Alameda Alliance for Health
Community Advisory Committee Meeting Agenda

YOU MAY SUBMIT COMMENTS ON ANY AGENDA ITEM OR ON ANY ITEM NOT ON THE AGENDA, IN WRITING VIA MAIL TO "ATTN: ALLIANCE COMMUNITY ADVISORY COMMITTEE" 1240 SOUTH LOOP ROAD, ALAMEDA, CA 94502; OR THROUGH E-COMMENT AT **orivas@alamedaalliance.org.** YOU MAY WATCH THE MEETING LIVE BY LOGGING IN BY COMPUTER. CLICK THE LINK PROVIDED IN YOUR EMAIL OR IN THE AGENDA BELOW OR YOU MAY LISTEN TO THE MEETING BY CALLING IN TO THE FOLLOWING TELEPHONE NUMBER**: 1.510.210.0967**, CODE: **844 636 224#.** 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. IF YOU PARTICIPATE BY TELEPHONE, YOU MAY SUBMIT ANY COMMENTS VIA THE E-COMMENT EMAIL ADDRESS DESCRIBED ABOVE OR PROVIDE COMMENT DURING THE MEETING AT THE END OF EACH TOPIC.

PLEASE NOTE: THE 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.

I. Meeting Information

Meeting Name: Community Advisory Committee (CAC)

Date	Time	Location
Thursday, June 11, 2026	10:00 AM- 12:00 PM	Video Conference Call and In-person. **Alameda Alliance for Health** Oakland/Hayward Rooms 1240 South Loop Road Alameda, CA 94502

Meeting Chair and Vice Chair	Call-In Number	Webinar URL
Natalie Williams, Chair Tandra DeBose, Vice Chair	**Telephone Number: 1.510.210.0967** **Code:** 844 636 224#	Join the meeting now in Microsoft Teams. Link is also in your email.

II. Meeting Objective

Advise the Alliance on cultural, linguistic and policy concerns and offer the Alliance a member's point of view about the needs and concerns of special groups such as older adults and persons with disabilities, families with children, and people who speak a primary language other than English.

III. Voting Members

Name	Title
☐ Abarca, Iris	Alliance Member
☐ Azeb, Nacerddine	Alliance Member
☐ Biding, Marilen, BSN	Alameda County Healthy Homes Department
☐ Brabata Gonzalez, Valeria	Alliance Member
☐ Davis, Darcell	Alliance Member
☐ DeBose, Tandra	Community Advocate, Vice Chair
☐ Espinel, Diana	Alliance Member
☐ Feng, Jie	Alliance Member
☐ Garner, Erika	Community Advocate
☐ Garcia, Irene	Alliance Member
☐ Griggsmurphy, Donna	Alliance Member
☐ Harris, Lenore	Parent of Alliance Member
☐ Kimmons, Tee	Parent of Alliance Member
☐ Le, Mimi	Alliance Member
☐ Leonard-Pageau, Donna	Alliance Member
☐ Lowe, Kerri, LCSW	Alameda County Public Health
☐ Moore, Jody	Parent of Alliance Member
☐ Omotoso, Omoniyi, MD	Native American Health Center
☐ Pageau Jr, Keith	Alliance Member

☐ Porter, Kenneth	Greater New Beginnings
☐ Tong, Shirley	Parent of Alliance Member
☐ Turner, Len	Greater New Beginnings
☐ Williams, Natalie	Alliance Member, Chair
☐ Williams, Robert	Alameda County Health and Human Resource Education Center
☐ Wynn, Cecelia	Alliance Member

IV. Meeting Agenda

Topic	Responsible Party	Time	Vote to Approve or Informational
Welcome and Introductions • New CAC Members • Member Roll Call • Alliance Staff • Visitors • Housekeeping	**Natalie Williams** Chair	5	Information
1. Approval of Minutes from • March 12, 2026	**Natalie Williams** Chair	3	Vote
2. Approval of Agenda	**Natalie Williams** Chair	2	Vote
CEO Update			
1. CEO Report *(All Lines of Business)*	**Matt Woodruff** Chief Executive Officer	20	Information
Follow-up Items			
1. Follow-up Items from • March 12, 2026 *(All Lines of Business)*	**Mao Moua** Manager, Cultural and Linguistic Services	5	Information
New Business			
1. Alameda County Public Health Department (ACPHD): Community Health Improvement Plan *(All Lines of Business)*	**Carolina Guzmán** Director, Program Performance & Accreditation - ACPHD **Andrea Wise** Program Specialist - ACPHD	20	Information/ Discussion
2. Quality Improvement Program *(All Lines of Business)*	**Michelle Stott** Senior Director, Quality	24	Information/ Discussion

