicable, and pending data source availability.

2. Data sources used in the RSS methodology, identification, and monitoring processes include the following:

Data Source	Resourced From	RSS Incorporation
Managed care and fee-for-service (FFS) medical and dental claims and encounters (NCQA PHM 2 Element 1: Medical and behavioral claims or encounters)	1. AAH claims data from HealthSuite (AAH's claims and eligibility system) 2. Provider submitted encounter data stored in the AAH reporting databases 3. DHCS monthly Plan Data Feed files	Data sources are used in the calculation of the Johns Hopkins ACG metrics, which are incorporated in the RSS methodology. Data sources are also used to identify members who qualify as high risk based on the PHM Policy Guide.

Data Source	Resourced From	RSS Incorporation
Pharmacy claims and encounters (NCQA PHM 2 Element 2: Pharmacy claims)	1. AAH claims data from HealthSuite 2. Historical pharmacy data extracts from AAH's Pharmacy Benefits Manager 3. Current pharmacy data extracts from DHCS (Service Dates 1/1/2022 forward)	Data sources are used in the calculation of the Johns Hopkins ACG metrics, which are incorporated in the RSS methodology.
County behavioral health Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS), and Specialty Mental Health System (SMHS) information available through the Short-Doyle/Medi-Cal and California Medicaid Management Information Systems (CA-MMIS) claims system (NCQA PHM 2 Element 1: Medical and behavioral claims or encounters)	1. Alameda County Behavioral Health (ACBH) utilization/encounter data for SMI (Note: Substance use disorder data not available without member consent) 2. DHCS monthly Plan Data Feed files	Data sources are used in the calculation of the Johns Hopkins ACG metrics, which are incorporated in the RSS methodology. Data sources are also used to identify members who qualify as high risk based on the PHM Policy Guide.
Electronic health records (EHR) (NCQA PHM 2 Element 5: Electronic Health Records)	1. Any EHR data received from providers/delegated entities are stored in the AAH reporting databases.	Data sources are used in the calculation of the Johns Hopkins ACG metrics, which are incorporated in the RSS methodology.
Housing reports (e.g., through the Homeless Data Integration System (HDIS), Homelessness Management Information System (HMIS), and/or Z-code claims or encounter data) (NCQA PHM 2 Element 7: Advanced Data Sources)	1. HMIS data from the Alameda County Social Health Information Exchange (SHIE) 2. Z-code data from AAH claims and encounter data 3. Z-code data from DHCS monthly Plan Data Feed files	Data sources are used in the determination of ECM eligibility/enrollment, which is a component in the RSS methodology.

Data Source	Resourced From	RSS Incorporation
Sexual orientation and gender identity (SOGI) information	1. Gender identity information from member eligibility data imported into HealthSuite from DHCS 834 files 2. SOGI information currently unavailable.	Gender identity is used in the calculation of the Johns Hopkins ACG metrics, which are incorporated in the RSS methodology. Sexual orientation data to be included when the DHCS PHM Service/RSS methodology is available.
Admissions, discharge, and transfer (ADT) data (NCQA PHM 2 Element 7: Advanced Data Sources)	1. ADT data received from facilities is stored in the AAH reporting databases	Data is used to assist with real-time Care Management (CM) program referral.
Referrals and authorizations	1. Referral and authorization data from AAH's clinical system, TruCare	Data is used to assist with real-time CM program referral. Data sources are also used to identify members who qualify as high risk based on the PHM Policy Guide.
Race, ethnicity, and language information	1. Member eligibility data imported into HealthSuite from DHCS 834 files	Data is utilized for RSS methodology evaluation and monitoring identify disparities/gaps to inform health equity initiatives.
Screenings, assessments, and/or health appraisal results/data including but not limited to data collected in the Health Risk Assessments (HRAs) and HIF/METs (NCQA PHM 2 Element 4: Health Appraisals)	1. HRA data is collected and documented in AAH's clinical system, TruCare. 2. Internal care management assessments are also developed in TruCare to capture member information during care management activities. 3. HIF/MET data is collected and documented in TruCare.	Data from some TruCare assessments are utilized to identify homelessness for ECM eligibility/enrollment which is used in the RSS methodology. Data is also used to assist with real-time Care Management (CM) program referral and identification of high risk members based on the PHM Policy Guide. Additional data to be included in the RSS methodology when the

