Quality Improvement Health Equity Committee Meeting

August 16, 2024

Meeting Name:	Quality Improvement Health Equity Committee		
Date of Meeting:	8/16/2024	**Time:**	9:00 AM – 11:00 AM
Meeting Coordinator:	Ashley Asejo	**Location:**	Alameda Alliance for Health HQ 1240 S. Loop Rd. Alameda
Webinar Meeting ID:	**Microsoft Teams** Meeting ID: 241 031 105 806 Passcode: 7DQGy6	**Meeting Materials:**	Standing Committees – Alameda Alliance for Health

IMPORTANT PUBLIC HEALTH AND SAFETY MESSAGE REGARDING PARTICIPATION AT ALAMEDA ALLIANCE FOR HEALTH COMMITTEE MEETINGS

YOU MAY SUBMIT COMMENTS ON ANY AGENDA ITEM OR ON ANY ITEM NOT ON THE AGENDA, IN WRITING VIA MAIL TO "ATTN: ALLIANCE QIHEC COMMITTEE" 1240 SOUTH LOOP ROAD, ALAMEDA, CA 94502; OR THROUGH E-COMMENT AT aasejo@alamedaalliance.org YOU MAY WATCH THE MEETING LIVE BY LOGGING IN VIA COMPUTER AT THE LINK PROVIDED ABOVE. IF YOU USE THE LINK AND PARTICIPATE VIA COMPUTER, YOU MAY, THROUGH THE USE OF THE CHAT FUNCTION, REQUEST AN OPPORTUNITY TO SPEAK ON ANY AGENDIZED ITEM, INCLUDING GENERAL PUBLIC COMMENT. YOUR REQUEST TO SPEAK MUST BE RECEIVED BEFORE THE ITEM IS CALLED ON THE AGENDA.

PLEASE NOTE: ALAMEDA ALLIANCE FOR HEALTH IS MAKING EVERY EFFORT TO FOLLOW THE SPIRIT AND INTENT OF THE BROWN ACT AND OTHER APPLICABLE LAWS REGULATING THE CONDUCT OF PUBLIC MEETINGS, IN ORDER TO MAXIMIZE TRANSPARENCY AND PUBLIC ACCESS. DURING EACH AGENDA ITEM, YOU WILL BE PROVIDED A REASONABLE AMOUNT OF TIME TO PROVIDE PUBLIC COMMENT. THE COMMITTEE WOULD APPRECIATE, HOWEVER, IF COMMUNICATIONS OF PUBLIC COMMENTS RELATED TO ITEMS ON THE AGENDA, OR ITEMS NOT ON THE AGENDA, ARE PROVIDED PRIOR TO THE COMMENCEMENT OF THE MEETING.

Meeting Objective
To improve quality of care and close health equity gaps for Alliance members by facilitating clinical oversight and direction.

Members	
Name	**Title**
Donna Carey, MD	Interim Chief Medical Officer, Alameda Alliance for Health
Paul Lao Vang	Chief Health Equity Officer, Alameda Alliance for Health
Sanjay Bhatt, MD Vice Chair	Senior Medical Director, Quality & Behavioral Health, Alameda Alliance for Health, Emergency Medicine

Aaron Chapman, MD	Behavioral Health Medical Director and Chief Medical Officer, Alameda County Behavioral Health Care Services
Tri Do, MD	Chief Medical Officer, Community Health Center Network
Felicia Tornabene, MD	Chief Medical Officer, Alameda Health System
James Florey, MD	Chief Medical Officer, Children First Medical Group
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

Meeting Agenda				
Topic	**Time**	**Document**	**Responsible Party**	**Vote to approve or Informational**
Call to Order/Roll Call:	1 min	Verbal	D. Carey	Informational
1. Follow-Up/Action Items from 5/17/24 QIHEC • Follow up on 30-day readmission rates for patient who don't have mental health follow up.	1min	Verbal	D. Carey	Informational
2. Alameda Alliance Updates • DHCS Audit Observations	5 min	Verbal	D. Carey	Informational
3. Chief of Health Equity Updates	5 min	Verbal	L. Vang	Informational
4. Committee Member Presentations • CHCN: QI Measures Strategy for Chronic Disease Measures.	10 min	Verbal	T. Do H. Roth	Informational
5. Policies and Procedures • Listed below	5 min	Document	D. Carey	Vote
6. Approval Committee Meeting Minutes • QIHEC – 5/17/2024 • UMC- 5/31/2024, 7/26/2024 • CAC- 3/14/2024 • CLS- 4/24/2024	2 min	Document	D. Carey	Vote

Meeting Agenda				
Topic	**Time**	**Document**	**Responsible Party**	**Vote to approve or Informational**
7. UM Workplan Update • UM Metrics Report	10 min	Document	M. Findlater	Informational
QI Workplan Updates				
8. HEDIS Results	10 min	Document	F. Zainal	Informational
9. Population Health & Equity Update	10 min	Document	G. Duran	Informational
10. Access & Availability Updates • Geo-Access & Provider Network Capacity	10 min	Document	L. Tran	Informational
11. PQI • PQI Dashboard • RN Audits Report • Exempt Grievance • PQI IRR Report	5 min	Document	S. Bhatt M. Stott	Informational
12. FSR Update/CAP	5 min	Document	K. Ebido	Informational
13. Behavioral Health Update • Behavioral Health Report	10 min	Document	P. Currie	Informational
14. Public Comment	1 min	Verbal	D. Carey	Informational
15. Adjournment	1 min	Verbal	D. Carey	Next Meeting November 15, 2024

Americans with Disabilities Act (ADA): It is the intention of the Alameda Alliance for Health to comply with the Americans with Disabilities Act (ADA) in all respects. If, as an attendee or a participant at this meeting, you will need special assistance beyond what is normally provided, the Alameda Alliance for Health will attempt to accommodate you in every reasonable manner. Please contact Ashley Asejo aasejo@alamedaalliance.org at least 48 hours prior to the meeting to inform us of your needs and to determine if accommodation is feasible. Please advise us at that time if you will need accommodation to attend or participate in meetings on a regular basis.

Policies & Procedures	
• QI-101: Quality Improvement Health Equity Program • QI-111: Delegation of Management and Oversight • QI-119: Provider Preventable Conditions (PPC) and Adverse Events • QI-105: Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical Accessibility Review Survey (PARS) • PHM-003: Risk Stratification and Segmentation • BH-004/UM-062: Behavioral Health Treatment • QI-108: Access to Behavioral Health Services • UM 16: Transportation Guidelines • CM-004: Care Coordination of Services • CM-005: Disease Management Programs • CM-008: SPD HRA - Survey and Interventions • CM-020: Health Information Form Member Evaluation Tool (HIF/MET) • CM-021: Community Supports - Asthma Remediation • CM-022: Community Supports - Housing Deposits • CM-023: Community Supports - Housing Tenancy and Sustaining Services • CM-024: Community Supports - Housing Transition Navigation Services • CM-025: Community Supports - Medically Supportive Food/Meals/Medically Tailored Meals	• CM-026: Community Supports - Recuperative Care (Medical Respite) • CM-027: Community Supports - Oversight, Monitoring & Controls • CM-029: Developmental Disabilities • CM-033: Home and Community Based Services (Waiver Programs) - DDS • CM-035: Community Supports - Respite Services • CM-036: Community Supports - Personal Care & Homemaker Services • CM-037: Community Supports - Environmental Accessibility Adaptions (Home Modifications • CM-038: Community Supports - Nursing Facility Transition/Diversion to Assisted Living Facilities • CM-039: Community Supports - Transition Services/Nursing Facility Transition to a Home • CM-040: Community Supports - Sobering Centers • HCS-015: Enhanced Care Management - Outreach/Member Engagement • HCS-020: Enhanced Care Management - IT/Data Sharing • UM 001: Utilization Management Program • UM 046: Use of Board Certified Consultants • CBAS-001: Initial Member Assessments and Reassessments for Community Based Adult Services Eligibility

Follow-Up/Action Items from QIHEC 5/17/24

Dr. Donna Carey

Follow up on 30-day readmission rates for patients who do not have a mental health follow up.

ALAMEDA Alliance FOR HEALTH

Chief Medical Officer Alameda Alliance Updates

Dr. Donna Carey

ALAMEDA Alliance FOR HEALTH

Chief Health Equity Officer Update

Lao P. Vang

ALAMEDA Alliance FOR HEALTH

Community Health Center Network:

QI Measures Strategy for Chronic Disease Measures.

Hallie Roth- Community Health Center Network
Dr. Tri Do- CMO, Community Health Center Network

ALAMEDA Alliance FOR HEALTH

COMMUNITY HEALTH CENTER NETWORK

Successes in HEDIS Disease Management Measures

AAH QIHEC

August 16, 2024

Intro and background

The Community Health Center Network (CHCN) is a partnership of community health centers committed to enhancing our ability to provide comprehensive, quality healthcare in a manner respectful of community traditions and values.

- 8 FQHCs
- Recent consolidation of CHCN analytics, QI, and health informatics under Quality department
- Added value-based care team to support APM, ACO

We Represent

Performance review: meeting MPL

Measure	Measure Description	Current Rate	MPL
Chronic Disease			
CDC LE9 / GSD	Glycemic Status Assessment for Patients with Diabetes **lower is better*	**24.99%**	38.00%
CBP	Controlling High Blood Pressure	**63.28%**	61.30%
COL	Colorectal Cancer Screening	**41.28%**	33.80%

Performance growth: health center spotlight

Measure	Health Center	Measure Description	Aug'22-July'23	Aug'23-July'24	% Change	MPL
CDC LE9 / GSD	***Network***	***Glycemic Status Assessment for Patients with Diabetes*** **lower is better*	***26.65%***	***24.99%***	***-1.66pp***	***38.00%***
	TVHC		42.48%	34.98%	-7.5pp	
CBP	***Network***	***Controlling High Blood Pressure***	***57.12%***	***63.28%***	***+6.16pp***	***61.30%***
	Baywell		53.05%	61.15%	+8.1pp	
COL	***Network***	***Colorectal Cancer Screening***	***37.52%***	***41.28%***	***+3.76pp***	***33.80%***
	Axis		30.86%	41.46%	+10.6pp	

Intervention highlights

Controlling High Blood Pressure

- Provider education sessions/huddles on best practices, tx algorithm
- Expansion of HTN clinics (RN-provider) with regular cadence at BACH, Baywell
- Pharmacy involvement – partnership with AAH for med adherence data
- Expansion of RPM partnership (Gojji, SmartMeter) and development of new workflows
  - Some HCs building billing workflows for Medicare patients

Intervention highlights

Diabetes Management

- Expansion of RPM partnerships (CareSignal at TVHC, Gojji pilot at AHS)
- DM workshops or educational group visits including medication management

Intervention highlights

Colorectal Cancer Screening

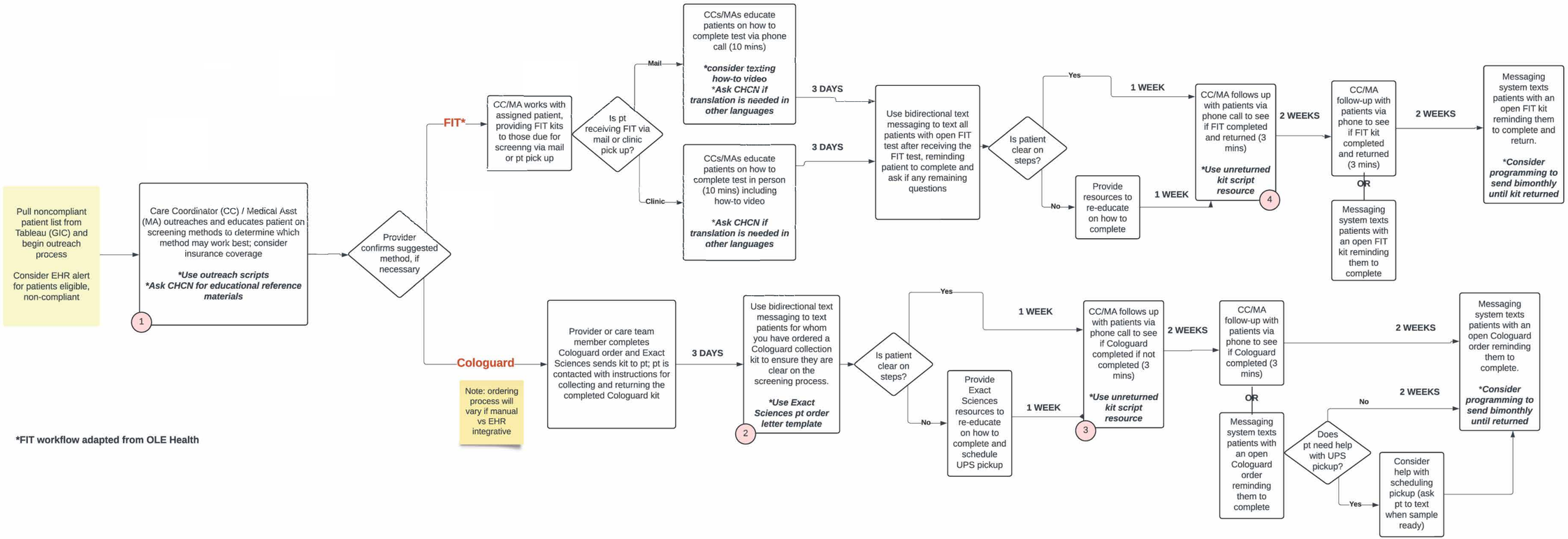
- Tableau dashboard to track progress on orders placed and results received for Cologuard and FIT
- Development of new workflows for MA or CC education and outreach (text, telephonic) including outreach frequency
- Staff competitions
- Looking ahead: opportunistic screening at mobile mammography events (LMC)

QI team best practices (non-measure specific)

- Annual HEDIS Palooza – CRC breakout activity
- Tableau/data training for new staff members
- QI fundamentals and PDSA training for staff
- Monthly forum for QI and QI-adjacent team members
- TA as needed for new or existing measures
- Health center PDSA support and workflow development (e.g., CRC)

Areas of opportunity

- Exploring structural barriers to CRC screening and race/ethnicity data
- Build on Tableau CBP dashboard to include detailed medication information, leveraging data from AAH pharmacy team
- Support of clinical sponsor / Med Director to analyze med adherence data for diabetes and hypertension and share with providers
- Research and education on continuous glucose monitoring for DM
- Expanding partnership with Yumlish for DPP across more health centers
    - Leveraging comorbidity report from AAH pharmacy team for patient eligibility


Pull noncompliant patient list from Tableau (GIC) and begin outreach process
Consider EHR alert for patients eligible, non-compliant
Care Coordinator (CC) / Medical Asst (MA) outreaches and educates patient on screening methods to determine which method may work best; consider insurance coverage
*Use outreach scripts
*Ask CHCN for educational reference materials
1
Provider confirms suggested method, if necessary
FIT*
CC/MA works with assigned patient, providing FIT kits to those due for screenng via mail or pt pick up
Is pt receiving FIT via mail or clinic pick up?
Mail
CCs/MAs educate patients on how to complete test via phone call (10 mins)
*consider texting how-to video
*Ask CHCN if translation is needed in other languages
Clinic
CCs/MAs educate patients on how to complete test in person (10 mins) including how-to video
*Ask CHCN if translation is needed in other languages
3 DAYS
3 DAYS
Use bidirectional text messaging to text all patients with open FIT test after receiving the FIT test, reminding patient to complete and ask if any remaining questions
Is patient clear on steps?
Yes
1 WEEK
CC/MA follows up with patients via phone call to see if FIT completed and returned (3 mins)
*Use unreturned kit script resource
4
2 WEEKS
CC/MA follow-up with patients via phone to see if FIT kit completed and returned (3 mins)
OR
Messaging system texts patients with an open FIT kit reminding them to complete
2 WEEKS
Messaging system texts patients with an open FIT kit reminding them to complete and return.
*Consider programming to send bimonthly until kit returned
No
Provide resources to re-educate on how to complete
1 WEEK
Cologuard
Note: ordering process will vary if manual vs EHR integrative
Provider or care team member completes Cologuard order and Exact Sciences sends kit to pt; pt is contacted with instructions for collecting and returning the completed Cologuard kit
3 DAYS
Use bidirectional text messaging to text patients for whom you have ordered a Cologuard collection kit to ensure they are clear on the screening process.
*Use Exact Sciences pt order letter template
2
Is patient clear on steps?
Yes
1 WEEK
CC/MA follows up with patients via phone call to see if Cologuard completed if not completed (3 mins)
*Use unreturned kit script resource
3
2 WEEKS
CC/MA follow-up with patients via phone to see if Cologuard completed (3 mins)
OR
Messaging system texts patients with an open Cologuard order reminding them to complete
2 WEEKS
Messaging system texts patients with an open Cologuard order reminding them to complete.
*Consider programming to send bimonthly until returned
No
Provide Exact Sciences resources to re-educate on how to complete and schedule UPS pickup
1 WEEK
Does pt need help with UPS pickup?
No
2 WEEKS
Yes
Consider help with scheduling pickup (ask pt to text when sample ready)
*FIT workflow adapted from OLE Health

Voting Item: Policies and Procedures

The complete Policies & Procedures Packet has been sent in a separate email.