Topic	Responsible Party	Time	Vote to Approve or Informational
3. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) *(All Lines of Business)*			
Alliance Reports			
1. STARs/MOC Outcomes *(Alliance Wellness/D-SNP)*	**Kayla Williams** Manager, Member Experience & Program Management **Allison Lam** Executive Director, Health Care Services	15	Information/ Discussion
CAC Business			
1. Brown Act Meeting Update *(All Lines of Business)*	**Danube Serri** Supervisor, Legal Services	3	Information
2. Annual CAC Charter Update *(All Lines of Business)*	**Mao Moua** Manager, Cultural and Linguistic Services	5	Information
3. Membership Update and Terms of Service *(All Lines of Business)*	**Mao Moua** Manager, Cultural and Linguistic Services	5	Information
Open Forum			
1. Public Comments 2. Next Meeting Topics	**Natalie Williams** Chair	5	Information
Adjournment	**Natalie Williams** Chair	2	Next meeting: **September 10, 2026**

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, such as auxiliary aids and services, beyond what is normally provided, the Alameda Alliance for Health will attempt to accommodate you in every reasonable manner. Please contact **Osiris Rivas** at **510.708.4071** 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.

COMMUNITY ADVISORY COMMITTEE (CAC)

Thursday, March 12, 2026, 10:00 AM – 12:00 PM

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

Other Attendees	Organization	Present
Kyle Navarro	Alameda County Healthy Homes	x
Melodie Shubat	CHME	x

Alliance Staff Members	Title	Present
Beverly Juan, MD	Medical Director, Case Management and Community Health	x
Crystal Villanueva	Marketing Communications Specialist	x
Dana Patterson	Business Analyst, Incentives & Reporting	x

Dani Staub	Director, Incentives & Reporting	x
Donna Carrey, MD	Chief Medical Officer	x
Farashta Zainal	Manager, Quality Improvement	x
Gil Duran	Manager, Population Health and Equity	x
Jennifer Karmelich	Director, Grievance and Appeals	x
Jessica Jew	Population Health and Equity Specialist	x
Karina Rivera	Director, Public Affairs and Medica Relations	x
Kayla Williams	Manager, Member Experience and Program Management	x
Lao Paul Vang	Chief Health Equity Officer	x
Linda Ayala	Director, Population Health and Equity	x
Loc Tran	Manager, Access to Care	x
Mao Moua	Manager, Cultural and Linguistic Services	x
Mara Macabinguil	Interpreter Services Coordinator	x
Matthew Woodruff	Chief Executive Officer	x
Michelle Lewis	Senior Manager, Outreach and Communications	x
Michelle Stott	Senior Director, Quality Improvement	x
Misha Chi	Interpreter Services Coordinator	x
Osiris Rivas	Cultural and Linguistic Services Specialist	x
Patrick Beene	Medicare Field Sales & Community Agent	x
Peter Currie	Senior Director, Behavioral Health	x
Rosa Carrodus	Disease Management Health Educator	x
Sanya Grewal	Manager, Community Health Initiatives	x
Shatae Jones	Director, Community Health Strategy	x
Stacey Stefflre	Medicare Product Manager	x
Stephanie Brow, MD	Medical Director, Medical Services	x
Thomas Dinh	Outreach Coordinator	x
Tome Myers	Executive Director, Medicare Programs	x
Yemaya Teague	Senior Analyst, Health Equity	x
Yen Ang	Director, Health Equity	x

AGENDA ITEM SPEAKER	DISCUSSION	ACTION	FOLLOW-UP
1. WELCOME AND INTRODUCTIONS			
N. Williams	Natalie Willliams, CAC Chair, called the meeting to order at 10:04 am. A roll call was taken, and a quorum was established. Introduction of staff and visitors was completed.	None	None
2. a. APPROVAL OF MINUTES AND AGENDA – APPROVAL OF MINUTES FROM DECEMBER 04, 2025			
N. Williams	Motion to approve December 04, 2025, CAC Meeting Minutes.	Motion: T. Debose Second: L. Turner Vote: Approved by consensus.	None
2. b. APPROVAL OF MINUTES AND AGENDA – APPROVAL OF AGENDA			
N. Willams	Motion to approve March 12, 2026, CAC Meeting Agenda.	Motion: T. Debose Second: O. Omotoso Vote: Approved by consensus.	None
3. CEO UPDATE – CEO REPORT (All Lines of Business)			
M. Woodruff	Matthew Woodrfuff, Chief Executive Office (CEO), presented on the Alliance Updates. Board of Governors (BOG) Chair • Voting will take place on March 13, 2026 for a new Chair to replace the previous Chair, Rebecca Gebhart, who stepped down. Term starts April 01, 2026. Community Supports (CS) • State has found a way to keep all CS. • Changes: Post-Hospitalization Housing and Medical Respite Care will be combined into one CS. State will come out with rules by June 30, 2026. ❖ *Staff Comment-K. Rivera: They are transitioning Medical Respite Care and Post-Hospitalization Housing from the 1115 waiver into ILOS Authority. This is a more permanent authority that will allow the state to continue this specific service.* Provider Grants	None	None