Data Source	Resourced From	RSS Incorporation
		DHCS PHM Service is available.
Disengaged member reports (e.g., assigned members who have not utilized any services)	1. AAH internal reports that identify disengaged members.	Reports are utilized for monitoring and to identify potential QI initiatives. Data to be included in the RSS methodology when the DHCS PHM Service is available.
Laboratory test results (NCQA PHM 2 Element 3: Laboratory Results)	1. Laboratory test results are collected from AAH's contracted laboratory providers. Data is stored in the AAH databases and utilized by AAH's NCQA certified HEDIS vendor, Cotiviti.	Laboratory test results are included in the calculation of HEDIS outcomes. HEDIS outcomes are evaluated to provide direction in gaps in care and reduction of health disparities/biases. Data to be included in the RSS methodology when the DHCS PHM Service is available.
Social services reports (e.g., CalFresh, WIC, CalWORKs, In Home Services and Supports (IHSS))		Data to be included in the RSS methodology when the DHCS PHM Service is available.
MCP behavioral health Screenings, Brief Interventions, and Referral to Treatment (SBIRT), medications for addiction treatment (MTOUD, also known as Mediations for Opioid Use Disorder), and other SUD; and other non-specialty mental health services information		Data to be included in the RSS methodology when the DHCS PHM Service is available.
Justice-involved data		Data to be included in the RSS methodology when the DHCS PHM Service is available.

Data Source	Resourced From	RSS Incorporation
Disability status		Data to be included in the RSS methodology when the DHCS PHM Service is available.
For members under 21, information on developmental and adverse childhood experiences (ACEs) screenings		Data to be included in the RSS methodology when the DHCS PHM Service is available.

3. AAH Analytics team runs the RSS algorithm monthly to reflect new information received, including newly enrolled members, and update member risk tiers as necessary.
   3.1. AAH also identifies any significant change in health status or member's level of care and occurrence of events or new information that may change a member's needs through internal review activities, provider referrals and member self-referrals including referrals to CCM, ECM, Transitional Care Services (TCS), and Community Supports (CS).
   3.2. Any necessary changes in RSS risk tier will be incorporated into the next monthly run.
   3.3. The monthly member level risk tier information is stored in the AAH databases for reporting, viewing, and historical purposes.

4. AAH uses risk tiers to:
   4.1. Identify members who require assessment. The Alliance assesses members upon enrollment and upon receipt of new information that the Alliance determines as potentially changing a member's level of risk and need.
   4.2. Connect all members, including those with rising risk, to an appropriate level of service, including but not limited to, care management programs, basic PHM, wellness and prevention services, and Transitional Care Services (TCS).
      4.2.1. Case Management staff use the monthly RSS report to assist in identifying higher risk members.
      4.2.2. Key delegates receive monthly RSS reports to assist in identifying higher risk members.
      4.2.3. The RSS report assists in identifying high risk members who will receive High Risk TCS.
      4.2.4. The RSS report also aids in identifying members for participation in the Alliance Disease Management programs.
   4.3. Monitor and improve the penetration rate of PHM programs and services, including, but not limited to, the percentage of members who require additional assessments who complete them as well as the connection of members to the programs and services they are eligible for.

5. On a monthly basis, AAH transmits a list of assigned members and their RSS risk tier via Secure File Transfer Protocol (SFTP) to each delegated provider as requested. This file is used to identify the appropriate level of care for the member.