ALAMEDA Alliance FOR HEALTH

Policy Procedures Summary of Changes

Policy	Department	Policy #	Policy Name	Brief Description of Policy	Description of Changes/Current Revisions	Policy Update (X)	New Policy (X)	Annual Review or Formatting Changes (X)
1	Quality Improvement	QI-101	Quality Improvement Health Equity Program	Describes the Alliance Quality Improvement Health Equity program, including development, implementation, monitoring, and delivery of quality and equitable health care services.	-Modified to comply with All Plan Letter 24-004 Quality Improvement Health Equity Transformation Requirements: 1) alignment with the DHCS Comprehesive Quality Strategy Report and review of DHCS reports: Health Disparity Report, Preventive Care Report, 2) participation in the DHCS' Regional Quality and Health Equity teams. -Modified to comply with DMHC APL 24-013 Health Equity and Quality Program Policies and Requirements: 1) reporting of health equity and quality measure sets (HEQMS)	x		
2	Quality Improvement	QI-111	Delegation of Management and Oversight	Describes the oversight of delegates for QI to ensure a systematic and effective Quality Improvement Health Equity (QIHE) program consistent with regulatory and contractual standards	none			X
3	Quality Improvement	QI-119	Provider Preventable Conditions (PPC) and Adverse Events	Describes the process by which PPCs are identified, processed, investigated, and reported to the DHCS. Medi-Cal managed care plans are prohibited from permitting payment of Medicaid providers for treatment of PPCs (except when the PPC existed prior to the initiation of treatment for that beneficiary by that provider).	None			X
4	Quality Improvement	QI-105	Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical Accessibility ReviewSurveys (PARS)	Outlines the Alliance site review process, including Facility Site Review (FSR), Medical Record Review (MRR), and Physical Accessibility Review (PARS), and the process by which Alliance conducts, scores, monitors, and reports site reviews in accordance with all applicable state and federal guidelines	-Modified for the following: 1) Revised from HCQC to QIHEC 2) Given the transition to a single plan model, deleted references to the coordination with other counties for site reviews in Alameda County	x		
5	PHM	003	Risk Stratification and Segementation	Describes Alliance Population Health Management data sources and processes for risk stratification and segmentation of members.	Updated to align with DHCS PHM Policy Guide to additionally include utilization, care management, and eligiblity data in capturing high-risk tier members.	X		x
6	Behavioral Health	BH-004/UM-062	Behavioral Health Treatment		Please retire UM-062 Policy. The BH Department implemented a new policy, BH-004 Behavioral Health Therapies (BHT): Applied Behavioral Health Analysis (ABA), on 04/10/2024. Please refer to the new policy.	X		
7	Quality Improvement	QI-108	Access to Behavioral Health Services	Describes the access and availability standards applicable to behavioral health services provided by the Alliance	Removed verbiage related to delegation of behavioral health services	x		

Policy Procedures Summary of Changes

8	CMDM	UM 16	Transportation Guidelines	Structure of Plan's Transportation Benefit	Addition of langugage regarding transportation for trips outside of time and distance standards, covered by our PA process for trips over 50 miles. Addition of langugage regarding reimbursement of OON trips for IHCP members.	X		
9	CMDM	CM-004	Care Coordination of Services	Structure of Plan's Care Coordination Services	Update to screenshot of CMDM referral form.	X		
10	CMDM	CM-005	Disease Management Programs	Identification, screening, risk stratification, enrollment, assessment, care plan development and management, evaluation and closure for disease management programs	revised to be in alignment with PHM policy guide requirements	X		
11	CMDM	CM-008	SPD HRA - Survey and Interventions	Structure of Health Risk Assessment (HRA) and Procedure for Seniors and Persons with Disabilities (SPD)	Member Adivsory Committee (MAC) changed to Community Advisory Committee (CAC).	X		
12	CMDM	CM-020	Health Information Form Member Evaluation Tool (HIF/MET)	Description of Plan's HIF/MET assessment tool and processing of responses.	N/A			X
13	CMDM	CM-021	Community Supports - Asthma Remediation	Member identification, referring, continuity of care, authoirzation process, data sharing, payment, eligibility, restrictions/limitations and discontining of Asthma Remediation services	Change in department and policy numbering from CM-021 to CS-005	X		
14	CMDM	CM-022	Community Supports - Housing Deposits	Member identification, referring, continuity of care, authoirzation process, data sharing, payment, eligibility, restrictions/limitations and discontining of Housing Deposits services	Change in department and policy numbering from CM-022 to CS-003	X		
15	CMDM	CM-023	Community Supports - Housing Tenancy and Sustaining Services	Maintaining safe and stable tenancy to members once housing is secured	Change in department policy numbers from CM-023 to CS-004	X		
16	CMDM	CM-024	Community Supports - Housing Transition Navigation Services	Assisting members with housing transition and navigation services	Change in department policy numbers from CM-024 to CS-002	X		
17	CMDM	CM-025	Community Supports - Medically Supportive Food/Meals/Medically Tailored Meals	Providing members with medically supportive food/medically tailored meals	Change in department policy numbers from CM-025 to CS-007	X		
18	CMDM	CM-026	Community Supports - Recuperative Care (Medical Respite)	Provide interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral condition	Change in department policy numbers from CM-026 to CS-006	X		
19	CMDM	CM-027	Community Supports - Oversight, Monitoring & Controls	Auditing and oversight of Community Supports provider activities	Change in department policy numbers from CM-027 to CS-001	X		
20	CMDM	CM-029	Developmental Disabilites	Case Management for members with developmental disabilities including division of responsbilites with RCEB	N/A			X
21	CMDM	CM-033	Home and Community Based Services (Waiver Programs) - DDS	Identification and Referral of Members into HCBS waiver programs	N/A			X
22	CMDM	CM-035	Community Supports - Respite Services	Services provided to caregivers of members who require intermittent temporary supervision.	Change in department policy numbers from CM-035 to CS-008	X		

23	CMDM	CM-036	Community Supports - Personal Care & Homemaker Services	Provided for members who need assistance with ADLs. They can also include assistance with IADLs.	Change in department policy numbers from CM-036 to CS-009	X		
24	CMDM	CM-037	Community Supports - Environmental Accessibility Adaptions (Home Modifications	Physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the member or enable the member to function with greater independence in the home	change in department policy numbers from CM-037 to CS-010	X		
25	CMDM	CM-038	Community Supports - Nursing Facility Transition/Diversion to Assisted Living Facilities	Assist members to live in the community and/or avoid institutationalization when possible	change in department policy numbers from CM-038 to CS-011	X		
26	CMDM	CM-039	Community Supports - Transition Services/Nursing Facility Transition to a Home	Assist members to live in the community and avoid further institutionalization	change in department policy numbers from CM-039 to CS-012	X		
27	CMDM	CM-040	Community Supports - Sobering Centers	Alternative destinations for members who are found to be publicly intoxicated and would otherwise be transported to the emergency department or jail.	change in department policy numbers from CM-040 to CS-013	X		
28	CMDM	HCS-015	Enhanced Care Management - Outreach/Member Engagement	Member outreach and engagement into ECM program	change in department policy numbers from HCS-015 to CM-041 minor edits to better reflect current processes	X		
29	CMDM	HCS-020	Enhanced Care Management - IT/Data Sharing	IT and data sharing for ECM program between AAH and ECM providers and DHCS requirements	change in departmetn policy numbers from HCS-020 to CM-042	X		
30	UM	UM 001	Utilization Management Program	UM Program details, staff responsibilities, protocols, and UM Hiearchy	Expanded role of the consultants to assist with non-covered benefits reviews and when there are no criteria available from DHCS Provider Manual or MCG, and readily available to the Medical Director Reviewer.	X		
31	UM	UM 046	Use of Board Certified Consultants	Licensing, scope and function of Board Certified Consulants.	Expanded role of the consultants to assist with non-covered benefits reviews and when there are no criteria available from DHCS Provider Manual or MCG, and readily available to the Medical Director Reviewer.	X		
32	UM	CBAS- 001	Initial Member Assessments and Reassessments for Community Based Adult Services Eligibility	Basic policy related to the initiation of CBAS Services	Annual Review- Dates Updated. Updated Dates/ Time frames for Member and provider notifications, fixed grammar/ capitalization. Updated reference resources.	X		X
33	PHM	PHM-003	Risk Stratification and Segementation	Describes Alliance Population Health Management data sources and processes for risk stratification and segmentation of members.	Updated to align with DHCS PHM Policy Guide to additionally include utilization, care management, and eligiblity data in capturing high-risk tier members.	X		X

Voting Item: Approval of Committee Meeting Minutes

- QIHEC – 5/17/2024
- UMC- 5/31/2024, 7/26/2024
- CAC- 3/14/2024
- CLS- 4/24/2024

  The complete Meeting Minutes Voting Packet has been sent in a separate email.

ALAMEDA Alliance FOR HEALTH

UM Workplan Update - UM Metrics Report

Michelle Findlater - Director of Utilization Management

ALAMEDA Alliance FOR HEALTH

UM Workplan Update

QIHEC
Michelle Findlater, Director of Utilization Management
August 16, 2024

ALAMEDA Alliance FOR HEALTH

Agenda

The purpose is to track and trend:

- UM Metrics Summary
- Readmissions
- Inpatient Denial Rates
- Outpatient Denial Rates
- Emergency Department Volume
  - By Network
  - By Facility

2024 Program Recommendations Focus areas

- **Data:** Refine UM data integrity and analysis
- **Delegates:** Enhance oversight for all regulatory processes
- **UM processes:** Enhancements on throughputs
- **ED / Hospital Over Utilization:** High frequency ED visits & OON & Readmissions
- **OON:** Enhance analysis and collaboration with PR on network

UM Metrics Summary

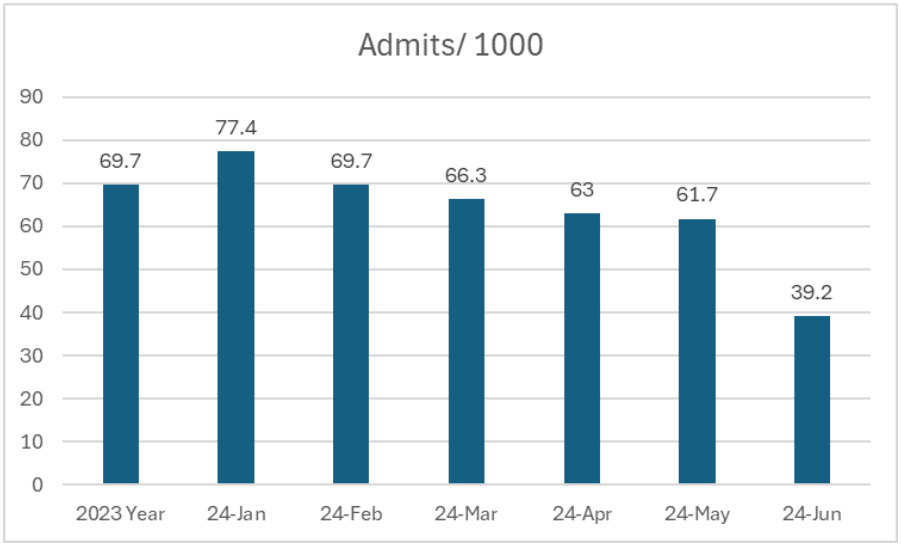
PowerBI: #12005 IP Claims Utilization

Date: 2023 Average – June 2024

Excluded: LTC AID Categories, LTACs and Sutter Herrick Psych Unit facilities

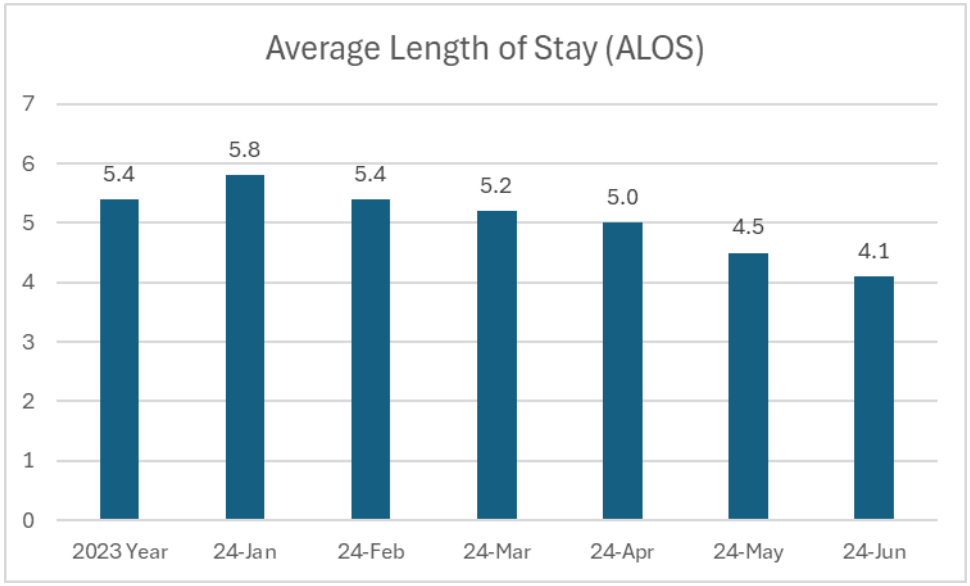
ALAMEDA Alliance FOR HEALTH

Admits/1000 (1/1/24- 6/30/24)



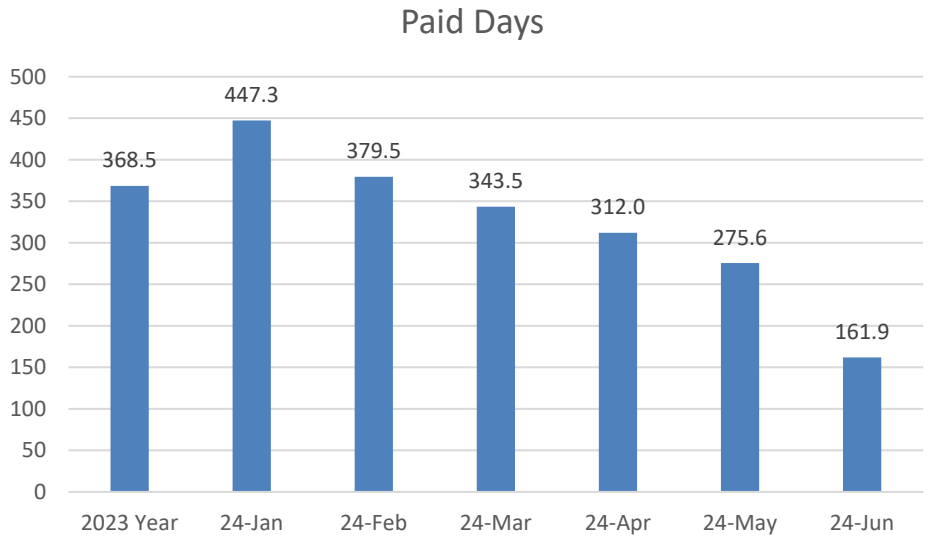
- 2024 Admits/1000 decreased to an average of 62.8 which is a (-6.9) change from the 2023 average based on claims data available for January through June 2024
  - Admits/1000 by delegate- Alliance has the highest Admits/1000 at 115.4 and CFMG the lowest at 8.5
  - Admits/ 1000 by Facility: Summit has the highest at 9.9 and Stanford is the lowest at 1.2
  - Admits/1000 by aid category: Duals is the highest at 193.7 and Adults are the lowest at 36.0

Average Length of Stay (ALOS)
1/1/24 - 6/30/24



- 2024 ALOS decreased to an average of 5.0 which is a (-0.4) change from the 2023 average based on claims data available for January through June 2024
  - ALOS by delegate- Alliance has the highest ALOS at 5.4 and CFMG the lowest at 2.4
  - ALOS by Facility: UCSF has the highest at 7.1 and LPCH is the lowest at 2.1
  - ALOS by aid category: SPD is the highest at 5.5 and Children are the lowest at 2.5

Paid Days/1000
1/1/24 - 6/30/24



- 2024 Paid Days/ 1000 decreased to an average of 320.0 which is a (-48.5) change from the 2023 average based on claims data available for January through June 2024
  - Paid Days/ 1000 by delegate- Alliance has the highest ALOS at 621.2 and CFMG the lowest at 20.2
  - Paid Days/ 1000 by Facility: HGH has the highest at 51.7 and UCSF has the lowest at 14.5
  - Paid Days/ 1000 by aid category: SPD is the highest at 1,044.1 and Children are the lowest at 22.1

Readmissions

PowerBI: #12005 IP Claims Utilization

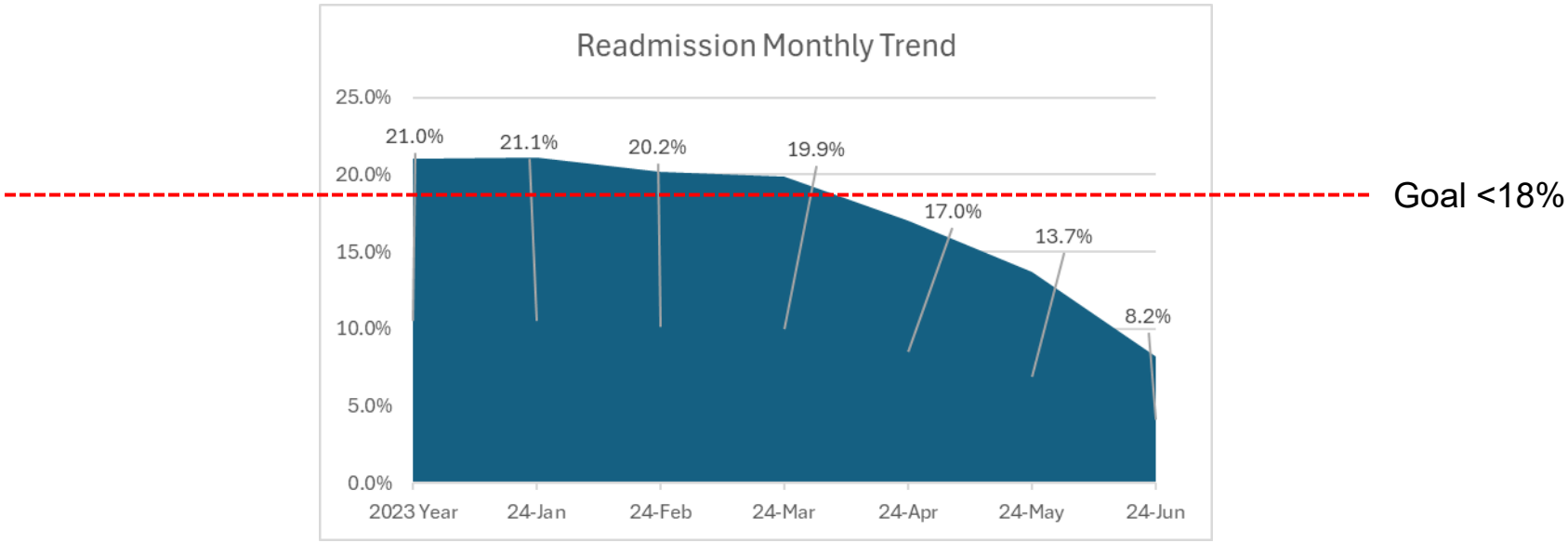
Date: 2023 Average – June 2024

Excluded: LTC AID Categories, LTACs and Sutter Herrick Psych Unit facilities

ALAMEDA Alliance FOR HEALTH

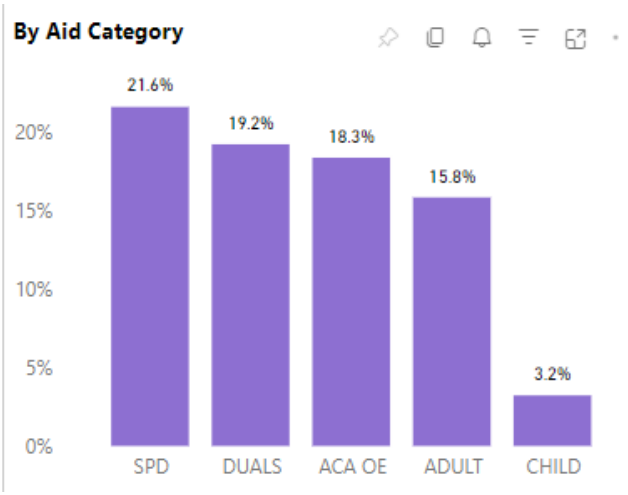
Monthly Readmissions Trend

1/1/24 - 6/30/24



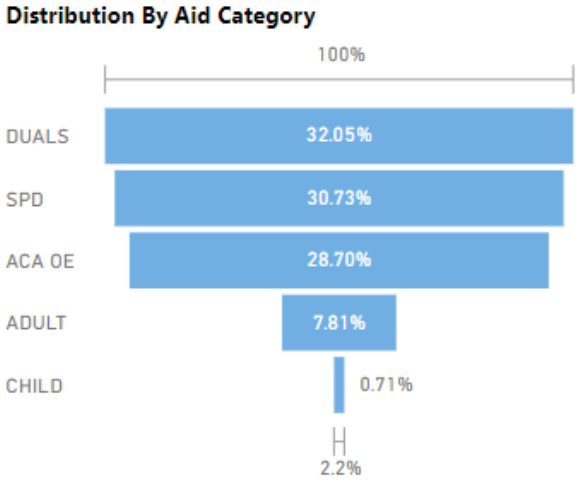
- Readmission Rates in 2024 appear to be having a downward trend however, there is claims data that may be outstanding and will impact the rates. Our goal remains unchanged at 18%

Readmission Rates
1/1/24 - 6/30/24



SPD continues to carry the highest readmission rate 21.6%, followed by
DUALS 19.2%
ACA OE 18.3%
Adult 15.8%
Child 3.2%