	• Recruiting: Alliance allocated $2 million each year in 2025 and 2026. This helps provider offices recruit for staff such as physicians, front office, medical assistants, etc. CEO to request budget allocation for recruitment in the May 2026 BOG Meeting. Financials • Alliance had net gains in December 2025 (under $1 million) and January 2026 ($9.14 million). This is unusual as more hospitalizations are historically observed in these months. Membership • Initial report showed over 12,000 members disenrolled in January and February 2026. • Under 3,000 of those members came back due to retroactivity. This is a high number as usual numbers stay within 100-300 members. • Alameda County is working to get members back into Medi-Cal. • Outreach: Alliance Communications and Outreach is collaborating with Alameda County Public Health, Social Services Agency, Community Health Center Network (CHCN), and Alameda Health System in different marketing campaigns to ensure that people re-enroll to Medi-Cal. ❖ *Staff Comment-M. Lewis: As part of the campaign, we'll have billboards, DMV ads, and we're mailing about 40,000 postcards per month to members who are up for renewal to remind them. We were also at the Black Joy Parade in February. That was our first time walking in the parade, and we were sharing our renewal message "When it's time to renew, make sure you do." It was a great way to engage with the community and there's lot of love from the community. We'll also have social media and we are looking into radio as well.* IT Workflow Automation • The Alliance has begun several automation projects over the past three (3) years. Once most the information is automated, the goal is to move into AI. • As an example, when a member calls in, AI can display all of the member's information on the Member Services representative's screen versus having to manually check from multiple systems.		

	❖ *Member Comment-N. Williams: And we can see on the other side of that, where members call in and you have the option of facial recognition instead of typing your information. I'm sure they'll catch up to that as well.* ➢ *Member Question-J. Moore: How will you use AI for that? Wouldn't it be a safety concern?* ➢ *Response-M. Woodruff: No, because they're all in our systems. It's all internal us. It's not going to be out on the web or outside our system. Currently, Member Services staff need to look at eleven (11) different systems, whereas, with AI, all information can be shown on one screen. This will allow staff to get information quicker and answer the phone faster.* **Medicare Overview** • Medicare D-SNP (Dual-Special Nees Population) product (Alameda Alliance Wellness) launched on January 1, 2026. • We had a slow rollout to ensure that everything is set up and done correctly. • 240-260 members enrolled currently, without any marketing or promotion. • Goal is to begin marketing and expanding no sooner than July 1, 2026.		
4. FOLLOW-UP ITEMS (All Lines of Business)			

M. Moua	Mao Moua, Manager of Cultural and Linguistic Services, provided updates on the follow-up items from December 04, 2025.
	
	• Include network adequacy as a future agenda topic: Added the agenda topic and details to the CAC agenda tracker as a future agenda item.
	• Share CEO Report-Budget: Sent CAC an email on 02/12/2026 with a direct link to the Board of Governors (BOG) webpage where the report could be accessed.
	• Share feedback regarding how to provide information to families about Social Security benefits for children with special needs
	  o Shared feedback with the Case Management (CM) team.
	  o CM noted this information varies case by case.
	  o CM shared with their staff a screening tool to help guide staff in providing information to members.
	• Send information on the City of Berkeley's World Café event via email
		None	None

	○ Due to the tight turnaround, the event information was not shared via email as planned. ○ Alliance staff attended and represented the Alliance at the World Café. ○ Going forward, we will ensure future events and opportunities for input are shared in a timely manner.		
5. a. NEW BUSINESS – ALLIANCE IN THE COMMUNITY (All Lines of Business)			
T. Dinh	Thomas Dinh, Community Outreach Coordinator, reported updates on the Community Conversations Initiative. Two events are planned for 2026 and three tentatively for 2027. Coffee and Conversations • 2026 ○ Roots Community Center – Armstead Hall 7830 MacArthur Blvd, Oakland, CA ▪ Saturday, April 11, 2026, 10:30 am – 11:30 am ▪ Doors open at 10 am. No RSVP required. Space is limited ○ Lifelong Medical Care – LifeLong Medical Care West Oakland Middle School and LifeLong Medical Care Emeryville Highschool Clinic ▪ Saturday, September 19, 2026, 10: 30 am – 11:30 am ▪ Doors open at 10 am. No RSVP required. Space is limited. • 2027 ○ La Clinica Havenscourt – Pending (Spring 2027) ○ La Clinica Hawthrone Elementary – Pending (Spring 2027) ○ La Clinica San Lorenzo Highschool Location – Pending (Spring 2027) • T. Dinh expressed appreciation for the participation of CAC members, Cecilia Wynn, Donna Griggsmurphy, and Tanda Debose, in the planning committee.	None	None
5. b. NEW BUSINESS – CULTURAL AND LINGUISTIC SERVICES PROGRAM DESCRIPTION ANNUAL REVIEW (All Lines of Business)			
M. Moua	Mao Moua, Manager of Cultural and Linguistic Services, discussed the CLS Program Annual Review. Brief Description of Changes to CLS Program • Yearly review, minor grammar and formatting.	None	None