6. The RSS methodology, key performance indicators and outputs will be continually evaluated to determine accuracy and effectiveness of the overall RSS model with the goal of addressing biases, reducing health disparities and improving outcomes.
   6.1. Alliance clinical staff participate in the creation and review of the RSS methodology.
   6.2. Reports and dashboards are developed to assist with monitoring and reviewing how the RSS methodology is performing overall and identification of any biases that may exacerbate health disparities.
      6.2.1. The Alliance maintains a Risk Stratification and Segmentation Dashboard to monitor our RRS methodology and review our member assignment to tiers based on race/ethnicity and language.
      6.2.2. The Alliance maintains a HEDIS dashboard that reviews for disparities based on race/ethnicity, language, gender and age.
   6.3. Identified biases will be addressed by adjustment of the methodology as needed. This might include adding additional data sources, in particular data related to social determinants of health, or lowering the weight of identified problematic data sources.

7. After the DHCS PHM Service RSS and risk tiering functionalities are available, the Alliance will:
   7.1. Utilize the PHM Service RSS outputs and tiers to support statewide standardization and comparisons. The PHM Service will place each individual into a risk tier (i.e., high, medium-rising, or low).
   7.2. Identify and assess member-level risks and needs ~~and,~~and as needed, connect members to services. The risk tiering will set a standard to identify members who require further assessment and connection to appropriate services.
   7.3. Inform and enable member screening and assessment activities, including pre-populating screening and assessment tools.
   7.4. Support member engagement and education activities.
   7.5. Utilize local data sources or real-time data that could supplement identification of additional members for further assessments and services.
   7.6. Not manually "override" a risk tier given by the PHM service on a member, as these risk tiers will be used to ensure equity and accountability across the state.
   7.7. Work with network providers to exercise judgment and shared decision-making with the member about the services a member needs, including through use of real-time information that may be available and through the assessment/reassessment process.
   7.8. Utilize the PHM Service risk tiers as a starting point for assessment, but not a requirement for or barrier to services.
   7.9. Adhere to the data-sharing requirements as defined by the California Health & Human Services Agency Data Exchange Framework.

8. The IHSS line of business will continue to utilize the AAH RSS methodology when the DHCS PHM Service is implemented for the Medi-Cal population.

DEFINITIONS / ACRONYMS

AAH	Alameda Alliance for Health
ACG	Adjusted Clinical Groups
CCM	Complex Case Management
CS	Community Supports
DHCS	Department of Health Care Services
ECM	Enhanced Care Management
ED	Emergency Department
HCS	Health Care Services department
IHSS	In Home Support Services line of business
NCQA	National Committee for Quality Assurance
PCP	Primary Care Provider
PHM	Population Health Management
PHM Service	Statewide technology service designed to support PHM Program functions
RSS	Risk Stratification and Segmentation
RUB	Resource Utilization Band
SDOH	Social Determinants of Health
SFTP	Secure File Transfer Protocol
SMI	Serious Mental Illness
TCS	Transitional Care Services

AFFECTED DEPARTMENTS/PARTIES

Analytics
Health Care Services

RELATED POLICIES AND PROCEDURES

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

PH-001 Population Health Management (PHM) Program

REVISION HISTORY

New Policy 9/19/2023, TBA

REFERENCES

DHCS APL22-024 Population Health Management ~~Program~~ Policy Guide
DHCS PHM Policy Guide

MONITORING

This policy will be reviewed annually.

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POLICY AND PROCEDURE

Policy Number	PH-003
Policy Name	Risk Stratification & Segmentation (RSS) Process
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Cal, IHSS
Effective Date	9/19/2023
Subcommittee Name	Quality Improvement and Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

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the Alliance to assess the needs and characteristics of all members and including at least 3 of the 7 NCQA data sources, and integrate data sources as defined in the 2023 MCP Contract.