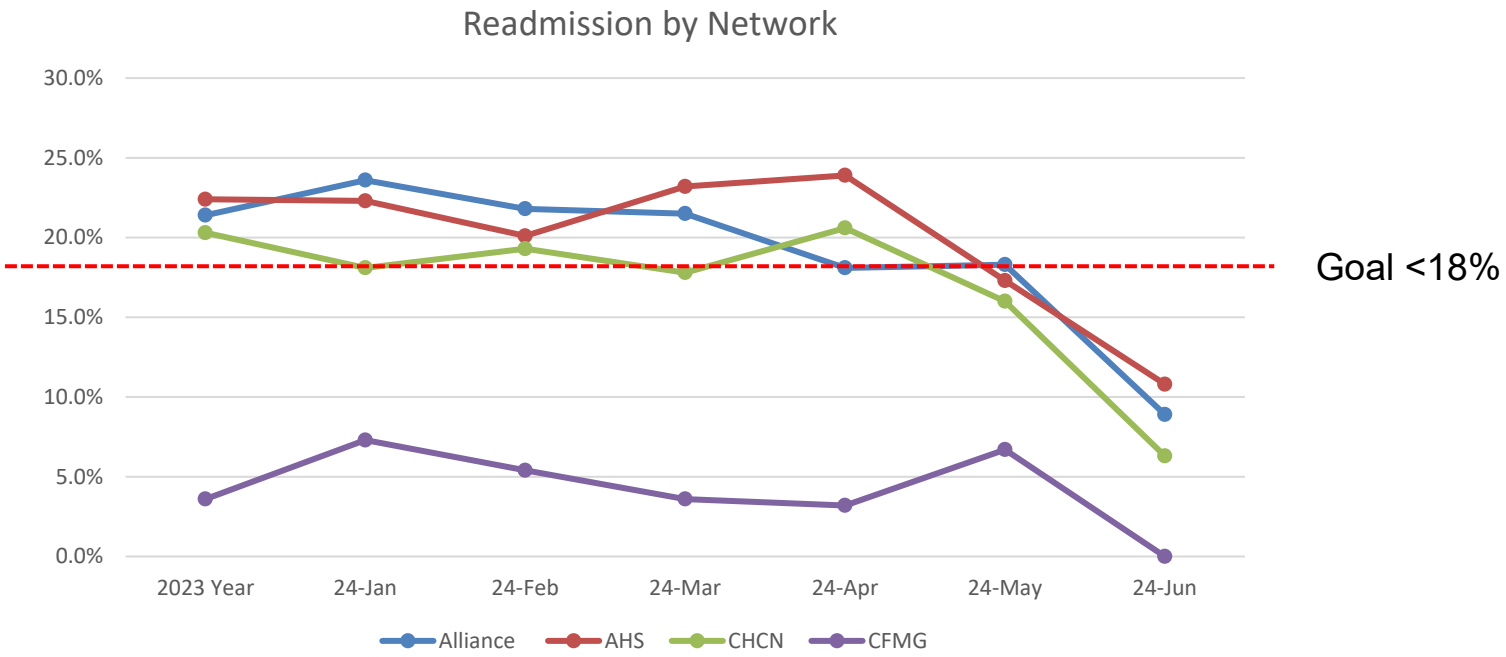
Child is the only Aid Category which has increase so far in 2024



Duals readmits comprise ~32.0% of total readmits followed by
SPD ~30.7%,
ACA OE 28.7%

AE is the only category which has increased so far in 2024

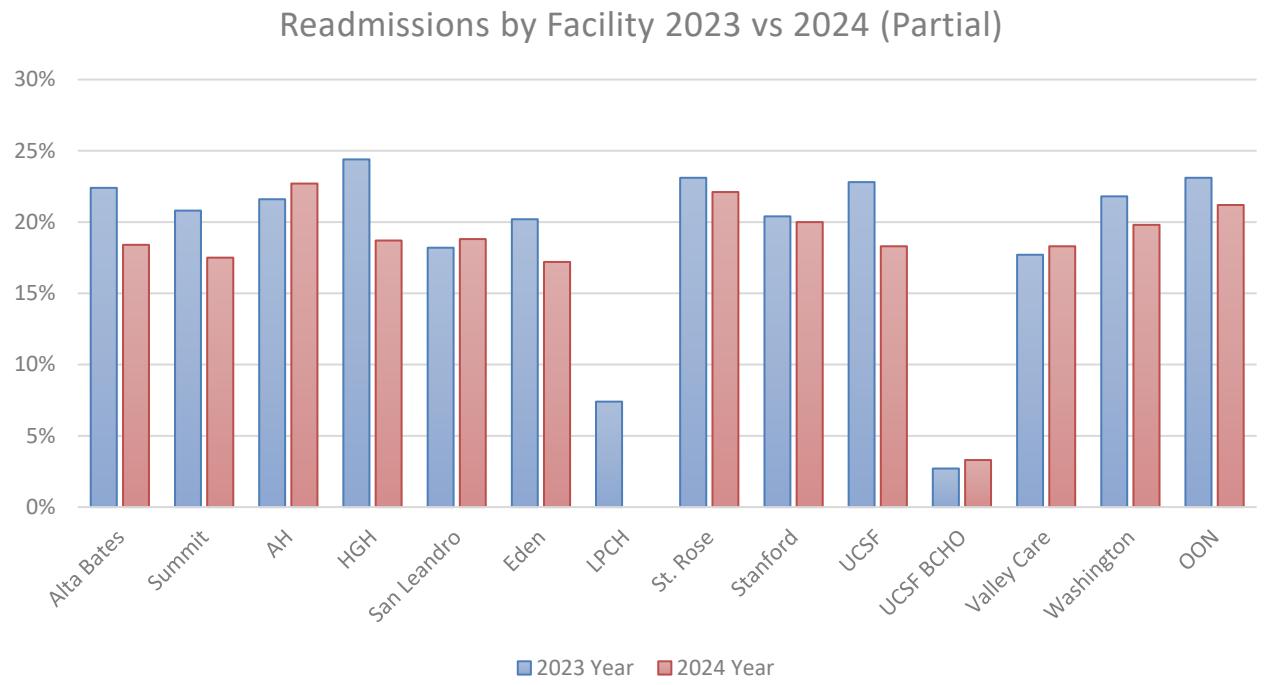
Readmission Rate by Network
1/1/24-6/30/24



Overall, all 3 networks (with the exception of CFMG) appear to be having readmission trends above the Alliance goal of 18%.

*May and June data likely appear lower than predicted due to claims lag.

Readmission Rates by Facility



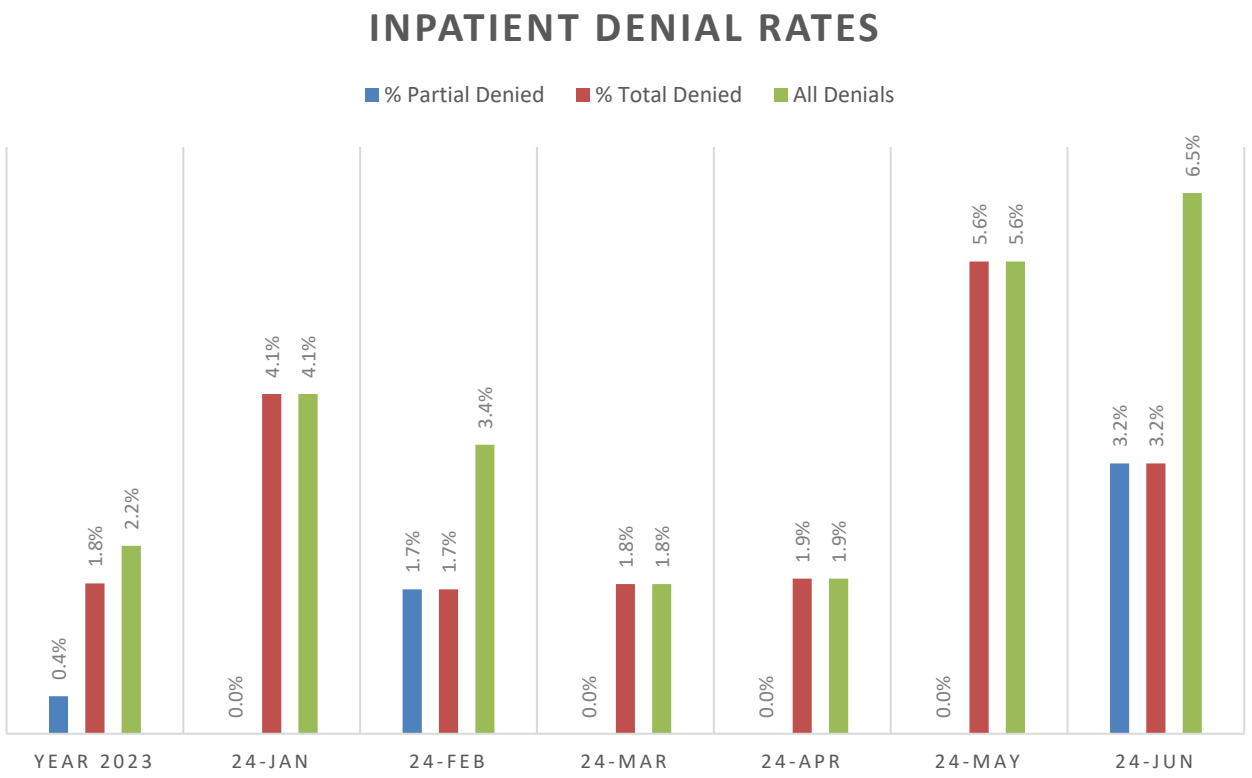
- Comparing 2023 average readmission rates to 1/1/24-6/30/24 readmission rates it appears that all hospitals with the exception if Alameda Hospital and San Leandro are having a decrease in readmissions so far in 2024.

Inpatient Denial Rates

Excel: #01292 All Auth Denial Rates
Date: 2023 Average – June 2024

ALAMEDA Alliance FOR HEALTH

Inpatient Denial Rates



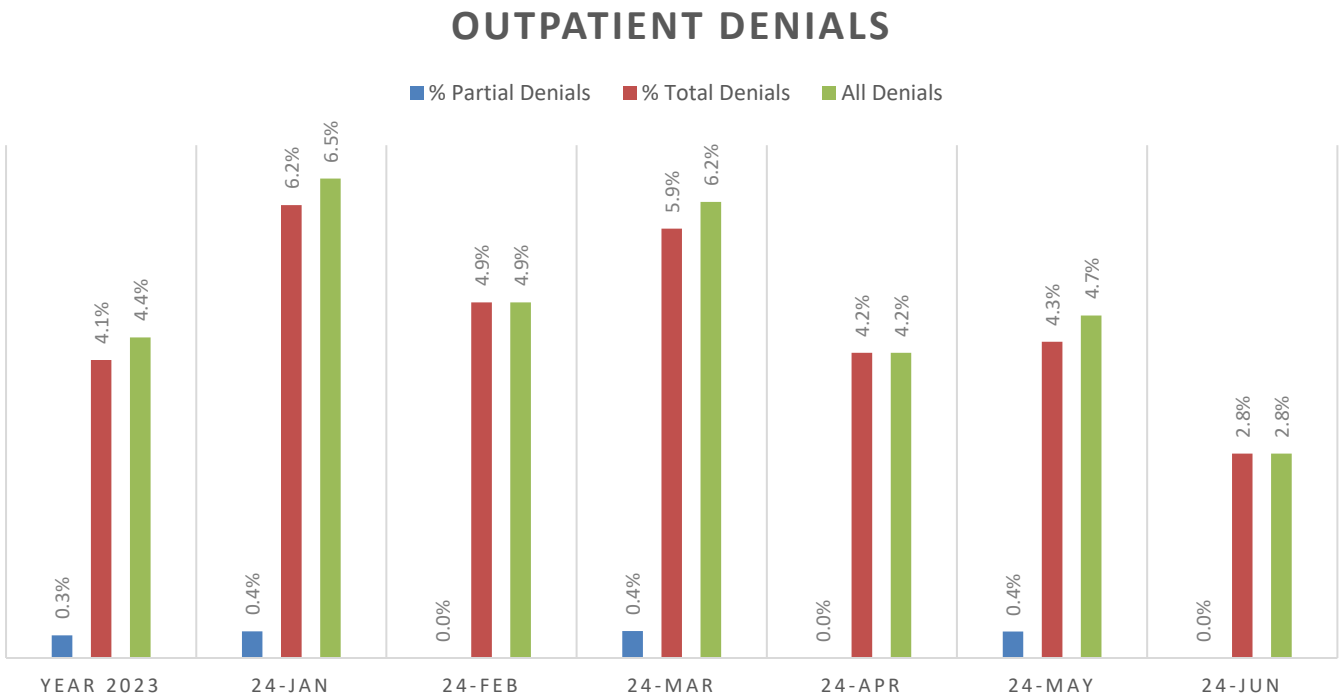
IP denials have increased as compared to the 2023 averages and we have seen more Full Denials than Partial Denials. Total Denials driven by "Members not Eligible" - 17 auth/month which have almost tripled since 2023.

Outpatient Denial Rates

#01292 All Auth Denial Rates (Claims based)
Date: 2023 Average – June 2024

ALAMEDA Alliance FOR HEALTH

Outpatient Denial Rates



Partial Denials remains stable in 2024 as compared to 2023

Two months in 2024 have an increase in Total denials (January & March) as compared to the average in 2023.

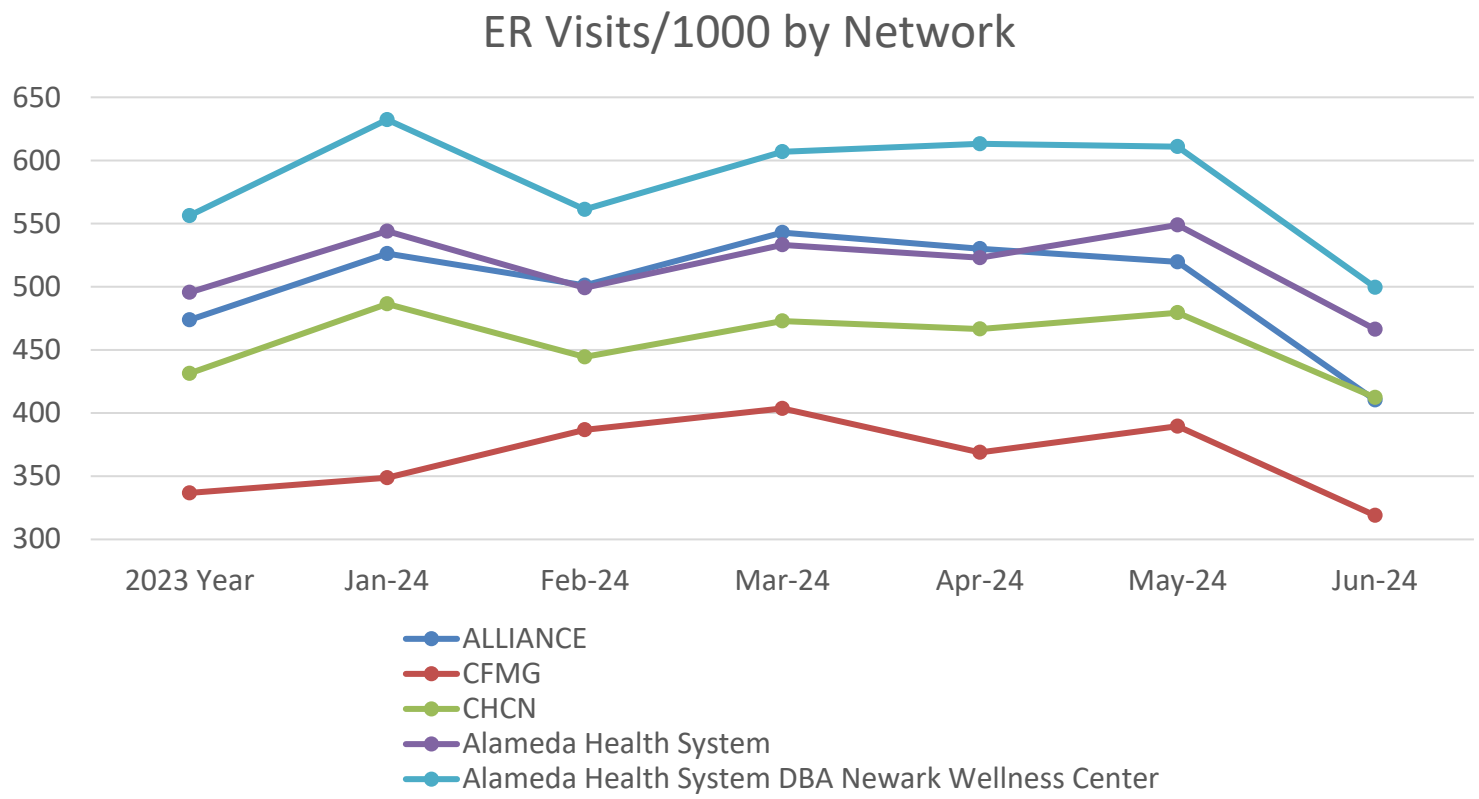
Emergency Department Volume

Excel: #03046 ER Visits by Network

Date: 2023 Average – June 2024

ALAMEDA Alliance FOR HEALTH

ER Visits by Network

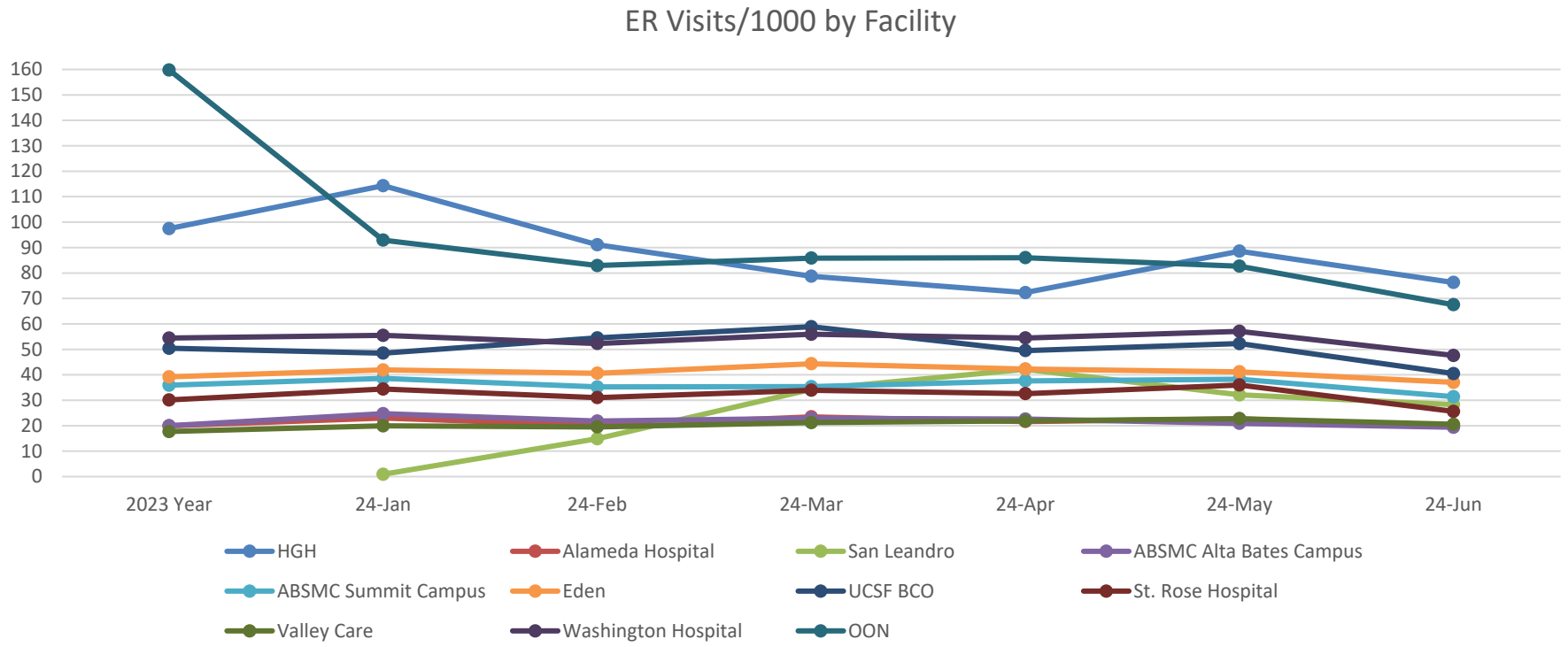


Total ED rates are decreasing, but individual networks have increased such as the Alliance and CFMG since 1/1/2024.

Highest Average ER Visits by Network:

- Newark Wellness Center > AHS > Alliance

ER Visits by Facility



Highest Average ER Visits by Facility:

OON Hospitals

Highland General

Washington

UCSF Benioff Children's Oakland

Thanks!

Questions?