	• Updated areas for input and advice to align with new All Plan Letter requirements. • Included Alliance Wellness (D-SNP) activities and work plan. ➢ *Staff Question-M. Woodruff: Is there a difference in translations for Medicare and Medi-Cal? We have threshold languages for Medi-Cal, are they the same for Medicare?* ➢ *Response-M. Lewis: The threshold languages are the same for Medicare, but with the addition of Tagalog. And this is to ensure that we provide excellent customer service to our members.* ➢ *Response-L. Ayala: That means that we translate all our documents. English is the primary language, and Spanish is the next most spoken language, followed by Cantonese and Mandarin. The other threshold languages are Vietnamese and Farsi. Farsi is new for our plan as of August 2025. And Tagalog is the additional language that we're keeping for Medicare.* ➢ *Response-M. Lewis: We include language assistance services in all our communications. If a member needs a document translated in a non-threshold language, they just have to call us and let us know, and we'll provide that document in that language or in an alternative format that works best for them.*		
5. c. NEW BUSINESS – 2025 CULTURAL AND LINGUISTIC SERVICES WORKPLAN GOALS UPDATE AND EVALUATION INPUT (Medi-Cal and Group Care)			

M. Moua	Mao Moua, Manager of Cultural and Linguistic Services, presented on the Cultural and Linguistic Services: 2025 Program Review & Evaluation Report.
	
	Cultural & Linguistic Services (CLS): 2025 Focus Areas
	• CLS Recap
	  ○ Most CLS goals were met.
	  ▪ Some goals will continue into 2026.
	  ○ Interpreter services were available when members needed them
	  ○ Overall membership decreased.
	  ▪ Membership increased for Spanish, Chinese, and Farsi speakers.
	  ○ Members shared positive feedback about interpreter services.
	  ○ Interpreter use and language access tracking improved.
	  ○ Outreach efforts led to twelve (12) new CAC members
	• What This Means for Members
		None	None

	○ Members were more likely to get help in their preferred language. ○ Services were provided in person, by phone, and by video. ○ CLS continues to look for ways to improve our language assistance services. Language Assistance & Member Satisfaction • Interpreter Services ○ Interpreter services met the goal of being available 95% or more of the time. ○ Behavioral health interpreter use is now being tracked. ○ Focus on using faster, on-demand interpreter services. • Member Survey Feedback ○ Most members said they received an interpreter when they needed one. ○ Adult and child survey results met or exceeded goals for qualified interpreters. ○ Member Satisfaction survey response rates increased compared to past years. ❖ *Member Comment-N. Williams: It was very easy this time to do the surveys because they were emailed out and the survey itself is in the email. There was no need to go through different links or pages.* Challenges and Focus Areas for 2026 • Challenges ○ Limited staff makes some work harder to complete quickly. ○ Some language-related issues took longer than planned to close due to delays from providers or vendors. ○ Incomplete ethnicity and language data limits our ability to connect members with services that meet their needs. • 2026 Focus Areas ○ Better understanding of member language and culture needs. ○ Growing the Community Advisory Committee (CAC). ○ Improving how quickly language-related problems are resolved. ○ Teaching members and providers how to request interpreter services. ○ Learning more about members in “Other” language groups. Program Evaluation and Your Input		

	• What We're Doing
	  ○ We are reviewing our Cultural and Linguistic Services program.
	• Why Your Feedback is Needed
	  ○ To learn what is working well.
	  ○ To understand what is not working.
	  ○ To make sure services meet member needs.
	
	What We're Asking
	• Do our goals match what you see in your community?
	• What services are helpful?
	• What should we change or improve?
	
	➢ *Member Question-N. Williams: What is being done regarding limited staffing?*
	➢ *Response-M. Moua: We are looking at ways to automate. As an example, with Interpreter Services, we are working closely with our vendor to see how we can automate scheduling which we can hopefully implement this year. In addition, we are providing due dates for providers' and vendors' resolutions when issues are escalated to them.*
	
	➢ *Member Question-N. Williams: Michelle, are you also working on automation projects for outreach?*
	➢ *Response-M. Lewis: Yes, we're exploring more digital communications, such as adding QR codes to our community engagement events so that members can scan them. So, to your point about surveys being easier when you don't have to click many links, you just scan it and see the information. We do have QR codes on our current postcard campaign and so we're looking at how we can incorporate that more for our health education materials. We also have text messaging campaigns. We are looking more towards digital communications and less print PDF type files that we have so many of. There's about 5,000 on the website. We want to make information more accessible and relevant to our members, so you get the kind of services that you deserve.*
	
	➢ *Member Question-T. Debose: Considering what is happening with our federal government and ICE, do you feel that it is the reason why our numbers have dropped this 1st quarter? Because there's a lot of changes and turmoil. Do you think people self-deporting and all the other issues coming up have affected your numbers?*		