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Data Source	Resourced From	RSS Incorporation
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Referrals and authorizations	1. Referral and authorization data from AAH's clinical system, TruCare	Data is used to assist with real-time CM program referral. Data sources are also used to identify members who qualify as high risk based on the PHM Policy Guide.
Race, ethnicity, and language information	1. Member eligibility data imported into HealthSuite from DHCS 834 files	Data is utilized for RSS methodology evaluation and monitoring identify disparities/gaps to inform health equity initiatives.
Screenings, assessments, and/or health appraisal results/data including but not limited to data collected in the Health Risk Assessments (HRAs) and HIF/METs (NCQA PHM 2 Element 4: Health Appraisals)	1. HRA data is collected and documented in AAH's clinical system, TruCare. 2. Internal care management assessments are also developed in TruCare to capture member information during care management activities. 3. HIF/MET data is collected and documented in TruCare.	Data from some TruCare assessments are utilized to identify homelessness for ECM eligibility/enrollment which is used in the RSS methodology. Data is also used to assist with real-time Care Management (CM) program referral and identification of high risk members based on the PHM Policy Guide Additional data to be included in the RSS methodology when the

Data Source	Resourced From	RSS Incorporation
		DHCS PHM Service is available.
Disengaged member reports (e.g., assigned members who have not utilized any services)	1. AAH internal reports that identify disengaged members.	Reports are utilized for monitoring and to identify potential QI initiatives. Data to be included in the RSS methodology when the DHCS PHM Service is available.
Laboratory test results (NCQA PHM 2 Element 3: Laboratory Results)	1. Laboratory test results are collected from AAH's contracted laboratory providers. Data is stored in the AAH databases and utilized by AAH's NCQA certified HEDIS vendor, Cotiviti.	Laboratory test results are included in the calculation of HEDIS outcomes. HEDIS outcomes are evaluated to provide direction in gaps in care and reduction of health disparities/biases. Data to be included in the RSS methodology when the DHCS PHM Service is available.
Social services reports (e.g., CalFresh, WIC, CalWORKs, In Home Services and Supports (IHSS))		Data to be included in the RSS methodology when the DHCS PHM Service is available.
MCP behavioral health Screenings, Brief Interventions, and Referral to Treatment (SBIRT), medications for addiction treatment (MTOUD, also known as Mediations for Opioid Use Disorder), and other SUD; and other non-specialty mental health services information		Data to be included in the RSS methodology when the DHCS PHM Service is available.
Justice-involved data		Data to be included in the RSS methodology when the DHCS PHM Service is available.

Data Source	Resourced From	RSS Incorporation
Disability status		Data to be included in the RSS methodology when the DHCS PHM Service is available.
For members under 21, information on developmental and adverse childhood experiences (ACEs) screenings		Data to be included in the RSS methodology when the DHCS PHM Service is available.

3. AAH Analytics team runs the RSS algorithm monthly to reflect new information received, including newly enrolled members, and update member risk tiers as necessary.
   3.1. AAH also identifies any significant change in health status or member's level of care and occurrence of events or new information that may change a member's needs through internal review activities, provider referrals and member self-referrals including referrals to CCM, ECM, Transitional Care Services (TCS), and Community Supports (CS).
   3.2. Any necessary changes in RSS risk tier will be incorporated into the next monthly run.
   3.3. The monthly member level risk tier information is stored in the AAH databases for reporting, viewing, and historical purposes.

4. AAH uses risk tiers to:
   4.1. Identify members who require assessment. The Alliance assesses members upon enrollment and upon receipt of new information that the Alliance determines as potentially changing a member's level of risk and need.
   4.2. Connect all members, including those with rising risk, to an appropriate level of service, including but not limited to, care management programs, basic PHM, wellness and prevention services, and Transitional Care Services (TCS).
      4.2.1. Case Management staff use the monthly RSS report to assist in identifying higher risk members.
      4.2.2. Key delegates receive monthly RSS reports to assist in identifying higher risk members.
      4.2.3. The RSS report assists in identifying high risk members who will receive High Risk TCS.
      4.2.4. The RSS report also aids in identifying members for participation in the Alliance Disease Management programs.
   4.3. Monitor and improve the penetration rate of PHM programs and services, including, but not limited to, the percentage of members who require additional assessments who complete them as well as the connection of members to the programs and services they are eligible for.