QI Workplan Updates

ALAMEDA Alliance FOR HEALTH

2024 Quality Improvement & Health Equity (QIHE) Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification	Q1, 2024	Q2, 2024	Q3, 2024	Q4, 2024	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues (if applicable)
Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	N/A	**Annual QIHE Program Evaluation**	Y	**New**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee (aka Member Advisory Committee)	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) drafted in collaboration with other departments. Finalized documents will be presented to QIHEC in April 2024.	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) were reviewed with the Alliance Board Chair and included as consent items to the Board in June 2024.	A high level summary of the QIHE Trilogy documents were presented to the Board by the CMO in July 2024. In addition, a presentation was given for all Trilogy documents (QIHE, UM, CM) at the HCS All Staff meeting in July 2024.		All Sub-Committees and QIHEC	Q2 2024	Incorporated BH and SNF/LTC Quality Monitoring
Quality of Care													
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Manager Name: Farashta Zainal	**HEDIS Rates MY 2024**	N	**Continued**	Increase the HEDIS/MCAS measures below MPL in MY2023 to meet or exceed MPL by December 31, 2024	Measure below MPL in MY23 - Lead Screening (LSD), Follow-up after ED visit for Mental Illness (FUM) and Topical Fluoride for Children (TFL). Provided funding to CHCN network to purchase POC units for providers in the network. Educate providers on HEDIS specifications, Codes, Best Practices, and the process for QUEST pick-up services of specimen	Continue provider education. Collaborate with high volume, low performing providers to provide members with incentives for completing lead screening.			Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2024	Due to the pandemic AAH saw a decline in HEDIS measures with multiple years of service. Furthermore, state wide insufficient lead screening kits may be a factor in declining lead screening rates.
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Megan Hils	**HEDIS Retrieval and Overreads MY 2024**	N	**Continued**	Alongside the analytics team, provide HEDIS support related to medical record retrieval, abstraction, and overreads. The goal is to overread 20% of the abstracted charts for the hybrid measures.	CHCN record retrievals completed. Change Healthcare experienced a data breach in February which impacted measure trainings and completing abstractions and overreads; access to all Change Healthcare systems was cut off. Team is now working with Datawant for abstraction and overreads as of March. Measure training and overread process will begin in April.	Overreads completed, all records submitted to auditors			Internal Quality Improvement Committee Quality Improvement Health Equity Committee	5/02/2024	The quality analytics team benefits from QI partnership in completing their goal of 100% overreads to reduce errors in the HEDIS data submission
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Lead QI Project Specialist Name: James Burke	**Pay For Performance (P4P) 2024**	N	**Continued**	Incentivizes providers to improve care on P4P measures with quarterly QI oversight. Facilitate webinars to discuss P4P updates, best practices and answer questions. - meet with 100% of the delegates by December 31, 2024 - meet with at least 30% of Directs by January 30, 2025	Trainings in January completed for Direct providers on 01/11/24 and 01/24/24. Total Providers in Attendance of both sessions: 19	Program continuing to run. As Quality Improvement meets with Delegates and Direct Providers, updates are provided on their P4P performance rates.			Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2024	The P4P program has been a successful tool used to support providers improve HEDIS rates
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal 2024: Linda Ayala(?)	Title: Lead QI Project Specialist Name: James Burke	**Health Equity Incentive Pilot**	Y	**New**	Incentivizes providers to close care gaps on 3 measures (W15, CCS and CBP) with a focus on race/ethnicities that were 5% below the overall admin rate in 2022. - Facilitate webinars to discuss Health Equity Incentive Pilot - Share care gap reports - Support providers on meeting equity goals	Training provided to Delegates in December of 2024 and Directs in January of 2024.	Program continuing to run.			Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: Lead QI Project Specialist Name: James Burke	**QI PDSA Cycle Training**	N	**Continued**	By December 31, 2024, offer two training opportunities for provider participation in learning and applying the PDSA methodology.	ABCs of QI Collaboration completed with CHCN in the month of February 2024: -02/13/24: 20 attendees -02/20/24: 11 attendees -02/27/24: 12 attendees	Planning for ABCs of QI series in July 2024, open to all providers and all Alliance employees.			All Sub-Committees	6/30/2024	As quality improvement (QI) projects spread throughout the Health Care Service team, it is essential that all staff have an understanding of the PDSA model for improvement. The model provides a vehical to drive QI projects
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Megan Hils	**Priority PIP: Improve FUA/FUM - improve 30 day follow-up rate**	N	**Continued**	Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within 30 days of emergency department (ED) by December 31, 2025	Baseline data submission due Sep 11, 2024. HSAG will conduct training in June 2024 to review submission requirements. New QIPS staff member Kalkidan (Kaki) Asrat will co-lead work on PIP. Megan and Kalé will meet to complete causal/barrier analysis.	Attended training in June. HSAG released an updated intervention tracking sheet. Work on submission materials is ongoing. Submission due Sep 11			Internal Quality Improvement Committee	12/31/2025	This is a newly assigned PIP. PIP topic was assigned by the state based on low performance
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Bob Hendrix Title: QI Project Specialist II Name: Falmata Abatcha	**Equity PIP: Improve Well Child - W15 (6) for African American Children**	Y	**Continued**	To address the disparity that exists with Well Child visits, by December 31, 2025, increase the percentage of well-child visits (W30-6) amongst African American children between the ages of 0-15 months from 30.54% to MPL.	Analysis Alliance WCV population is done and ensure we have all the rates are accurately reflected for the State mandated PIP. Identified Black/African American. Identified the Exclusion and stratification of the population based on race and ethnicity. Decided not to use the Sound sampling for this PIP. Identified performance indicator for sampling will not be used.	Completed Barrier analysis and studies the results of the Member Experience survey conducted by FS in March 2024. Created Driver diagram. Worked on Planning stage of the PDSA. Predicted outcome of the intervention and set goals for the transportation outreach. Identified 21 members for CFMG. Sent a list of the 21 members to First 5 to conduct an outreach. The outreach will inform of the transportation benefit offered by the Alliance and will also let Parents/guidance know to schedule Well-Child visit with their PCP.			Internal Quality Improvement Committee	12/31/2025	This is a newly assigned PIP. PIP topic was assigned by the state based on low performance
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Sangeeta Singh	**Workgroup: Women's Health**	N	**Continued**	By December 31, 2024, the Alliance will improve on women's health measures in the MCAS/P4P, by conducting improvement projects to increase the low performing measures to above the MPL and to further increase rates to meet the 90th percentile Women's Health Measures: CCS, BCS, PPC 1 and PPC 2 and CHL.	The Women's Health Workgroup completed: Review the previous year, 2023 charter and goals. Updated the 2024 Project Charter and Driver Diagram. Reviewed the PPC measure and following the Prenatal Visits rate. Continuing use of mobile mammography and CCS birthday cards. Promotion of Pap-a-thon services to providers.	The Women's Health Workgroup continues to meet and have continued the promotion of mobile mammography services to all providers and usage of gap in care reports. Planning for updated CCS/BCS member faced flyers in collaboration with Health Education. Planning for upcoming community partner event for the Allen Temple Baptist Church Holistic Fair. Cancer Prevention webinar for providers targeting CCS/BCS. For CCS: member incentive birthday card mailers continued to outreach to members, however the non-incentive birthday cards ended in April. Pap-A-Thons have been discussed with our providers who are performing below the MPL. Exploring at Home HPV Testing. Promoting usage of gap in care lists. For PPC: Exploring the workflows and barriers with providers who are performing below the mpl and did not meet the measure in MY2023. Met with BACH to review the PPC workflow and chart reviews for missed opportunities. Preparing PPC Measure highlight for providers			Internal Quality Improvement Committee	12/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Bob Hendrix Title: QI Project Specialist II Name: Falmata Abatcha	**Workgroup: Well Child**	N	**Continued**	By December 31, 2024 the Alliance will improve on well-child measures in the MCAS, by conducting improvement projects to increase the rates from below the MPL and to further increase rates to meet the 90th percentile: Well Child Measures: W15, W30, WCV, CIS10, IMA, DEV, TFL	The Well-Child Workgroup completed: -Evaluate the '23 Project Charter -Updated the '24 Project Charter and Driver Diagram -Developed a plan for an Organization-wide Campaign on Well-Visits -Reviewed gaps in data on the CIS measure	The Well-Child Workgroup continues to meet monthly. All projects are in planning and implementation stages. The Org-wide Campaign on Well-Visits is planned to launch late August/early September 2024.			Internal Quality Improvement Committee	12/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Megan Hils	**Workgroup: Chronic Disease Management**	N	**Continued**	By December 31, 2024, Alameda Alliance for Health (AAH) will improve on chronic disease management measures in the MCAS/P4P to meet MPL and to further increase rates to meet the 90th percentile. Chronic Disease Measures: AMR, CBP, HBD 2, CRC	The Workgroup completed: - Evaluated the '23 Project Charter - Created diabetes gap in care and med adherence report - Began root cause analysis of AMR rate decline - Continuing to pursue collaboration with Exact Sciences and Let's Get Checked - Began planning for BP monitor outreach PDSA - Created DM and HTN comorbidity report	Created AMR claims analysis and continued to develop diabetes gap in care and medication adherence reports. Met with Analytics and Hallie Roth from CHCN to evaluate reports and work to streamline and update reports. Collaboration with Exact Sciences and Let's Get Checked still in progress, currently in contracting phase. BP monitor outreach project has started; so far 21/105 members requested a monitor, however an issue was identified where members had not recently been seen at Alameda Health so a prescription was not sent, working to contact last servicing providers to follow up			Internal Quality Improvement Committee	12/31/2024	This workgroup supports the goal of creating a culture of quality improvement goals throughout the organization and increases alignment of quality improvement efforts across QI department teams.
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist II Name: Kalé Asrat	**Workgroup: Behavioral Health**	N	**New**	By December 31, 2024 Alameda Alliance for Health will improve on behavioral health measures in the MCAS to meet MPL and to further increase rates to reach the 75th percentile. Behavioral Health Measures: (FUA, FUM) Collaborate with BH Department in development of disease management for depression.	Continued exploration of providing FUA and FUM follow-up in-house Met with other health plans and providers to understand high performance on follow-up measures Reestablished regular meetings with ACBH Considered participation in DHCS/HI Learning Collaborative but declined Explored FUA/FUM ED utilization New staff member Kalkidan (Kalé) Asrat joined QI Performance team, transitioning to workgroup lead Began work to establish ED navigator program/partnerships	Started working with the Director of Housing & Community Services to partner with Journey Health who may be able to help us conduct the follow-up using Community Health Workers The BH team is currently exploring working with Grow Therapy to conduct the follow ups Meeting with ACBH once a month to at our BH Quality work group to continue collaboration Provided an in depth data analysis to Alameda Health Systems, discovered that Substance Use Navigators (SUNs) in the ED are conducting visits that would count for follow ups but the visit is not being captured on claims, currently working with AHS to see if SUNs and CHWs at their EDs can use the CPT codes that would capture their work for the follow up			Internal Quality Improvement Committee	12/31/2024	This workgroup supports the goal of creating a culture of quality improvement goals throughout the organization and increases alignment of quality improvement efforts across QI department teams.

2024 Quality Improvement & Health Equity (QIHE) Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification	Q1, 2024	Q2, 2024	Q3, 2024	Q4, 2024	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues (if applicable)
Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	N/A	**Annual QIHE Program Evaluation**	**Y**	**New**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee (aka Member Advisory Committee)	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) drafted in collaboration with other departments. Finalized documents will be presented to QIHEC in April 2024.	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) were reviewed with the Alliance Board Chair and included as consent items to the Board in June 2024.	A high level summary of the QIHE Trilogy documents were presented to the Board by the CMO in July 2024. In addition, a presentation was given for all Trilogy documents (QIHE, UM, CM) at the HCS All Staff meeting in July 2024.		All Sub-Committees and QIHEC	Q2 2024	Incorporated BH and SNF/LTC Quality Monitoring
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: Lead QI Project Specialist Name: James Burke	**Engagement Outreach Program**	**N**	**New**	Annually, the Alliance QIHE Engagement Program will help close care gaps in the California Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures, and Health Equity gaps, by reaching or exceeding the MPLs through: •Engaging with members through outcalls and collaborating with provider and community partners on member focused campaigns. •Participate in quality improvement projects related to member engagement. •Participate and collaborate in QI Department initiatives.	In process of developing program description and onboarding program. Job Description were re-submitted to HR for grading, pending completion.	In process of recruiting two QI Engagement Program Coordinators. Estimated arrival of roles will be late August/early September 2024.			Internal Quality Improvement Committee	12/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: Lead QI Project Specialist Name: James Burke	**Provider Training on HEDIS measures**	**N**	**Continued**	By December 31, 2024, the QI Performance team will offer learning opportunities to the provider network on HEDIS measures, including measures specification and best and promising practices in and out of the Alameda Alliance network.	MY2024 Measure Highlight Webinar Series completed: -W30 on 02/07/24: 13 attendees -WCV on 03/13/24: 14 attendees	MY2024 Webinar Highlight Series completed: -Chronic Disease on 04/11/24: 14 attendees -Cancer Prevention on 05/01/24: 15 attendees -W30 on 05/15/24: 14 attendees Planning in process for a TFL-CH Webinar in September 2024. QI Virtual Town Hall is scheduled for 09/11/2024.			Internal Quality Improvement Committee	12/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Megan Hils	**Non / Under Utilization Outreach**	**N**	**Continued**	Member outreach to at least 20% of non-utilizers over the age of fifty, and connect 2% to primary care services; outreach to 20% of non-utilizers ages six and under, connect % to pediatric primary care services by 6/30/24	Worked with Xaqt to update script and tracking sheet. Calls began in March focusing on adults first. As of March 26 working with Xaqt to understand which call list is being used- there may have been a mix up between 2023 call list and the current year's list.	Outreach calls to adults completed with one attempt. Working on calls to children ages 13-19, next group is children ages 9-12. Received final tracking of calls to adults in late June, analysis will begin in July. Amended SOW through Dec 31 2024 in process for signature.			Internal Quality Improvement Committee	12/31/2024	More than half of members have not seen a PCP, which contributes to low IHA rates and may contribute to low performance in other indicators, including increased ED use.
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: Lead QI Project Specialist Name: James Burke	**IHI/DHCS Equity Learning Collaborative - Children's Health**	**Y**	**New**	**Roots Comunity Health Center**: By December 2024, Roots Community Health Center, in partnership with Alameda Alliance for Health, will increase completed well-child visit rates for: Black/African Americans Medi-Cal Patients: -4-6 years old, from 27.27% to 48.07%. -9-14 years old, from 25.00% to 48.07%. Hispanic Medi-Cal Patients: -4-6 years old, from 40.00% to 48.07%. -9-14 years old, from 38.46% to 48.07%. **LifeLong LeNoir Health Center**: By December 2024, LifeLong LeNoir Health Center, in partnership with Alameda Alliance for Health, will increase completed well-child visit rates for: Black/African Americans Medi-Cal Patients: - 4-6 years old, from 56.10% to 61.15%. -9-12 years old, from 57.47% to 61.15%. Hispanic Medi-Cal Patients: -4-6 years old, from 77.78% to 100.00%. -9-12 years old, from 52.63% to 55.08%.	DHCS assigned this in March 2024. Participating Providers: Roots Community Health Center and LifeLong LeNoir Health Center	Completed Tasks: Reviewed data w/participating clinics, established an AIM statement for each clinic (see column G), started conducing gift card incentive PDSAs, and started conducting provider and member interviews.			N/A	March 2025	
Population Health Management													
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Population Needs Assessment**	**Y**	**New**	Define meaningful participation in Alameda County and City of Berkeley CHA/CHIP processes in coordination with Kaiser by August 1, 2024. Establish project plans with Alameda County and City of Berkeley by September 30, 2024.	Conducted monthly meetings with ACPH, City of Berkeley, and Kaiser to discuss shared goals and opportunities for meaningful participation.	Shared objective developed with City of Berkeley. Shared objective developed with ACPHD. Continued monthly meetings with ACPHD and City of Berkeley.			Internal Quality Improvement Committee Quality Improvement Health Equity Committee	9/30/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Population Health Management - PHM Monitoring**	**Y**	**Continued**	Expand PHM monitoring and evaluation processes to include further analysis for understanding KPIs, Quality Measures, PHM Strategy goals, and identifying barriers and opportunities for action by the end of 2024.	Collaborated with the PHM workgroup to develop the PHM Evaluation of the 2023 PHM Strategy. Provided feedback to DHCS re: KPI specifications.	Worked with NCQA consultants to ensure compliance with NQCA requirements. Submitted PHM Evaluation to QIHEC 5/2024.			Internal Quality Improvement Committee Quality Improvement Health Equity Committee	9/30/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Population Health Management - PHM Strategy**	**Y**	**Continued**	Develop the Alliance 2024 PHM Strategy to address priority gaps in care and disparities in compliance with DHCS and NCQA requirements.	Completed the annual PHM assessment to identify gaps in care and disparities. Collaborated with the PHM workgroup to update strategies, activities and resources in the 2024 PHM strategy.	Developed and updated the 2024 PHM strategy in compliance with NCQA requirements. Submitted to QIHEC for approval 5/2024.			Internal Quality Improvement Committee Quality Improvement Health Equity Committee	5/30/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	TBD	**QIP #4: Increase Initial Health Appointment rates**	**N**	**Continued**	By 12/31/2024 Improve IHA completion rates from MY2023 to MY2024 by 3%.	Continue to share IHA reports with providers for outreach and connection to care. Continue to conduct IVR calls to remind new members to schedule an appointment with their provider. Develop and share a Measure Highlight tool outlining IHA requirements, codes, and best practices. Close CAP with DHCS	Include IHA Measure Highlight tool in the provider communication.			Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2024	State issued CAP for IHA
Safety of Care													
Title: Sr. Director, Pharmacy Services Name: Helen Lee Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Clinical Pharmacist Name: Ramon Tran Tang	N/A	**QIP #5: Opioid / SUD - Continuation**	**N**	**Continued**	Goal 1: By 12/31/24, educate chronic opioid users on health habits, management of chronic pain, and alternative therapy and care (>120 MME) daily). Goal 2: By 12/31/24, educate opioid users at risk of becoming chronic users (i.e., 50 to 119 MME/day).	Automated mailing list set for 6/7/24 from analytics.	Educational mailings for providers and members updated. Communication and SLT approved with updates. Mailings to sent out on 7/23/24	Next automated mailing list set for 12/7 from analytics		Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/24	Staff bandwidth and staffing transistion
Title: Sr. Director, Pharmacy Services Name: Helen Lee Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Clinical Pharmacist Name: Ramon Tran Tang	N/A	**QIP #5: Opioid / SUD - Continuation**	**N**	**Continued**	Goal 3: By 12/31/24, educate providers who are assigned members that utilize high dose opioids (>120MME) and who are presenting to the Emergency Department with opioid and / or benzodiazepine overdose.	Automated mailing list set for 6/7/24 from analytics.	Educational mailings for providers and members updated. Communication and SLT approved with updates. Mailings to sent out on 7/23/24			Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/24	Staff bandwidth and staffing transition
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Supervisor Name: Christine Rattray	**Potential Quality Issues (PQIs) Continuation- Quarterly**	**N**	**Continued**	Monitor, evaluate, and take effective action with >= 95% PQI closure within 120 days to address any needed improvements in the quality of care delivered by all providers rendering services on behalf of the Alliance in any setting along with internal data validation.	PQI case closures above 95% threshold	PQI case closures above 95% threshold			Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/24	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Supervisor Name: Christine Rattray	**Exempt Grievances Auditing- Biannual**	**N**	**Continued**	Ensure clinical monitoring of Exempt Grievances for Quality of Care, Service, Access and Language issues per P&P QI-104 through bi-annual review of 100 randomly selected Exempt Grievances.	Presented at IQIC on 1/17/24-next audit due Q3 2024 (audit period Q4 2023 & Q1 2024)	Presented at IQIC on 7/10/24-next audit due Q1 2025 (audit period O2-3 2024)			Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/24	