	➢ *Response-M. Woodruff: Yes, but there are two (2) different sides. Year-to-date we've had almost 3% undocumented members disenrolled and over 4% citizen members disenrolled. It's a smaller percentage but a bigger number overall because it's a smaller population. We went from up to 82,000 undocumented members, and we're now at about 70,000. The majority of the disenrollments are coming from citizens in the Adult Expansion Program, because the COVID protections are now gone. They now have to enroll and take action which they did not have to do before. Under the COVID protections, if you were eligible for one program, you would be enrolled in every program. We're actually seeing more citizens being disenrolled so far.* ➢ *Member Question-T. Debose: Are we doing what we need to contact these members and offer support? I know the Alliance does outreach, but how are we connecting to those people that are getting disenrolled?* ➢ *Response-M. Woodruff: A lot of different ways. We send out 40,000 postcards a month to remind members that their redetermination date is coming up. Plus, we have social media. Alameda Health System is doing a lot of radio spots, including ethnic radio spots. Community Health Center Network and Alameda County Health are also doing their own outreach. And the difference is that they can outreach to people after they're disenrolled, however, the Alliance cannot. So, we're trying to get them on the front end and the county and the providers are working on the back end to reach out, remind, and support people regarding completing their paperwork.* ❖ *Member Comment-T. Debose: That's what it sounds like because for most people, doing paperwork is not on top of mind right now.* ➢ *Response-M. Lewis: Yes, it is a lot. Fortunately, we have 18 community partner sites that can assist with completing enrollment paperwork. Our postcard includes information on these sites such as Baywell Health, Asian Health Services, Bary Area Community Health, and others.* ➢ *Member Question-O. Omotoso: How do we make sure that we're capturing the correct language preferences when members enroll?* ➢ *Response-M. Moua: The Alliance receives a monthly membership data report and that's what we use to look at our members' demographic information. When we identify a member with an incorrect preferred language listed, we encourage them to call the Social Services Agency to make sure it gets updated.*		

	➢ *Response-L. Ayala: There's additional complexity to that as language options in the application are limited. Depending on the place where you are in California, certain languages that are spoken by many people may not be tracked. It presents a challenge for us in the way that data comes to us and gets added to our data systems. We've been doing some work with our IT department, thinking through how that data gets funneled into data that's usable for us. When we track language requests for interpreter services, it provides a whole other dimension or expansion of the number of languages that we can see our members are speaking.* ➢ *Member Question-J. Moore: What does the state require? What does the state regulate when it comes to languages?* ➢ *Response-L. Ayala: They decide on certain categories or languages data that they collect and send to us. They also look at threshold languages which are the most common languages. They tell each county which languages have highest percentages of members that speak them, and therefore the plan is required to offer information in those languages. In addition, there's the top 15 most common languages in California, however, Mam is not included even though we have a very large Mam-speaking community. Mam is not included as a language option in the application, however, it is also not a commonly written language, so it is complicated in that way.* ❖ *Member Feedback-J. Moore: Let me offer a suggestion. I'm often communicating with my Uber drivers in multiple languages and I use Google Translate. I wonder if there's some type of grant that will help us get devices of some type. I believe that we have so much technology available to us that could easily help with language interpretation.* ➢ *Response-L. Ayala: As those interpreter systems get better, we might get to the day where we could rely on those for things as important as our medical communication. Currently, with Medi-Cal regulations, we have to be very vigilant to make sure that interpreters supporting our members and the translations we create for them are made by qualified interpreters and translators. There's a level of quality that we have to ensure which requires processes. What we have done is put more kiosks with iPads at high-volume clinics, which is a way we make qualified interpreters right at hand. And so, there are technological solutions that we're trying to implement. But unfortunately, Google is not on that qualified list, even though it can be helpful.*		

	❖ *Member Comment-J. Moore: Your idea is really great and wonderful way to get interpreter services remotely, but still from a human. I understand those limitations. I was just thinking about those rare circumstances where we really want to help our people, to just be able to convey to them how we're going to be able to communicate, even if we can't right at that moment.* ❖ *Staff Comment-M. Lewis: We do we do use Google Translate on our public website to provide a multilingual site and translate a lot of information at one time. And there are studies going on where providers are using the Meta glasses in which you can have a bilingual conversation. They're able to talk to their patients in their preferred language and it translates it in real time. I think it will happen. It's just not there yet. And to Linda's point, we want to make sure that our translators are certified and that they stand and provide the information that our members need. And because there have been instances wherein things were translated, and it didn't say what it was supposed to say. We just want to make sure that we're doing that as well.* ❖ *Member Comment- R. Williams: Personally, I use a headset that auto translates for me when I speak to anyone out in the community. These devices can be used as extra support, and do not necessarily take over the job of a human being. It is just an asset or a tool for the individual who's receiving the translation.* ➢ *Response-M. Moua: Could you share with me offline what tools those are? I'd be interested in just knowing more about that tool that you're using out in the community.* ❖ *Member Feedback-J. Moore: We should encourage involvement of families and caregivers. When we do things as a family or as a community and within our relationships, it's more motivating than doing it alone. With the postcards for example, we can reach out to families and caregivers with messaging such as "Make sure your mom is enrolled" or "Make sure your brother is covered".* ➢ *Response-M. Moua: That's very good feedback and we'll definitely note that in our evaluation as part of our feedback from the CAC.* ➢ *Member Question-J. Moore: Can you clarify what you were discussing earlier regarding delay in responses from providers and vendors?* ➢ *Response-M. Moua: It is when issues come to us for escalation. For example, my team and I handle the potential quality issues related to*		