5. On a monthly basis, AAH transmits a list of assigned members and their RSS risk tier via Secure File Transfer Protocol (SFTP) to each delegated provider as requested. This file is used to identify the appropriate level of care for the member.

6. The RSS methodology, key performance indicators and outputs will be continually evaluated to determine accuracy and effectiveness of the overall RSS model with the goal of addressing biases, reducing health disparities and improving outcomes.
   6.1. Alliance clinical staff participate in the creation and review of the RSS methodology.
   6.2. Reports and dashboards are developed to assist with monitoring and reviewing how the RSS methodology is performing overall and identification of any biases that may exacerbate health disparities.
      6.2.1. The Alliance maintains a Risk Stratification and Segmentation Dashboard to monitor our RRS methodology and review our member assignment to tiers based on race/ethnicity and language.
      6.2.2. The Alliance maintains a HEDIS dashboard that reviews for disparities based on race/ethnicity, language, gender and age.
   6.3. Identified biases will be addressed by adjustment of the methodology as needed. This might include adding additional data sources, in particular data related to social determinants of health, or lowering the weight of identified problematic data sources.

7. After the DHCS PHM Service RSS and risk tiering functionalities are available, the Alliance will:
   7.1. Utilize the PHM Service RSS outputs and tiers to support statewide standardization and comparisons. The PHM Service will place each individual into a risk tier (i.e., high, medium-rising, or low).
   7.2. Identify and assess member-level risks and needs and as needed, connect members to services. The risk tiering will set a standard to identify members who require further assessment and connection to appropriate services.
   7.3. Inform and enable member screening and assessment activities, including pre-populating screening and assessment tools.
   7.4. Support member engagement and education activities.
   7.5. Utilize local data sources or real-time data that could supplement identification of additional members for further assessments and services.
   7.6. Not manually "override" a risk tier given by the PHM service on a member, as these risk tiers will be used to ensure equity and accountability across the state.
   7.7. Work with network providers to exercise judgment and shared decision-making with the member about the services a member needs, including through use of real-time information that may be available and through the assessment/reassessment process.
   7.8. Utilize the PHM Service risk tiers as a starting point for assessment, but not a requirement for or barrier to services.
   7.9. Adhere to the data-sharing requirements as defined by the California Health & Human Services Agency Data Exchange Framework.

8. The IHSS line of business will continue to utilize the AAH RSS methodology when the DHCS PHM Service is implemented for the Medi-Cal population.

DEFINITIONS / ACRONYMS

AAH	Alameda Alliance for Health
ACG	Adjusted Clinical Groups
CCM	Complex Case Management
CS	Community Supports
DHCS	Department of Health Care Services
ECM	Enhanced Care Management
ED	Emergency Department
HCS	Health Care Services department
IHSS	In Home Support Services line of business
NCQA	National Committee for Quality Assurance
PCP	Primary Care Provider
PHM	Population Health Management
PHM Service	Statewide technology service designed to support PHM Program functions
RSS	Risk Stratification and Segmentation
RUB	Resource Utilization Band
SDOH	Social Determinants of Health
SFTP	Secure File Transfer Protocol
SMI	Serious Mental Illness
TCS	Transitional Care Services

AFFECTED DEPARTMENTS/PARTIES

Analytics
Health Care Services

RELATED POLICIES AND PROCEDURES

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

PH-001 Population Health Management (PHM) Program

REVISION HISTORY

New Policy 9/19/2023, TBA

REFERENCES

DHCS APL22-024 Population Health Management Policy Guide
DHCS PHM Policy Guide

MONITORING

This policy will be reviewed annually.