2024 Quality Improvement & Health Equity (QIHE) Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification	Q1, 2024	Q2, 2024	Q3, 2024	Q4, 2024	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues (if applicable)
Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	N/A	**Annual QIHE Program Evaluation**	**Y**	**New**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee (aka Member Advisory Committee)	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) drafted in collaboration with other departments. Finalized documents will be presented to QIHEC in April 2024.	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) were reviewed with the Alliance Board Chair and included as consent items to the Board in June 2024.	A high level summary of the QIHE Trilogy documents were presented to the Board by the CMO in July 2024. In addition, a presentation was given for all Trilogy documents (QIHE, UM, CM) at the HCS All Staff meeting in July 2024.		All Sub-Committees and QIHEC	Q2 2024	Incorporated BH and SNF/LTC Quality Monitoring
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Supervisor Name: Christine Rattray	**Potential Quality Issues (PQIs) Annual Training**	**N**	**Continued**	Plan provides documented evidence of ongoing annual training on PQIs by clinical staff for both new and seasoned customer service staff who serve as the front-line entry for the intake of all potential quality of care grievances	Annual training provided to HCS Dept in January. Plan to offer training to MSD and LTC in April	Annual training was added for LTC and MSD in April and will be done again at next annual training in January 2025 with HCS.			Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	End of Q4	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Supervisor Name: Christine Rattray	**PQI ModivCare Focus**	**N**	**New**	On tracking and trending of PQI cases as well as a review of grievances, we note a substantial number of C1 / C2 cases and member complaints related to missed rides.	Missed rides to Dialysis continue to be a focus of investigation and collaboration with Modivcare along with AAH CM dept	Missed rides to Dialysis continue to be a focus of investigation and collaboration with Modivcare along with AAH CM dept, this continues to be a challenging population to provide transportation for; therefore, close collaboration will continue to ensure optimal results.			Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	End of Q4	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title: Sr. QI Nurse Specialist Name: Kathy Ebido	**Facility Site Review (FSR) Continuation**	**N**	**Continued**	100% of corrective action plans for periodic (full-scope) site reviews (FSR/MRR) are received within 30 days and closed within 90 days of FSR/MRR Report. CAP closure do not exceed 120 days from FSR/MRR Report.	8 CAPs (80%) received within 30 days, 10 CAPs (100%) closed within 90 days.	11 CAPs (85%) received within 30 days, 13 CAPs (100%) closed within 90 days. There are 2 open CAPs active and pending closure as of 6/30/24.			Access to Care Sub-Committee Quality Improvement Health Equity Committee	End of Q4	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Supervisor Name: Christine Rattray	**Inter-rater Reliability (IRR) Continuation-Annual**	**N**	**Continued**	IRR is performed annually to ensure >/=90% IRR consistency and accuracy of review criteria applied by all clinical reviewers - physicians and non-physicians - who are responsible for conducting clinical reviews and to act on improvement opportunities identified through this monitoring.	IRR was completed in February 2024 with passing scores for RN and MD reviewers. Next IRR planned for Q1 2025	IRR was completed in February 2024 with passing scores for RN and MD reviewers. Next IRR planned for Q1 2025			Internal Quality Improvement Committee	12/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. QI Nurse Name: Kathy Ebido	**Skilled Nursing Facility/Long Term Care (SNF/LTC) Quality Monitoring**	**N**	**New**	Develop quality monitoring tools for SNF/LTC to meet APL 23-004 SNF/LTC Benefit Standardization: 1) Obtain 100% of the SNF attestation by7/1/24. 2) Develop site audit tool for SNF and SubAcute and visit low performing sites (as needed) by 9/1/2024. 3) Monitor quality measures (i.e. HEDIS/MCAS) once programmed by Analytics by June 30, 2024.	As of 3/18/2024, 52 (52%) attestations were received out of 100 SNF sites.	As of 6/26/2024, 53 (56%) attestations were received out of 95 SNF sites. Ongoing monitoring of CDPH Cal Health database for deficiencies and complaints. Ongoing monitoring of CMS star ratings.			Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2024	
Member Experience													
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title: QI Specialist Name: Tanisha Shepard	**CG-CAHPS Survey Continuation (Quarterly)**	**N**	**Continued**	Ensure that quarterly survey questions align with DMHC timely access and language requirements to evaluate member clinical & group satisfaction/experience with Timely Access Standards - Office Wait Time, Call Return Time, Time to Answer Call. To ensure that the survey results are actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. *Starting Q3 2022, the compliance threshold goal was changed from 80% to 70% (with a stretch goal of 80%) for Call Return Time and Time to Answer Call. In Office Wait Time goal remains 80% for 2023.	**Call Return Time** 4th Quarter 2023 Numerator: 1,145 Denominator: 1,522 Compliance Rate: 75.2% Goal Met: Y Gap to goal: 0% **In Office Wait Time** 4th Quarter 2023 Numerator: 2,920 Denominator: 3,172 Compliance Rate: 92% Goal Met: Y Gap to goal: 0% **Time to Answer Call** 4th Quarter 2023 Numerator: 1,781 Denominator: 2,468 Compliance Rate: 72.2% Goal Met: Y Gap to goal: 0%	**Call Return Time** 1st Quarter 2024 Numerator: 1,229 Denominator: 1,659 Compliance Rate: 74.1% Goal Met: Y Gap to goal: 0% **In Office Wait Time** 1st Quarter 2024 Numerator: 3,026 Denominator: 3,297 Compliance Rate: 91.8% Goal Met: Y Gap to goal: 0% **Time to Answer Call** 1st Quarter 2024 Numerator: 1,745 Denominator: 2,440 Compliance Rate: 71.5% Goal Met: Y Gap to goal: 0%			Access to Care Sub-Committee Quality Improvement Health Equity Committee	3/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title: QI Specialist Name: Tanisha Shepard	**Provider Satisfaction Survey Continuation (Annual)**	**N**	**Continued**	Annually, timely completion of measures for provider and staff satisfaction/experience with the health plan and department services. To ensure that the survey meets NCQA requirements and is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. **Fielding Oct - December 2022.** Goal: 88.3% (2% increase from MY 2022)	Results received Feb, 2024. Overall Satisfaction Plan Rating 78.4% down by 7.9% points from 2022 - 86.3%. Met or significantly higher scores compared to benchmark scores. Results shared with COO/CEO for review and evaluation of next steps. Meeting with SPH to discuss survey results on April18, 2024	Met with SPH on April 18, 2024, unable to discuss unable to discuss about survey results as representative for the survey was out. SPH will send out meeting invite to discuss on Survey Results. Provider Services will be presenting data at the Q3 2023 A&A Sub-Committee.			Access to Care Sub-Committee Quality Improvement Health Equity Committee	01/30/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title: QI Specialist Name: Fiona Quan	**CAHPS 5.1 (Member Satisfaction Survey) Continuation (Annual)**	**N**	**Continued**	Measures member experience with health plan and affiliated providers. To ensure that the annual survey aligns with NCQA standards and is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities for member experience. **Fielding: Feb. - May of 2023.** Goal TBD.	MY2023 Survey Results still in pending from SPH	From SPH JOM on 04.18.24. Survey is currently in fielding. Feb - May 2024			Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/30/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title: QI Specialist Name: Tanisha Shepard	**After Hours Care Continuation (Annual)**	**N**	**Continued**	Audits provide after-hours protocols (Emergency Instructions/Access to Provider) and availability according to DMHC/NCQA methodology/standards for PCP, Spec. and BH providers. To ensure that the survey is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. Maintains 80% compliance rate for After Hour Survey. Fielding Oct - Nov 2022	**Primary Care Providers** Numerator: 68 Denominator: 69 Compliance Rate: 98.6% Goal Met: Y Goal: 80% **Specialists** Numerator: 166 Denominator: 178 Compliance Rate: 93.3% Goal Met: Y Goal: 80% **Behavioral Health** Numerator: 65 Denominator: 78 Compliance Rate: 83.3% Goal Met: Y Goal: 80%	On Track: According to the SPH JOM on April, 2024.			Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/30/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title:QI Specialist Name: Fiona Quan	**Initial Pre-Natal Visits Continuation (Annual)**	**N**	**Continued**	To ensure that the survey aligns with DHCS requirements and is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities related to OB/GYN appts offered according to Timely Access Standards. Reach or exceed 75% compliance rate for First Prenatal appointment. **Fielding Sep - Nov. 2022** **HEDIS Prenatal visits: 85.36 baseline to 85.40 admin (MPL) - increase by 3%**	MY2023 Survey Results for were presented at the March 6, 2024 A&A Sub Committee	On Track			Access to Care Sub-Committee Quality Improvement Health Equity Committee	3/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Specialist Name: Fiona Quan	**PAAS (Provider Appt Availability Survey) Continuation (Annual)**	**N**	**Continued**	To ensure that the annual survey aligns with DMHC requirements to assess appointment availability is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. Maintains a 75% compliance rate for urgent and non-urgent appointment. Fielding Aug - Dec. 2022	MY2023 Survey Result pending from QMetrics	On Track: Kick-Off with QMetric on June 5, 2024. First year outsourcing PAAS.			Access to Care Sub-Committee Quality Improvement Health Equity Committee	End of Q4	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Specialist Name: Fiona Quan	**Provider Visits and Training**	**N**	**New**	Conduct at least 2 site visits per quarter to provider offices/clinics and provide training on timely access standards through the end of 2024.	**1/12/24 - Training:** Robert Phillips (WOHC), Amit Pabla (AXIS), Shanna Cruz (Lifelong), Mayra Casirejon and Tania Martinez (La Clinica) **1/19/24 - Training:** Zenaida Aguilera (La Clinica), Danae Rodrigues (Lifelong), Isela Diaz and Ivonne Spedalieri (TVHC) **3/19/24** - Onsite Visit: AmCare Medical Group	4/1/24 - Virtual Visit: La Clinica 5/30/24 - Virtual Visit: BACH 5/31/24 - Virtual Visit: La Clinica			Access to Care Sub-Committee Quality Improvement Health Equity Committee	End of Q5	
Health Education													

2024 Quality Improvement & Health Equity (QIHE) Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification	Q1, 2024	Q2, 2024	Q3, 2024	Q4, 2024	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues (if applicable)
Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	N/A	**Annual QIHE Program Evaluation**	**Y**	**New**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee (aka Member Advisory Committee)	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) drafted in collaboration with other departments. Finalized documents will be presented to QIHEC in April 2024.	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) were reviewed with the Alliance Board Chair and included as consent items to the Board in June 2024.	A high level summary of the QIHE Trilogy documents were presented to the Board by the CMO in July 2024. In addition, a presentation was given for all Trilogy documents (QIHE, UM, CM) at the HCS All Staff meeting in July 2024.		All Sub-Committees and QIHEC	Q2 2024	Incorporated BH and SNF/LTC Quality Monitoring
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Health Education Operations**	**N**	**Continued**	1.1 - Maintain a 95% fulfillment rate for health education material requests and referrals within 10 business days for threshold languages and within 15 business days for translated materials through the end of 2024. 1.3 - Support coordination and logistics of Community Advisory Committee meetings, monthly and quarterly team meetings through the end of 2024.	89.7% of 117 materials requests fulfilled within 10 business days. Average of 6.1 business days.	98.3% of 121 materials requests fulfilled within 10 calendar days. Average fulfillment of 3.7 days.			Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	12/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Health Education Programs**	**N**	**Continued**	2.1 - Implement the Health Education Intake form and enable reporting on Health Education activities by Q2 of 2024.	Not started	Draft developed. Refining with stakeholders. In progress.			Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	6/30/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Health Education Programs**	**N**	**New**	2.2 - Develop one new health education initiative by the end of 2024.	Reviewed health education programming and contracts with Compliance. Identified gaps in contractual relationships. Developed research into maternal mental health peer support coaching and inequities to support program development.	Scoping maternal mental health peer supports; exploring potential for CHW reimbursement and tie to disease management equity efforts. Met with 18 reasons to explore offerings. Exploring proposal to develop a tailored Black Diabetes Prevention Program curriculum and program.			Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	6/30/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Health Education Programs**	**Y**	**New**	2.3 - Support CBOs in the training (eligibility and PAVE enrollment) of community Doulas who will contract with the Alliance to expand our provider network by 125% by Q3 2024. 2.4 - Develop and implement a maternal and child health equity program utilizing Doulas by the end of 2024.	Completed stakeholder engagement listening session with Doula CBOs and ACPHD. Developed Doula RFQ. Developed Doula initial and ongoing training.	Interviewed Doula RFQ finalists and selected a CBO. Contract development in progress.			Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	12/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Disease Management**	**Y**	**New**	3.1 - Collaboratively develop a strategy to support Disease Management populations with closing care gaps and addressing inequities by the end of 2024.	Reviewing disease management disparities data and building a disease management health equity data index. Refining current reports to include information on vulnerable populations (e.g. risk criteria for perinatal population).	Continuing to review disease management disparities data and incorporating feedback from QI and chronic disease management workgroups. Identifying a target population of members missing care gaps. Supporting QI blood pressure PDSA.			Utilization Management/Quality Improvement and Health Equity Committee	12/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Disease Management**	**N**	**New**	3.2 - Develop a comprehensive Disease Management dashboard that can track all applicable measures. Each DM program will utilize the dashboard to find and analyze 75% of the data they will require for reporting by the end of 2024.	Submitted disease management population dashboard request. Working with CM and analytics to refine data requests and develop a comprehensive dashboard that can be utilized across departments.	Disease management population dashboard went live 6/2024. Reviewing dashboard, refining data visualizations, and report outs.			Utilization Management/Quality Improvement and Health Equity Committee	12/31/2024	
Cultural and Linguistic Services													
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Member Cultural and Linguistic Assessment**	**Y**	**Continued**	Assess the cultural and linguistic needs of plan enrollees.	1. CLS needs assessed at 01/24/2024 CLSS Meeting.	1. CLS needs assessed at 04/24/2024 CLSS Meeting.			Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2024	
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Language Assistance Services**	**Y**	**Continued**	Reach or exceed an average fulfillment rate of ninety-five percent (95%) or more for in-person, video, and telephonic interpreter services.	1. Q1- 97% fulfillment rate for all modalities.	1. Q2- 98% fulfillment rate for all modalities.			Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2024	
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Language Assistance Services**	**Y**	**New**	Ensure tracking of interpreter services utilization for behavioral health services.	1. Met with vendor to discuss options for tracking behavioral health services provided via on-demand telephonic and in-person interpreter services.	1. Reviewed options presented by vendor to track behavioral health services and utilization of interpreter services. Awaiting for vendor confirmation on portal/reporting capabilities to update the category/type of appointment field.			Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2024	
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Provider Language Capacity (Member Satisfaction)**	**Y**	**Continued**	Based on the Member CG-CAHPS Survey 81% of adult members and 92% of child members who need interpreter services will report receiving a non-family qualified interpreter through their doctor's office or health plan.	1. Planned implementation Q2.	1. Pending Q2 data.			Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2024	
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Language Assistance Services (Member Satisfaction)**	**Y**	**New**	Based on the Timely Access Requirement (TAR) Survey results, develop and implement action steps, as needed, to address member's satisfaction with: a)scheduling appointments with an interpreter; b)availability of interpreters who speak member's preferred spoken language; c)knowledge, skill, and quality of interpreters.	1. Planned implementation Q2.	1. Mail Drop to Alliance members on 04/01/2024. 2. Data Collection ended on 04/19/2024. 3. Received raw data files on 04/24/2024. 4. Scrubbed raw data files and developed final report. 5. Submitted the Adult TAR Survey Report to DMHC via Regulatory Affairs on 04/30/2024.			Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	6/30/2024	
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Provider Language Capacity and Race and/or Ethnicity (Provider Network)**	**Y**	**Continued**	Complete NCQA NET 1 A Analysis of Capacity of Alliance Provider Network to meet Cultural and Linguistic needs of members.	1. Submitted a new analytics report to pull provider race/ethnicity from credentialing process for active providers in 2023. 2. Started to pull data and reports.	1. Completed gathering of data and reports. 2. Started on draft Net 1 A Report. 3. Submitted to NCQA consultants and received feedback. 4. Assessed feedback and gap in reporting. 5. Updated report to fill gap in reporting/data. 6. Presented/shared Net 1 A Report at QIHEC and received approval. 7. Resubmitted Net 1 A Report to NCQA for review with updated reporting/data.			Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	4/1/2024	
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Community Engagement: Community Advisory Committee (CAC)**	**Y**	**Continued**	Ensure implementation of DHCS 2024 Contract updates to CAC and community engagement.	1. Developed CAC Selection Committee proposal. 2. Started planning for CAC Selection Committee recruitment. 3. Completed CAC Demographic Survey.	1. CAC Selection Committee Proposal approved. 2. Started recruitment for CAC Selection Committee through targeted outreach (i.e., flyer in provider communication and specific contacts to meet required representation). 3. Updated CAC Charter to include CAC Selection Committee as a Committee. 5. Developed CAC Selection Committee and presented to the BOG for review/approval. 6. Finalized CAC Selection members and started planning for initial meeting.			Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	6/30/2024	
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Potential Quality Issues-Quality of Language (PQI-QOL)**	**Y**	**New**	Monitor, evaluate, and conduct appropriate interventions for PQI-QOLs with a closure rate of 95% or more within 30 business days.	1. Q1-96% closure rate.	1. Q2-86% closure rate.			Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	6/30/2024	

HEDIS Results

Farashta Zainal -Quality Improvement Manager

ALAMEDA Alliance FOR HEALTH

HEDIS Performance

ALAMEDA Alliance FOR HEALTH

2023 Final HEDIS Rates

		2022		2023							Benchmarks		
P4P	Measure Description	PY Admin Rate	PY Hybrid Rate	EP	Num	My 2023 Variance from PY	Admin Rates	Hybrid Rates	Above MPL	Number to Treat to MPL	MPL	75th Pctl	90th Pctl
	Behavioral Health												
N	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30 Day	29.82%		1,784	694	9.08%	38.90%		Y	0	36.34%	42.67%	53.44%
Y	Follow-Up After Emergency Department Visit for Mental Illness - 30 Day	49.03%		1,675	916	5.66%	54.69%		N	4	54.87%	64.29%	73.26%
	Disease Management												
N	Asthma Medication Ratio	74.71%		2,138	1,494	-4.84%	69.88%		Y	0	65.61%	70.82%	75.92%
N	Controlling High Blood Pressure	41.77%	54.74%	16,993	8,301	7.08%	48.85%	65.21%	Y	2,118	61.31%	67.27%	72.22%
Y	HbA1c Poor Control (>9.0%)	37.06%	29.20%	14,395	4,673	4.59%	32.46%	30.37%	Y	0	37.96%	33.45%	29.44%

2023 Final HEDIS Rates

		2022		2023							Benchmarks		
P4P	Measure Description	PY Admin Rate	PY Hybrid Rate	EP	Num	My 2023 Variance from PY	Admin Rate	Hybrid Rates	Above MPL	Number to Treat to MPL	MPL	75th Pctl	90th Pctl
						Well Child							
Y	Childhood Immunization Status - Combo 10	45.20%	52.80%	3,584	1,478	-3.96%	41.24%	45.74%	Y	0	30.90%	37.64%	45.26%
Y	Immunizations for Adolescents - Combo 2	49.36%	50.61%	4,603	2,268	-0.09%	49.27%	47.69%	Y	0	34.31%	40.88%	48.80%
N	Developmental Screening in the First Three Years of Life Total	44.24%		8,538	4,644	10.19%	54.39%		Y	0	34.70%	51.60%	
Y	Lead Screening in Children	57.52%	60.58%	3,593	2,184	3.26%	60.78%	61.31%	N	73	62.79%	70.07%	79.26%
N	Topical Fluoride for Children Rate1 - dental or oral health services	12.18%		85,107	12,026	1.95%	14.13%		N	4,400	19.30%	23.30%	
Y	Well-Child Visits in the First 15 Months of Life - 6 or More Visits	46.56%		1,418	832	12.12%	58.67%		Y	0	58.38%	63.34%	68.09%
Y	Well-Child Visits for Age 15 Months to 30 Months - Two or More Visits	69.01%		3,404	2,520	5.02%	74.03%		Y	0	66.76%	71.35%	77.78%
Y	Child and Adolescent Well-Care Visits	49.69%		81,658	45,973	6.61%	56.30%		Y	0	48.07%	55.08%	61.15%
						Women's Health							
Y	Breast Cancer Screening - ECDS	56.08%		16,298	9,712	3.51%	59.59%		Y	0	52.60%	57.48%	62.67%
Y	Cervical Cancer Screening	52.44%	53.83%	55,469	32,353	5.89%	58.33%	60.58%	Y	0	57.11%	61.80%	66.48%
N	Chlamydia Screening in Women	64.14%		7,388	4,960	3.00%	67.14%		Y	0	56.04%	62.90%	67.39%
N	Timeliness of Prenatal Care	85.36%	87.50%	2,482	2,132	0.53%	85.90%	90.87%	Y	0	84.23%	88.33%	91.07%
N	Timeliness of Postpartum Care	81.72%	85.42%	2,482	2,153	5.03%	86.74%	89.95%	Y	0	78.10%	82.00%	84.59%