	quality of language. We noticed that with some providers and vendors, it does take a little bit more time to get a response, to looking into the issue, and providing an outcome and resolution. We now make sure to specify a deadline that is also reasonable, to provide a response or resolution. ❖ *Member Feedback-J. Moore: It is also good to look into what is preventing them from getting back to you. Most people are inundated with work and other things that they do.* How Your Feedback Helps • Used in the final CLS program evaluation. • Shared with Alliance committees • Guide 2026 workplan goals and priorities		
6. ALLIANCE REPORTS – GRIEVANCE AND APPEALS: OVERVIEW OF PROCESS (All Lines of Business) AND 2025 REPORT (Medical and Group-Care)			

J. Karmelich	Jennifer Karmelich, Director of Grievance and Appeals, presented on the Grievance and Appeals Process
	
	What is Grievance?
	• A grievance is when a member is unhappy about something other than when a benefit is denied.
	• It can be about:
	  ○ Services
	  ○ Staff behavior
	  ○ Access to care
	• Members do not have to say "grievance" for it to count.
	• A grievance can be filed any time after the problem happens.
	• All complaints are handled as grievances, even if the member does not ask to file one.
	
	Grievance Examples
	• Trouble getting an appointment or waiting too long to be seen
	• Rude or disrespectful behavior from doctors, nurses, or staff
	• Problems getting referrals or approvals for care
	• Poor coordination between providers
	• Issues with clinic or office condition
	
	Type of Grievances
		None	Alliance staff to follow up with K. Porter regarding the incident of Greater New Beginnings Organization's clients getting disenrolled last January 1, 2026.

	• Access to Care
	  ○ Long wait times to get an appointment
	  ○ Not enough primary care doctors or specialists
	  ○ Phone calls not answered or returned
	  ○ No interpreter or language help
	  ○ Buildings that are hard to access (no ramps, small waiting rooms)
	• Quality of Service
	  ○ Rude or unhelpful staff or providers
	  ○ Clinics or offices that are dirty or poorly maintained
	  ○ Poor customer service from the health plan
	• Coverage Issues
	  ○ Getting a bill for costs the member did not expect
	  ○ Being charged when the member believes the plan should pay
	• Other Issues
	  ○ Problems with eligibility or enrollment
	  ○ Concerns about fraud, waste, or abuse
	  ○ Privacy or HIPAA concerns
	• Quality of Care Grievances
	  ○ A quality of care (QOC) grievance is a complaint about the care a member received.
	  ○ The member feels the care was not safe, appropriate, or what they needed.
	  ○ These complaints are reviewed by medical professionals.
	  ▪ The medical director is responsible for the final resolution.
	  ○ QOC cases are reviewed for a potential quality issue (PQI).
	  ○ If identified as a PQI, the case will with reviewed by the Quality Improvement Department for further action.
	
	➢ *Member Question-K. Pageau: I am an Alliance Member, and we did have several grievances going on my behalf because I was not getting the right care. After we call in to report a grievance, we would get a letter in the mail about three (3) weeks later which states that the grievance was resolved, and nobody ever contacted us after that. Is there a way for the Alliance to talk to the member and provider first to make sure that they are happy with the resolution before closing out the case?*
	➢ *Response-J. Karmelich: When we get a grievance, we first send an acknowledgement letter to formally notify you that we received your grievance and to advise you to contact us if there is additional*		