2023 Quality Improvement Projects

Projects with Impact to Rates

- Provider
  - Education: webinars, 1:1 meetings and measure highlight tools
  - Collaboration – mobile mammography, birthday card mailing, member/provider incentives
- Member
  - Outreach – outreach calls, mailing and text
  - Incentives
- Data and Reporting
  - Other coverage exclusions
  - Expanded year-round record retrieval
  - Care gap reports

2024 HEDIS Rates as of July

		2023		2024					Benchmarks	
P4P	Measure Description	PY Admin Rate	PY Hybrid Rate	EP	Num	Rate	Above MPL	Number to Treat to MPL	MPL	90th Pctl
	Behavioral Health									
N	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30 Day	38.90%		1,229	350	28.48%	N	97	36.34%	53.44%
Y	Follow-Up After Emergency Department Visit for Mental Illness - 30 Day	54.69%		1,112	218	19.60%	N	393	54.87%	73.26%
	Disease Management									
N	Asthma Medication Ratio	69.88%		1,333	903	67.74%	Y	0	65.61%	75.92%
Y	Controlling High Blood Pressure	48.85%	65.21%	20,450	8,643	42.26%	N	3,895	61.31%	72.22%
Y	Glycemic Status >9.0%	32.06%		16,888	8,318	49.25%	N	1,908	37.96%	29.44%
Y	Colorectal Cancer Screening - ECDS	46.46%		41,738	15,039	36.03%	Y			

2024 HEDIS Rates as of July

		2023		2024					Benchmarks	
P4P	Measure Description	PY Admin Rate	PY Hybrid Rate	EP	Num	Rate	Above MPL	Number to Treat to MPL	MPL	90th Pctl
Well Child										
Y	Childhood Immunization Status - Combo 10	41.24%	45.74%	3,115	996	31.97%	Y	0	30.90%	45.26%
Y	Immunizations for Adolescents - Combo 2	49.27%	47.69%	3,910	1,617	41.36%	Y	0	34.31%	48.80%
Y	Developmental Screening in the First Three Years of Life Total	54.39%		7,339	3,693	50.32%	Y	0	34.70%	
Y	Lead Screening in Children	60.78%	61.31%	3,125	1,983	63.46%	Y	0	62.79%	79.26%
Y	Topical Fluoride for Children Rate1 - dental or oral health services	14.13%		97,856	617	0.63%	N	18,270	19.30%	
Y	Well-Child Visits in the First 15 Months of Life - 6 or More Visits	58.67%		1,277	583	45.65%	N	163	58.38%	68.09%
Y	Well-Child Visits for Age 15 Months to 30 Months - Two or More Visits	74.03%		2,878	2,126	73.87%	Y	0	66.76%	77.78%
Y	Child and Adolescent Well-Care Visits	56.30%		94,398	24,776	26.25%	N	20,602	48.07%	61.15%
Women's Health										
Y	Breast Cancer Screening - ECDS	59.59%		16,982	8,842	52.07%	N	91	52.60%	62.67%
Y	Cervical Cancer Screening	58.33%	60.58%	80,489	33,422	41.52%	N	12,546	57.11%	66.48%
N	Chlamydia Screening in Women	67.14%		6,530	3,729	57.11%	Y	0	56.04%	67.39%
N	Timeliness of Prenatal Care	85.90%	90.87%	1,837	1,580	86.01%	Y	0	84.23%	91.07%
N	Timeliness of Postpartum Care	86.74%	89.95%	1,837	1,434	78.06%	N	1	78.10%	84.59%

New Projects

Continuing projects from 2023

New in 2024

- Well child campaign
- Immunization campaign
- Focus on Anthem and Adult Expansion
- Working with Pharmacy to identify care gaps for Asthma, Diabetes and Hypertension
- Utilizing CHWs to close care gaps

Population Health & Equity Update

Gil Duran- Manager, Population Health and Equity

ALAMEDA Alliance FOR HEALTH

2024 Population Health & Equity (PHE) Workplan Update

Gil Duran

Manager, Population Health & Equity

ALAMEDA Alliance FOR HEALTH

2024 PHE Workplan Update

Meaningful participation in CHA/CHIP and collaborative shared goals with Alameda County and City of Berkeley

- Continued meetings with Alameda County Health, City of Berkeley, and Kaiser.
- Participated in Alameda County CHIP Kickoff Meeting on 5/1 with three Alliance CAC members also in attendance.
- Discussing partnerships with two Alameda County CHIP signature programs, Immunization Program and EmbraceHer.
- Participating in Alameda County CHIP focus area workgroup meetings and CHNA planning meetings.
- The Alliance is planning to assist with Alameda County and City of Berkeley CHA efforts this summer through recruitment for community member surveys and/or focus groups and possible data sharing.

Alameda County Health

CHIP Priority Program Areas

ACCESS TO CARE

- Early screening for chronic conditions: diabetes, heart diseases, STIs, immunization
- Preventative services for pregnant and parenting individuals
- Early childhood screening services and health promotion

PROMOTE ECONOMIC SECURITY & OPPORTUNITIES

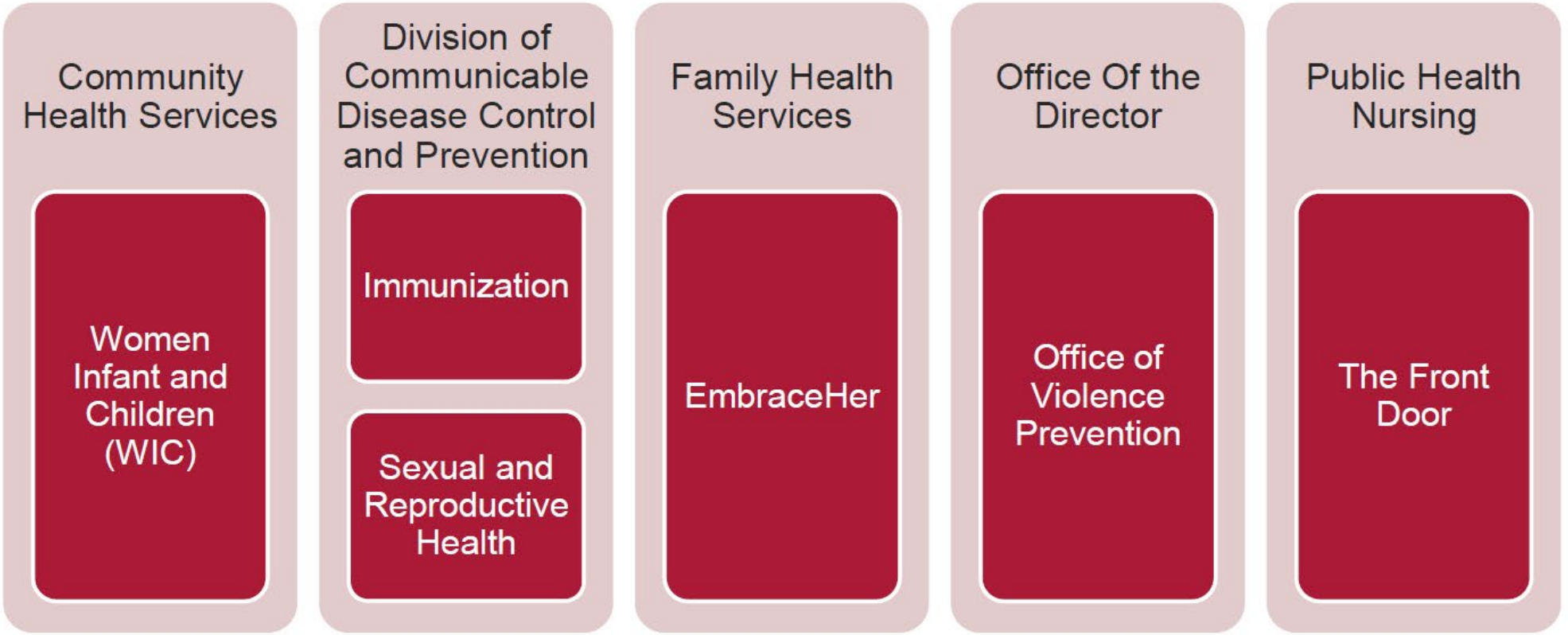
- Combat hunger and food insecurity.
- Promote guaranteed basic income among pregnant and parenting individuals
- Connect people to safety net services and programs

COMMUNITIES AND INDIVIDUALS FREE FROM VIOLENCE

- Data collection: Define the nature and scope of the violence problem.
- Narrative change: Understand and convey why violence occurs, who it affects, define risk and protective factors
- Scaling up best and promising practices: researching prevention and intervention strategies.
- Policy Advocacy: Promote and support community power and leadership efforts

Alameda County Health

CHIP Signature Pilot Programs



2024 PHE Workplan Update

Expand PHM monitoring and evaluation processes

- PHM DHCS-required Key Performance Indicators (KPIs) submissions were put on hold from February 2024 until further notice. DHCS collected feedback from MCPs about the KPIs and will be reviewing the specifications.
- Added enhancements to HEDIS dashboards to analyze and track DMHC Health Equity measures by race/ethnicity.

PHM KPIs

Utilization PHM KPIs

1. Members Utilizing Emergency Department Care More Than Primary Care
2. Members Engaged in Primary Care
3. Members Not Engaged in Ambulatory Care

Care Management PHM KPIs

4. Percentage of Eligible Members Enrolled in Complex Care Management
   - **Rate A**: CCM enrollment among all eligible members
   - **Rate B**: CCM enrollment among eligible members who were not already enrolled during the previous reporting period
5. Care Management for High-Risk Members after Discharge

DMHC HEQMS – MY2024

HEQMS Measure	Both stratified and aggregate
Colorectal Cancer Screening*	Both
Breast Cancer Screening	Both
Glycemic Status Assessment for Patients with Diabetes	Both
Controlling High Blood Pressure	Both
Asthma Medication Ratio	Both
Prenatal and Postpartum Care	Both
Childhood Immunization Status	Both
Well-Child Visits in the First 30 Months of Life	Both
Child and Adolescent Well-Care Visits	Both
Immunizations for Adolescents	Both

HEQMS Measure	Aggregate only
Depression Screening and Follow-Up for Adolescents and Adults*	Aggregate only
Plan All-Cause Readmissions*	Aggregate only
CAHPS Health Plan Survey: Getting Needed Care	Aggregate only

*HEDIS measures not held to MPL by DHCS for MY2024

2024 PHE Workplan Update

Depression Disease Management - ***BirthWise Wellbeing*** – Launched 5-14-2024

- Alliance members who are pregnant or were pregnant in the past 12 months may be eligible for the following services:
  - → **Assessment** for case management programs, including but not limited to Enhanced Care Management (ECM).
  - → **Referrals** and assistance connecting to behavioral health services, including providers in the Alliance network serving mild to moderate concerns, and the local County Mental Health plan providers: Alameda County Behavioral Health for severe mental health and CenterPoint for substance use concerns.
  - → **Health education** on pregnancy, baby care, mental health, and self-care.
  - → **Care coordination** for doula services, breastfeeding consults, and other pregnancy and postpartum related services based on eligibility.

2024 PHE Workplan Update

Depression Disease Management
- ***BirthWise Wellbeing*** –
Launched 5-14-2024

- Members who meet criteria are sent the BirthWise Wellbeing flyer, which describes the program and services and explains how to opt-in to the program.

Alameda Alliance for Health
BirthWise Wellbeing

Pregnancy, baby, and your mental health

Alameda Alliance for Health (Alliance) and your doctor are your partners in your health. Do you have questions about your pregnancy, baby, or mental health? You can contact your doctor or reach out to us. The Alliance offers a ***BirthWise Wellbeing Program*** that can help connect you to the support you need.

You are prepared for dirty diapers, loads of laundry, and late-night feedings, but are you prepared for the possibility of anxiety or depression? Feeling down or anxious is common during pregnancy and in the first year after birth.

These feelings and thoughts can go away on their own. Sometimes these feelings are more serious and stay longer. The good news is they can be treated and get better with help.

YOU OR YOUR PARTNER MAY HAVE:

- Changes in your eating or sleeping habits
- Difficulty caring for yourself or your baby
- Extreme mood swings
- Feelings of anger, worry, or sadness
- Less interest in things you used to enjoy
- Upsetting thoughts that don't go away

If this sounds like you, please get help right away. You are not alone.

Access & Availability Update

Loc Tran- Manager, Access to Care

ALAMEDA Alliance FOR HEALTH

Q3 2024 Geo-Access Time & Distance Grid

	Distance					Time		
Provider Type	**Anticipated Memebers Zip Code**	**Anticipated Member City**	**Provider City**	**Provider Zip Code**	**Met/Not Met**	**Anticipated Members Zip Code**	**Anticipated Member City**	**Met/Not Met**
SPEC-Endocrinology - Ped*	94514; 94505; 94538; 94539; 94550; 94586; 95377; 95391	Byron; Discovery Bay; Fremont; Livermore; Sunol; Tracy; Mountain House	NA	Discovery Bay; Livermore; Pleasanton	Not Met	94505	Discovery Bay	Not Met
SPEC-Ent Oto - Adult	94550; 95377; 95391	Livermore; Tracy; Mountain House	NA	NA	Not Met	95377	Tracy	Not Met
SPEC-Ent Oto - Ped	94550; 94586; 95377; 95391	Livermore; Sunol; Tracy; Mountain House	NA	NA	Not Met	95377	Tracy	Not Met
SPEC-Hematology - Ped	94514; 94505; 94550; 94551; 94566; 95377; 95391	Byron; Discovery Bay; Livermore; Pleasanton; Tracy; Mountain House	NA	NA	Not Met	95377; 95391	Tracy; Mountain House	Not Met
SPEC-HIV AIDS ID - Ped	94514; 94505; 94538; 94539; 94550; 94586; 95377; 95391	Byron; Discovery Bay; Fremont; Livermore; Sunol; Tracy; Mountain House	NA	NA	Not Met	94505	Discovery Bay	Not Met
SPEC-Nephrology - Ped	94505; 94514; 94546; 94552; 94568; 94536; 94537; 94538; 94539; 94555; 94540; 94541; 94542; 94543; 94544; 94545; 94557; 94550; 94551; 94566; 94588; 94577; 94578; 94579; 94580; 94586; 95377; 95391; 94587	Byron; Discovery Bay; Castro Valley; Dublin; Fremont; Hayward; Livermore; Pleasanton; San Leandro; San Lorenzo; Sunol; Tracy; Mountain House; Union City	NA	Dublin	Not Met	94514; 94505; 94550; 94551; 94566; 94568; 94586; 95377; 95391	Byron; Discovery Bay; Dublin; Livermore; Pleasanton; Sunol; Tracy, Mountain House	Not Met
SPEC-Oncology - Ped	94505; 94514; 94550; 94551; 94566; 94586; 95377; 95391	Byron; Discovery Bay; Livermore; Pleasanton; Sunol; Tracy; Mountain House	NA	NA	Not Met	95377; 95391	Tracy; Mountain House	Not Met
SPEC-Ophtalmology - Adult	94505; 94514; 94550; 95377; 95391	Byron; Discovery Bay; Livermore; Tracy; Mountain House	NA	NA	Not Met	95377	Tracy	Not Met
SPEC-Ophtalmology - Ped	94505; 94514; 94550; 95377; 95391	Byron; Discovery Bay; Livermore; Tracy; Mountain House	NA	NA	Not Met	95377	Tracy	Not Met
SPEC-Phys Med RH - Ped	94514; 94505; 94550;94586; 95377; 95391	Byron; Discovery Bay; Livermore; Sunol; Tracy; Mountain House	NA	NA	Not Met	94505	Discovery Bay	Not Met
SPEC-Pulmunology - Ped	94514; 94505; 94550; 95377; 94586; 95391	Byron; Discovery Bay; Livermore; Sunol; Tracy; Mountain House	NA	NA	Not Met	94505	Discovery Bay	Not Met

QIHEC Meeting Presented: 8/16/24
Data Gathered from: July 2024 Network Adequacy Report

Provider Name	Address	NPI	Network	Provider PR Key	Capacity	Membership	%	Action	FYI- Providers at 80+% (Outreach)	Close Auto Assignment	QI Comments
An Tan Pham, MD	600 International Boulevard Suite 102, Oakland, CA 94606	1205996048	CFMG	5318	2000	1755	87.75%		**Provider set as "established patients only"**		N/A
Carol Elizabeth Glann, MD	3055 MacArthur Boulevard, Oakland, CA 94602	1760568117	CFMG	5612	2000	1782	89.10%		**Approaching Capacity,Provider outreach needed**		Time to Answer Call
Esteban Daniel Lovato, MD	3022 International Boulevard Suite 312, Oakland, CA 94601	1376610923	AAH	502	2000	1616	80.80%		**Approaching Capacity,Provider outreach needed**		Call Return Time 3 Non-Urgent Appt 1 Urgent Appt
Robert D Watts, MD	3001 High Street Suite D, Oakland, CA 94619	1427000926	CFMG	5098	2000	1698	84.90%		**Approaching Capacity,Provider outreach needed**		N/A
Gautam Pareek, MD	3755 Beacon Avenue, Fremont, CA 94538	1386756427	AAH	516	2721	2427	89.20%		**Approaching Capacity,Provider outreach needed**		4 Call Return Time 3 Time to Answer Call

Yellow= Providers over 80%

PQI Update

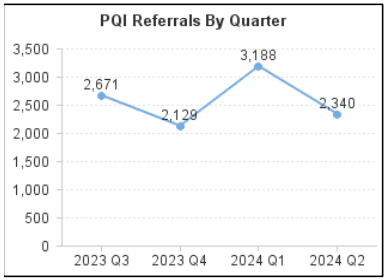
Dr. Sanjay Bhatt- Senior Medical Director
Michelle Stott- Senior Director, Quality Improvement

ALAMEDA Alliance FOR HEALTH

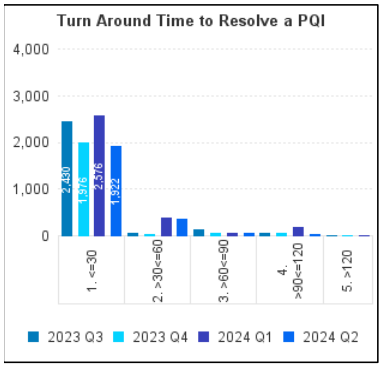
PQI Dashboard

2024 Q2

Run Date: 07/22/2024

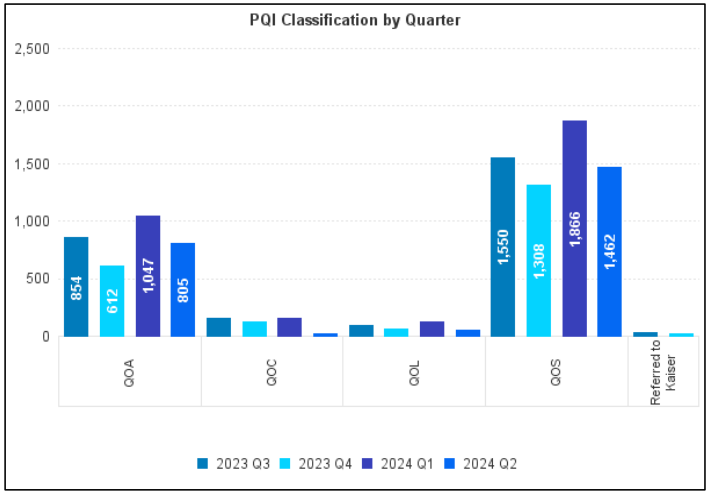


Quarter	# PQIs
2023 Q3	2671
2023 Q4	2129
2024 Q1	3188
2024 Q2	2340
Total:	**10328**