	information that you would like to provide. And when you receive a resolution letter, that is our resolution after our investigation, which includes a lot of care coordination and if there's additional care coordination that needs to happen, we'll make a referral to our Case Management Department. They will reach out to assist the members with any other services that they need assistance with. ➢ *Member Question-J. Moore: What areas does the Alliance perform worse than others? Are there trends?* ➢ *Response-J. Karmelich: We're going to do the reports after the presentation, and we'll do a deep dive into certain categories of grievances. But I can tell you the number one grievance that we do have is access to care.* ➢ *Member Question-J. Moore: Are you also going to provide information on how many of the grievances get resolved versus don't?* ➢ *Response-J. Karmelich: They all get resolved.* ➢ *Member Question-J. Moore: Even though they get resolved, what do we do to ensure that things actually improve?* ➢ *Response-J. Karmelich: Yes, so there's a difference. When we have individual grievances, we do a process based on that individual member's needs. And a resolution to us is that the member is made whole. If the member is calling in and saying that they can't get an appointment, we need to get the member an appointment. If they can't find a specialist, we will find them a specialist. That is how we resolve the case. Systemic issues that we identify based on this grievance and appeals process are looked at in our reports. We do our tracking and trending. If, for example, we see 100 grievances regarding one issue. We identify that as a systemic issue, and we will review that within our committees, and put actions in place to fix that issue.* ❖ *Member Comment-J. Moore: Thank you. Also, I just want to say your team have really been great when I've needed help with my son. I want to commend you for your work.* ➢ *Response-J. Karmelich: Thank you. That is our goal. I always tell our staff that this is a very complex system for a lot of people and that our job is to help navigate them through this very complex system and to help them during very stressful times. To remember when they're calling and express dissatisfaction and frustration, for staff to have some*		

	compassion and empathy and try to work through this process. I will take your appreciation back to our team. ➢ *Member Question-K. Porter: My question is not necessarily regarding grievance. My organization works with juveniles and they are already Alameda Alliance members upon their inception into our program. But something weird happened on January 1, 2026. They were switched to Baywell Health without prior notification. We recently had to go through the process of reenrolling them back to Alameda Alliance. I am curious to know why that would happen, that they would get automatically switched and therefore could no longer see the doctors that they were regularly seeing at the Children's Hospital.* ➢ *Response-Dr. Carey: The only thing that I can think of is that perhaps they lost their Medi-Cal and were instead enrolled into the county's HPAC Program, and Baywell Health is one of the county clinics that accepts that insurance.* ➢ *Member Response-K. Porter: The nature of our clients is that they are all wards of the court, therefore, they automatically qualify for Medi-Cal. This has never happened before, so it caught us by surprise. We now have all of them reenrolled into Alameda Alliance but found that strange.* ➢ *Staff Response-M. Lewis: Alameda Alliance Members can also select Baywell Health as primary care provider, so we could look into this more.* ❖ *Member Comment-C. Wynn: I too had a problem getting my eyes checked this year at my regular optometry office. I was advised to go to Highland instead.* ❖ *Member Comment-N. Williams: And usually there's a 6-months or so wait when scheduling an appointment at Highland. It sounds like providers are just not accepting Medi-Cal.* ❖ *Member Comment: D. Leonard-Pageau: Yes, as of January 1, 2026, I could no longer see my Sutter doctors that I have been seeing for 25-30 years. I can only see my Highland, UCSF, and Stanford doctors. Sutter did not sign up to accept Medi-Cal, so I lost 60% of my specialists.* ➢ *Member Question-J. Moore: I'm still not understanding what these all mean and why that may happen.* ➢ *Response-M. Woodruff: Let me try to quickly break down everything that happened. When it comes to the juvenile members, it does not seem to make a whole lot of sense, especially to that many clients. Let's discuss offline how you can give me their names in a HIPAA compliant manner, as I would like to investigate it and find out what happened there. All I*		

	can think of right now is that they somehow got switched in the system somewhere. ❖ *Member Comment-K. Porter: This might have contributed to the number of members dropping if this happened to others as well.* ➢ *Response-J. Karmelich: To add, they could have also bounced off and then bounced back on and then you go through the whole process again and then auto assigned to a new PCP.* ➢ *Response-M. Woodruff: As far as the issues with the optometry office you went to Cecilia, the Alliance switched to VSP, which is the largest optometry group in the state. If they do not accept VSP, then that may be the reason why you could no longer see them. As far as Sutter is concerned, you are correct Donna. Providers can opt out of the Medi-Cal Program.* ❖ *Member Comment-M. Le: I received a letter from Social Services, and they informed me that I need to renew my Medi-Cal, otherwise, I will be disenrolled on January 1, 2026. I did not get the form, so I went to the office to request the renewal form. Maybe others did get the notice to renew, but did not take action, and that's why they got cut off. We need to pay attention to the notices from Medi-Cal.* J. Karmelich continued with the presentation: Discrimination Grievances • A complaint about being treated unfairly or differently • These complaints are handled by the Alliance's Compliance Department. • Discrimination is not allowed under state and federal law: o California Unruh Civil Rights Act and Government Code – Section 11135 o Title VI (race, color, national origin) o Title IX (sex) o Age Discrimination Act o Americans with Disabilities Act (ADA) and Rehabilitation Act (Sections 504 & 508) o Affordable Care Act – Section 1557 • The Alliance is required to report discrimination grievances to the State. What is an Appeal? • An appeal is when a member asks the Alliance to review the decision made about their benefits.		