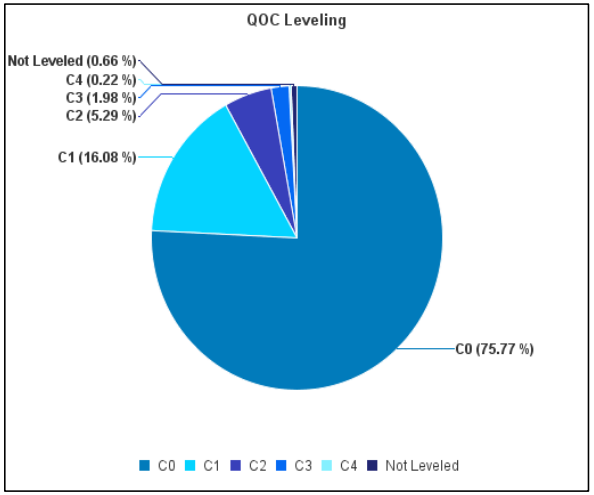


PQIs Still Open by Quarter Received

Quarter	# PQIs
2023 Q4	1
2024 Q1	14
2024 Q2	206
Total:	**221**



	2023 Q3	2023 Q4	2024 Q1	2024 Q2	Total
QOA	854	612	1047	805	**3318**
QOC	152	124	153	25	**454**
QOL	88	64	122	48	**322**
QOS	1550	1308	1866	1462	**6186**
Referred to Kaiser	27	21			**48**
Total:	**2671**	**2129**	**3188**	**2340**	**10328**



	2023 Q3	2023 Q4	2024 Q1	2024 Q2	Total
C0	105	101	123	15	**344**
C1	29	19	16	9	**73**
C2	13	3	7	1	**24**
C3	3	1	5		**9**
C4	1				**1**
Not Leveled	1		2		**3**
Total:	**152**	**124**	**153**	**25**	**454**

Name of Report: Clinical Reviewer PQI Case File Audit Report for Quality-of-Service Issues				
Reported by: Christine Clark Rattray, BSN RN QI Clinical Supervisor			**Date:** 7/10/2024	
Reporting period: Q4 2023 – Q1 2024				
Purpose: To ensure accurate and appropriate clinical documentation, monitoring, and oversight of Quality-of-Service (QOS) PQI case files. Quality of Access (QOA) cases are referred to the Access & Availability team while Quality of Language (QOL) cases are referred to the Cultural and Linguistics team for evaluation and appropriate intervention. All Quality-of-Care cases are audited by the Senior Medical Director of Quality or designated Medical Director at weekly case review meetings.				
Results	**Q2 2023** **Case Files Reviewed Volume** QOS cases = 55 **Compliance Rate: 100%** Goal: ≥90% Goal exceeded **4/4 RN Reviewers**	**Q3 2023** **Case Files Reviewed Volume** QOS cases = 45 **Compliance Rate: 100%** Goal: ≥90% Goal exceeded **4/4 RN Reviewers**	**Q4 2023** **Case Files Reviewed Volume** QOS cases = 60 **Compliance Rate: 100%** Goal: ≥90% Goal exceeded **4/4 RN Reviewers**	**Q1 2024** **Case Files Reviewed Volume** QOS cases = 60 **Compliance Rate: 98%** Goal: ≥90% Goal exceeded **4/4 RN Reviewers**
Oversight Methodology	QI Clinical Supervisor or designated clinical staff audits 5 QOS PQI case files/month for each Quality Review RN. Case files are audited for accurate and appropriate documentation that includes: i. Timely review and resolution within 120 days ii. PQI type - appropriately classified iii. Assessment of problem/grievance iv. Planned investigation v. Intervention carried out according to plan vi. Evaluation/Resolution -Pass rate of ≥90% must be met. -Retraining of QI Review Nurse will be conducted for a score of less than 90%.			
Data source:	PQI Application Database			
Improvement Opportunities	No opportunities for improvement identified at this time for any RN reviewer			
Interventions for Improvement Opportunities:	Continuous auditing of Quality of Service (QOS) cases to determine compliance with established TATs and provision of refresher training where appropriate.			
Next Steps:	Ongoing Auditing of PQI case files with identification for training opportunities			

Exempt Grievance Audit Report

Q4 2023 – Q1 2024

Presented at IQIC
July 10, 2024

ALAMEDA Alliance FOR HEALTH

Overview

Purpose:

- To ensure clinical monitoring of Exempt Grievances for Potential Quality of Care, Service, Language and Access Issues per Alliance Policy and Procedure: QI-104, Potential Quality Issues.

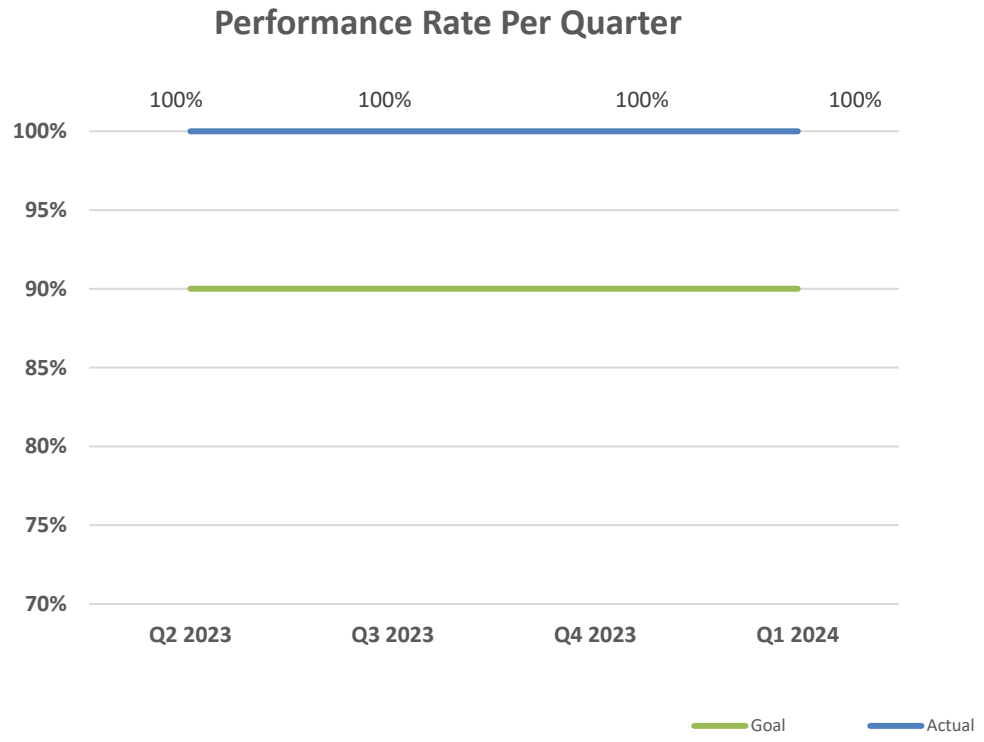
Methodology:

- Quarterly review of **100** randomly selected Exempt Grievances from the universe of all Exempt Grievances received during the reporting period. Cases are reviewed to determine if they were correctly identified for referral to the Quality Dept for investigation.
- Goal: ≥ 90% of Exempt Grievances will be correctly identified and appropriately referred to Quality for review.

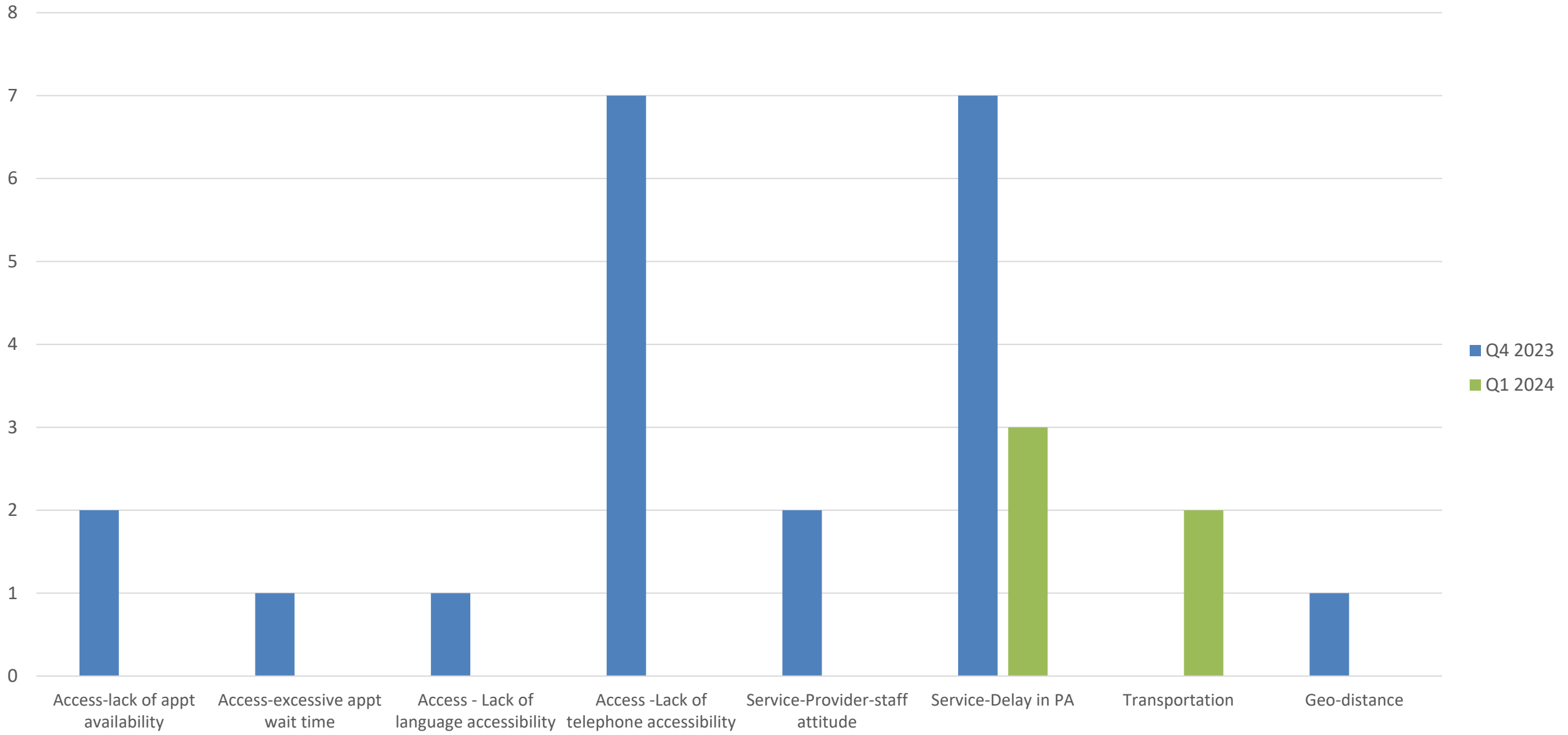
Results

Performance rates

	Q2 2023	Q3 2023	Q4 2023	Q1 2024
Numerator	100	100	100	100
Denominator	100	100	100	100
Performance Rate	100%	100%	100%	100%
Gap to Goal	NA	NA	NA	NA
Universe (n)	5352	5604	4448	7162



Exempt Grievance Categories referred as PQI
Q4 2023 & Q1 2024



Results and next steps:

- Of the subcategories identified as Exempt Grievances that were referred for PQI review, the majority of grievances referred were related to telephone access and delay in prior auths, followed by appointment availability and transportation issues.
- The goal of 90% was met successfully at a rate of 100% in the 200 randomly selected cases for Q4 2023 and Q1 2024. No areas were identified for process improvement and the current workflow will be maintained. These findings have been shared with Member Services and G&A leadership for feedback.
- Quality Improvement will continue to audit, and track and trend Exempt Grievance results at the rate of 100 cases per quarter with collaborative efforts for improvement where appropriate with Member Services and G&A.

Questions?

ALAMEDA Alliance FOR HEALTH

Potential Quality Issues (PQI) Inter-rater Reliability (IRR) Report
Reported By: Sanjay Bhatt, MD, Sr QI Medical Director | **Report Date:** 02/14/24
Reporting Period: Q1 2024

1. Purpose of Metric

To ensure the consistency of processing and outcome leveling for potential quality issues per AAH P&P QI-133

2. Methodology

Eight (8) reviewed PQIs within the PQI App are randomly selected from the universe of all PQIs and reviewed to determine if PQIs were appropriately classified with respect to PQI type and leveling during the audit period.

3. Data Source

PQI Application Listing

4. PQI Type and Leveling Guide

PQI Type	Description	Leveling	Description
QOA	Quality of Access	Quality of Care 0	C0: No QOC issue
QOS	Quality of Service	Quality of Care 1	C1: May include medical/surgical complication in the absence of negligence
QOC	Quality of Care	Quality of Care 2	C2: With potential for adverse effect or outcome
		Quality of Care 3	C3: Actual adverse effect or outcome (non-life or limb threatening)
		Quality of Care 4	C4: With significant adverse effect or outcome (life or limb threatening)

5. Goal

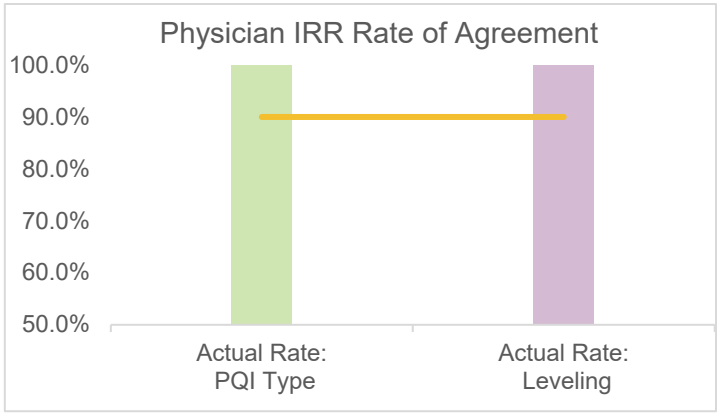
The goal is to have ≥ 90% of PQIs to be appropriately classified with respect to PQI type and leveling.

6. IRR Results

Physician IRR Result Summary			
Physician 1: Sanjay Bhatt, MD, Sr Med Director, Quality Improvement **Physician 2:** Beverly Juan, MD, Med Director, Community Health			
Case Number	**Service Request Number**	**Agreement on PQI Type**	**Agreement on Leveling**
1	1006706	Yes	Yes
2	1003855	Yes	Yes
3	1020907	Yes	Yes
4	1023694	Yes	Yes
5	1025644	Yes	Yes
6	21413	Yes	Yes
7	1142405	Yes	Yes
8	1234400	Yes	Yes

Total Number of Case Agreements on PQI Type: 8/8 = 100%

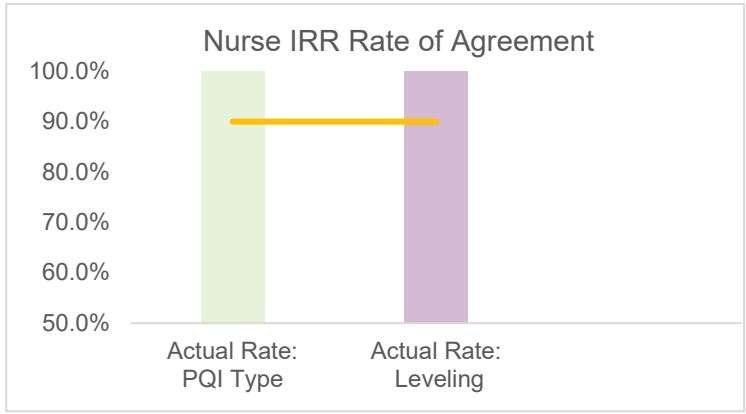
Total Number of Case Agreements on Leveling: 8/8 = 100%



Nurse IRR Result Summary			
Nurse 1: Christine Clark, RN **Nurse 3:** Homaira Momen, RN		**Nurse 2:** Hellai Momen, RN **Nurse 4**: Angela Moses, RN	
Case Number	**Service Request Number**	**Agreement on PQI Type**	**Agreement on Leveling**
1	1006706	Yes	Yes
2	1003855	Yes	Yes
3	1020907	Yes	Yes
4	1023694	Yes	Yes
5	1025644	Yes	Yes
6	21413	Yes	Yes
7	1142405	Yes	Yes
8	1234400	Yes	Yes

Total Number of Case Agreements on PQI Type: 8/8 = 100%

Total Number of Case Agreements on Leveling: 8/8 = 100%



Physician IRR Detailed Result Summary

Physician 1: Sanjay Bhatt, MD, Sr Medical Director, Quality Improvement

Physician 2: Beverly Juan, MD, Medical Director, Community Health

Case Number	Service Request Number	Physician 1 PQI Type	Physician 1 Leveling	Physician 2 PQI Type	Physician 2 Leveling	Agreement on PQI Type	Agreement on Leveling
1	1006706	QOC	C0	QOC	C0	Yes	Yes
2	1003855	QOC	C1	QOC	C1	Yes	Yes
3	1020907	QOC/QOS	C0/QOS	QOC/QOS	C0/QOS	Yes	Yes
4	1023694	QOC	C0	QOC	C0	Yes	Yes
5	1025644	QOC/QOS	C0/QOS	QOC/QOS	C0/QOS	Yes	Yes
6	21413	QOC	C1	QOC	C1	Yes	Yes
7	1142405	QOC	C0	QOC	C0	Yes	Yes
8	1234400	QOC/QOA	C1/QOA	QOC/QOA	C1/QOA	Yes	Yes
Total Number of Case Agreements on PQI Type:							8/8 = 100%
Total Number of Case Agreements on Leveling:							8/8 = 100%

Nurse IRR Detailed Result Summary

		Nurse 1: Christine Clark, RN		Nurse 2: Hellai Momen, RN		Nurse 3: Homaira Momen, RN		Nurse 4: Angela Moses, RN			
Case Number	**Service Request Number**	**PQI Type**	**Leveling**	**PQI Type**	**Leveling**	**PQI Type**	**Leveling**	**PQI Type**	**Leveling**	Agreement on PQI Type	Agreement on Leveling
1	1006706	QOC	C0	QOC	C0	QOC	C0	QOC	C0	Yes	Yes
2	1003855	QOC	C1	QOC	C1	QOC	C1	QOC	C1	Yes	Yes
3	1020907	QOC/QOS	C0/QOS	QOC/QOS	C0/QOS	QOC/QOS	C0/QOS	QOC/QOS	C0/QOS	Yes	Yes
4	1023694	QOC	C0	QOC	C0	QOC	C0	QOC	C0	Yes	Yes
5	1025644	QOC/QOS	C0/QOS	QOC/QOS	C0/QOS	QOC/QOS	C0/QOS	QOC/QOS	C0/QOS	Yes	Yes
6	21413	QOC	C1	QOC	C1	QOC	C1	QOC	C1	Yes	Yes
7	1142405	QOC	C0	QOC	C0	QOC	C0	QOC	C0	Yes	Yes
8	1234400	QOC/QOA	C1/QOA	QOC/QOA	C1/QOA	QOC	C1/QOA	QOC	C1/QOA	Yes	Yes
										Total Number of Case Agreements on PQI Type: 8/8=100%	
										Total Number of Case Agreements on Leveling: 8/8=100%	

7. Findings

The case agreement percentage is 100% and this a total of 8 cases were reviewed. The remaining 22 standby cases were not reviewed. All nurse and physician reviewers agreed on the case level and decision making.

8. Barriers/Opportunities for Improvement

All parties involved agreed that IRR continues to provide important insight into the PQI process.

9. Interventions

None

10. Next Steps

Continue annual IRR

Approval and Authority to Proceed

We approve the report as described above and authorize the team to proceed with next steps.

Name	Title	Date
Sanjay Bhatt, MD, MS, MMM	Senior Medical Director, Quality Improvement	2/14/24

FSR Update/CAP

Kathy Ebido- Senior Quality Improvement Nurse Specialist

ALAMEDA Alliance FOR HEALTH

Facility Site Review / Medical Record Review
Q1 - Q2 2024

Purpose: To provide a high-level overview of PCP FSRs/MRRs completed within Q1-Q2 2024, with attention to review type, status of CAPs, non-passing scores, and membership hold.

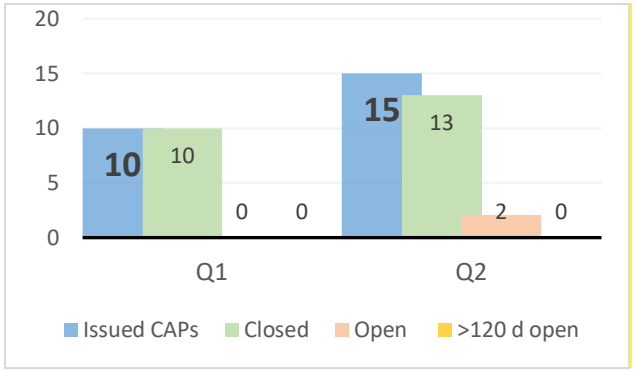
Facility Site Reviews / Medical Record Reviews

Year: 2024	Q1	Q2
FSR: Initial	0	1
FSR: Full Scope Periodic	7	7
FSR: Full Scope Annual	2	1
FSR: Urgent Care	1	0
MRR: Initial	0	3
MRR: Full Scope Periodic	3	8
MRR: Full Scope Annual	1	2
MRR: Focused	1	5
Interim Monitoring	9	0
PARS	2	5
Total Reviews	**26**	**32**

Legend:
FSR = Facility Site Review
MRR = Medical Record Review
PARS = Physical Accessibility Review Survey

Type of Review	Definition
Full Scope FSR/MRR Periodic	Periodic review every 3 years
Full Scope FSR/MRR Annual	Annual review every year (due to failed review or CAP not closed 120 days
Initial FSR / MRR	Initial review of new provider or new site location
MRR Focused	Follow up medical record review focused on specific sections or deficiencies from previous MRR
Interim Monitoring	Interim monitoring between the full scope reviews. Reviews can be onsite or provider self-assessment

FSR/MRR Corrective Action Plans (CAPs)



No open CAPs >120 days from deadline

Failed Reviews

2022	Number of sites	FSR Score	MRR Score
Q1	N/A		
Q2	1	92%	79.02%

Non-Passing Score: 79% and below. New member assignment is on hold until CAP is closed. Scores and AAH action plan are reported to DHCS.

Membership Hold

2022	Issued	Open
Q1	1	0
Q2	4	1

Per DHCS APL 22-017 new member assignment is on hold for PCP sites that receive failing scores on FSR/MRR and/or providers who do not correct site review deficiencies within established CAP timelines until CAP is closed.

FSR Updates

DHCS-conducted FSR
- In Alameda County possible week of September 16
- Waiting for notification and list of providers

New FSRs
- School-based clinics
- OB/GYN
  - Start date January 2025
  - Awaiting APL

AAH FSR database
- Interoperable with DHCS MCQMD Site Review Portal (MSRP)
- MSRP launch date delayed

Facility Site Review / Medical Record Review
Q1 - Q2 2024

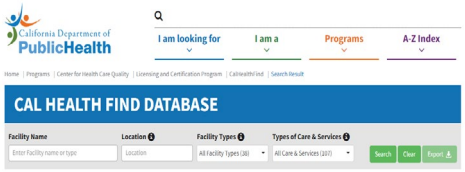
Purpose: To provide a high-level overview of PCP FSRs/MRRs completed within Q1-Q2 2024, with attention to review type, status of CAPs, non-passing scores, and membership hold.

LTC Monitoring Updates

- Quality Assurance Performance Improvement (QAPI) Attestation
- CMS Star rating

  ★★★★★

  CMS Five-Star Rating
- Census
- PQI – QOC
- CDPH Database



- ICF-DD Monitoring

SNF Quality Monitoring Q2

Star Ratings	Number of Facilities	Number of Attestations Received
★	9	5 (55%)
★★	10	8 (80%)
★★★	17	10 (59%)
★★★★	27	14 (52%)
★★★★★	31	19 (61%)
TOTAL	**94**	**56 (60%)**

Behavioral Health Update

Peter Currie- Senior Director, Behavioral Health

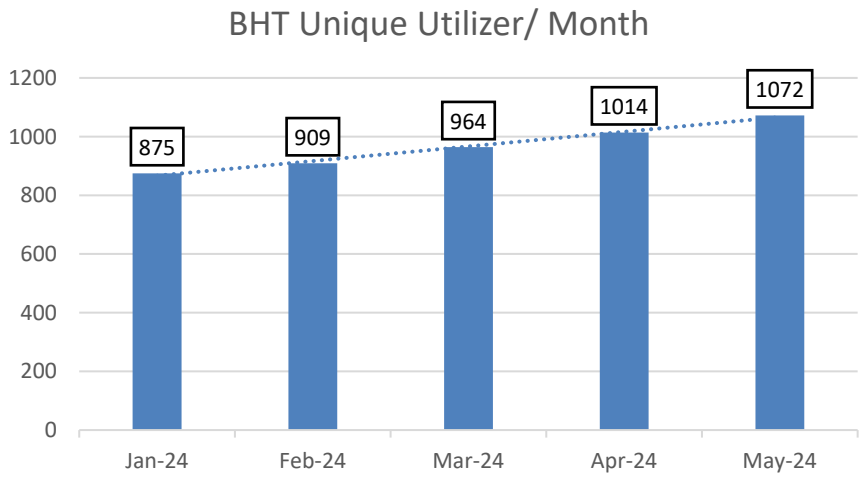
ALAMEDA Alliance FOR HEALTH

QIHEC Behavioral Health Report

August 2024

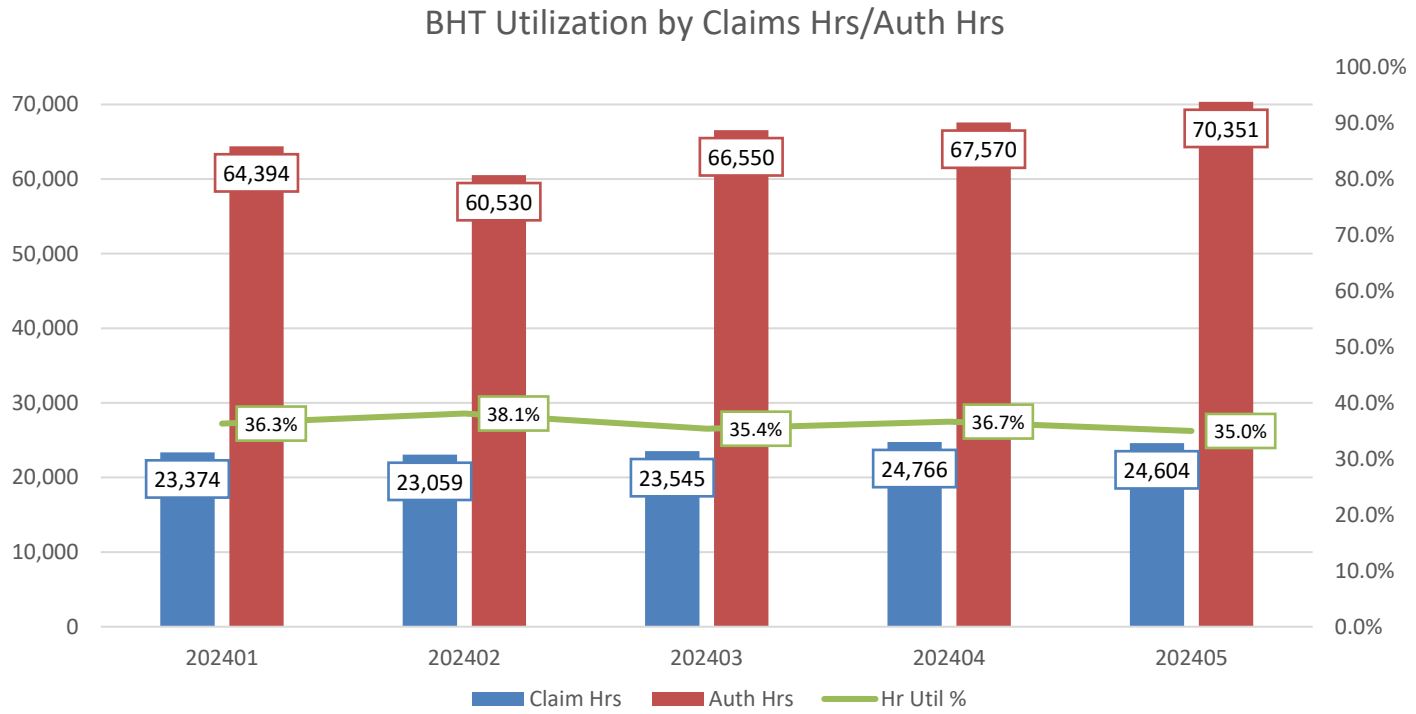
ALAMEDA Alliance FOR HEALTH

BHT Unique Utilizer(s)



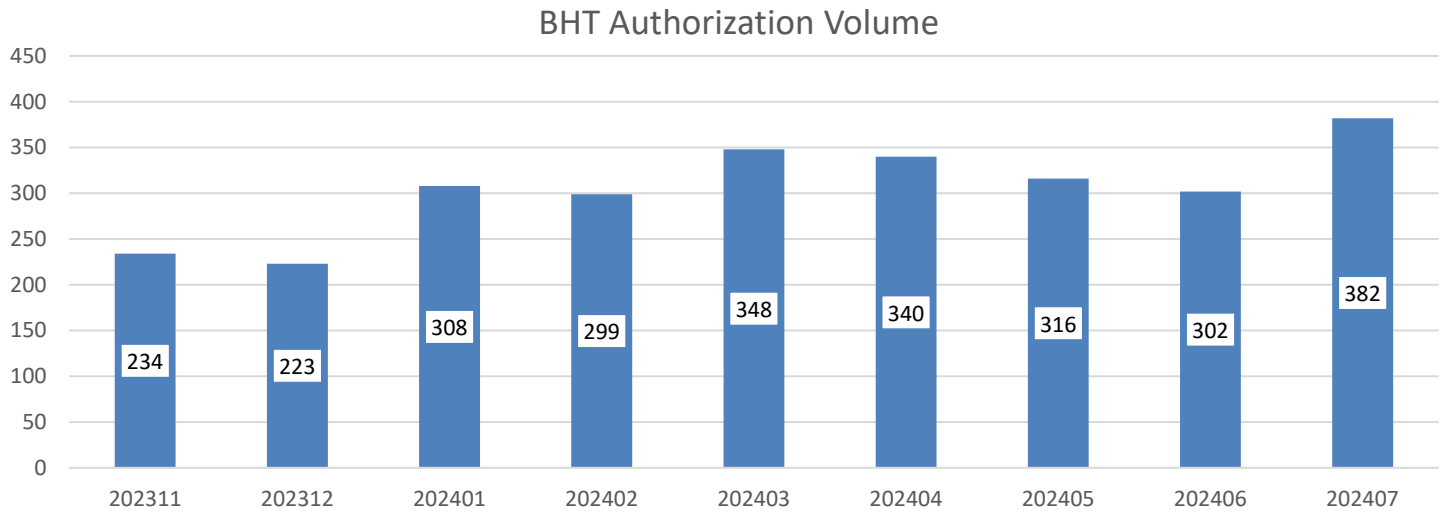
- From January 2024 to May 2024, BHT Unique Utilizers has experienced a significant increase of 22.51%.

BHT Utilization



- This graph presents a comprehensive analysis of the total authorized hours and the total claims paid by the hour submitted from January 2024 through May 2024.
- The percentage of authorized hours that were utilized as evidenced by billed claims within the matching authorization period, reveals that the volume of services authorized are not actually utilized. This pattern of underutilization of authorized services may be due to multiple factors including the child's availability, provider availability and network limitations.

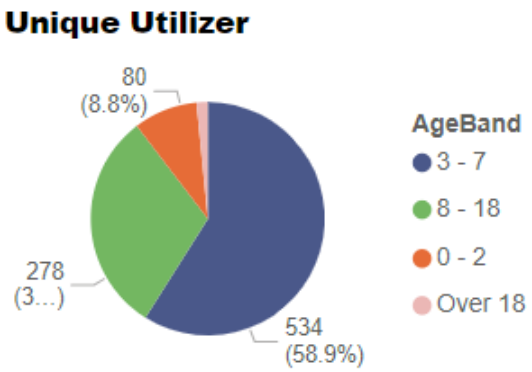
BHT Authorization(s)



- As shown under BHT Utilization, demand increased by 38% from December 2023 to January 2024 with the Anthem transition. We averaged 328 prior authorization requests per month in 2024.
- Notably, there was a spike in authorizations from June 2024 through July 2024, which is attributed to authorizations expiring every six months requiring updated BHT treatment plans be reviewed for reauthorization.

BHT Member Demographics

January 2024 through May 2024



This data represents the unique utilizers categorized by age group from January 2024 through May 2024.

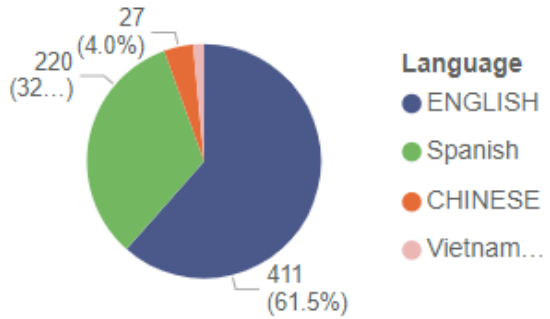
- The age group of 3-7 years old represents the highest number of individuals receiving services.
- Currently, there are 703 males and 203 females undergoing treatment.

BHT Member Demographics

January 2024 through May 2024

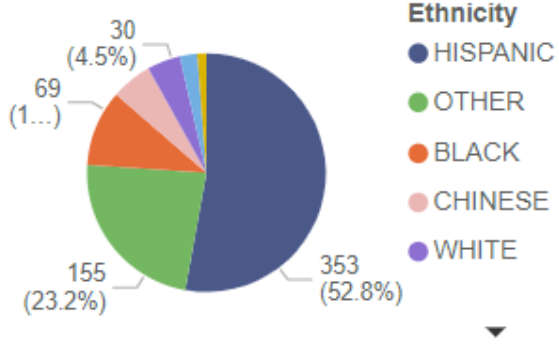
Language

Unique Utilizer



Ethnicity

Unique Utilizer



- We discovered that some providers were hesitant to accept members who do not speak the same language. This reluctance stems from the challenges associated with conducting comprehensive evaluations and developing effective treatment plans for these members when the provider does not speak the same language as the member's family.
- The Behavioral Health Department is supporting our providers by utilizing AAH interpreter services, Cyracom for telephonic interpretation services, and Hanna for in-person appointments. This approach aims to ensure that our members receive the essential communication support throughout their evaluations and treatments.

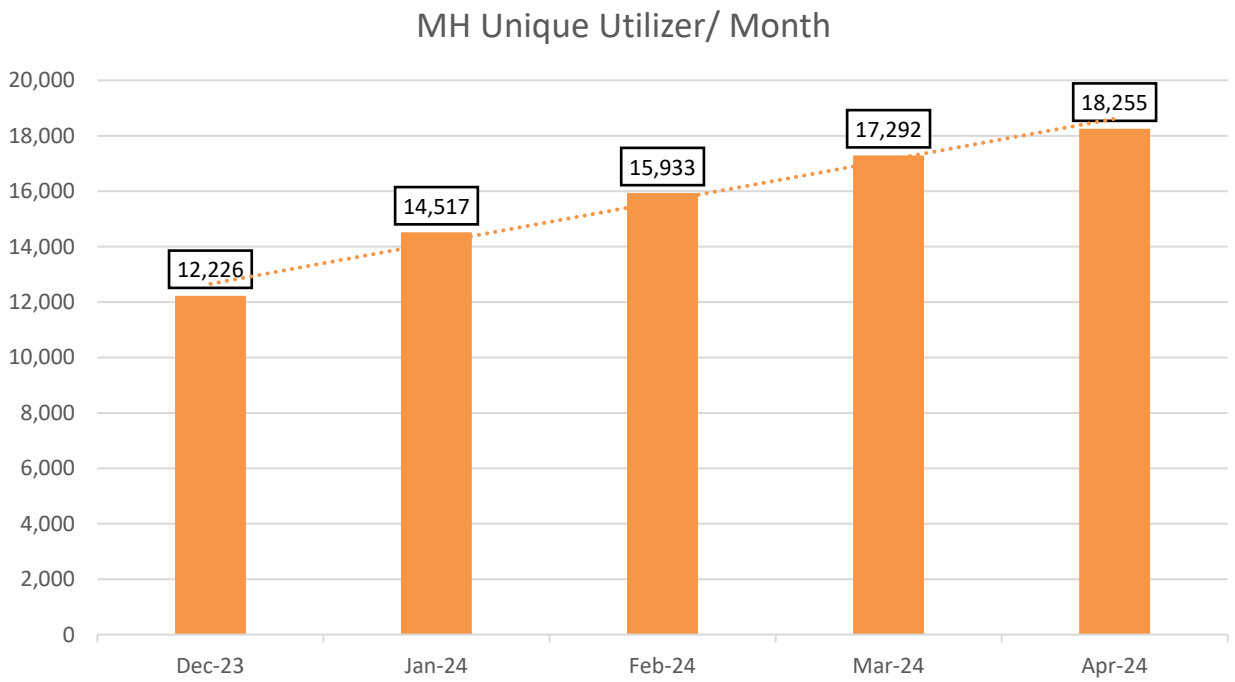
BHT Opportunities

- Network
  - At capacity provider network
  - Lack of additional regional provider groups with whom to contract
  - Instability (High Turn Over) of the ABA paraprofessional providers who provide direct services
- Member Experience
  - Network Limitations resulting in continuing wait times
  - Afternoon / evening hours and for non-English speaking families are associated with longer wait times while the AAH BHT Team works to match members with providers
- Alliance
  - Ongoing improvement of processes and work-flows to ensure regular communication with families
  - Ongoing staff hiring and training

Where do we want to go?

- Expand Network
  - “Out-of-the-box” network development strategies to increase access - especially for the Limited CDE Provider Psychologists and related specialists (e.g., Speech, OT)
- Help establish additional CDE centers of excellence
- Reduce barriers to access and the # of members awaiting BHT/ABA services.
- Improved care coordination between BHT/ABA providers and referring pediatricians/psychologists.

Increase in Mental Health Utilization



- From March 2024 to April 2024, there was a 5.5% increase in the utilization of mental health services which is consistent with prior month increases.
- The 5.5% increase from March to April is a clear indicator that AAH continues to improve access to mental health services through member education and responsive referral and care coordination processes.

Behavioral Health Denial Rates and TAT

BH Denial Rates Goal ≤ 5%						
24-Jan	**24-Feb**	**24-Mar**	**24-Apr**	**24-May**	**24-June**	**24-July**
0.01%	0.01%	0	0	0.01%	0.01%	0.01%

- Denial rates remain low for BHT and MH services.

Public Comment

ALAMEDA Alliance FOR HEALTH

Thank You for Joining Us

Next Meeting: November 15, 2024

ALAMEDA Alliance FOR HEALTH