	• A member or their authorized representative can file an appeal.
	• Time limits to file an appeal:
	  ○ DHCS: within 60 days of the decision
	  ○ DMHC: within 180 days of the decision
	
	Appeal Communications
	• Notice of Action (NOA): A letter that explains a decision about your benefits.
	• Notice of Appeals Resolution (NAR): A letter that tells you the result of an appeal.
	• "Your Rights" Attachment: Explains your right to appeal, ask for a State Hearing, or request an Independent Medical Review (IMR).
	
	Appeal Examples
	• You can file an appeal if:
	  ○ A service is denied or only partly approved.
	  ○ Payment for a service is denied.
	  ○ You are asked to pay for care you believe should be covered.
	  ○ You are denied care from a provider outside the Alliance network.
	  ○ A service you were getting is reduced, stopped, or ended.
	
	How can members file a grievance or appeal?
	• There are four ways to file a grievance or appeal with the Alliance:
	  ○ Calling Member Services
	  ○ At the Alliance office
	  ○ Mailing the Alliance
	  ○ Online - Member Grievance Form
	• A member or authorized representative can file for help.
	• The Alliance can help complete forms and steps.
	• Help is available in member's preferred language.
	
	Processing a Grievance
	• Exempt grievance: Resolved by the next business day (no letter required).
	• Standard grievance:
	  ○ Acknowledgment within 5 days
	  ○ Written decision within 30 days
	• Expedited grievance:		

	○ For serious or urgent health concerns ○ Resolved within 72 hours Processing an Appeal • Expedited appeal: ○ For urgent health needs ○ Decision within 72 hours • Standard appeal: ○ Acknowledgment within 5 days ○ Decision within 30 days • The decision letter explains the reason and your next steps. If you do not agree with the decision • You can request a State Hearing with a judge. • You can file a complaint or request an Independent Medical Review (IMR). ○ With the Department of Managed Health Care (DMHC) • These reviews are done by an outside doctor who is not related to the Alliance. ➢ *Member Question-D. Leonard-Pageau: When a person has the same grievance against the same provider, do you have a record of that? Because it gets tiring filing grievances against the same providers.* ➢ *Response-J. Karmelich: Yes. If a member is continuously filing grievances against the same provider or vendor, we investigate those and we report on them during our committee meetings. We have tracking and trending reports. If it's against a specific provider, we do have a credentialing process outside of the grievance process, which is the process of how we credential our providers and we have a committee as part of that credentialing process. It includes all our MDs and our CMO. They review all the grievances against that provider when they come up for credentialing. We take these cases very seriously and everything is reviewed when we make those decisions.* J. Karmelich continued with the Grievance and Appeals Report: Medi-Cal • 2025 Total Cases: 49,231 (Compliance Rate: 96.1%) • Standard Grievances: 27,649 (Compliance Rate: 93.3%) • Expedited Grievances: 28 (Compliance Rate: 85.7%) • Exempt Grievances: 20,745 (Compliance Rate: 99.9%)		

	• Standard Appeals: 782 (Compliance Rate: 94.6%)
	• Expedited Appeals: 27 (Compliance Rate: 85.1%)
	
	• Appeal Data/Analysis
	  ○ 2025 Total Prior Authorization Appeals: 818
	  ○ Prior Authorization Appeals:
	  ▪ CFMG: 3 (Overturned: 1)
	  ▪ CHCN: 112 (Overturned: 13)
	  ▪ Plan: 703 (Overturned:165)
	
	• Grievance Data/Analysis
	  ○ Highest number is Access to Care Grievances: 21,796.
	
	• Grievances filed against the Plan
	  ○ Highest number is Access to Care Grievances (8,042): Members have difficulty accessing/navigating through the AAH member portal, not receiving their member ID cards timely, other health insurance errors in the system, and unable to reach AAH staff by telephone.
	  ○ Coverage Disputes (381): Disputes related to benefit and reimbursement requests.
	  ○ Other (6,577): Complaints about enrollment, eligibility, protected health information, and fraud/waste/abuse.
	  ○ Quality of care (18): Complaints about the quality of care received from the plan.
	  ○ Quality of Service (6,440): Complaints against our internal departments, such as G&A, Member Services, Behavioral Health, and Case Management regarding customer service.
	• Grievances filed against our Delegated Networks/Vendors
	  ○ Highest number is ModivCare (Transportation Vendor): 1,563
	
	Grievance and Appeals Report: IHSS Commercial
	• Appeal Data/Analysis
	  ○ 2025 Total Prior Authorization Appeals: 81 (Overturned: 8)
	• Grievance Data/Analysis
	  ○ 2025 Total Grievances: 2,170
	  ○ Highest number is against the Plan: 843
	• Grievances filed against the Plan
	  ○ Access to Care (360): Members have difficulty accessing/navigating through the AAH member portal, not		

	receiving their member ID cards timely, other health insurance errors in the system, and unable to reach AAH staff by telephone. o Coverage Disputes (109): Disputes related to benefit and reimbursement requests. o Other (120): Complaints about enrollment, eligibility, protected health information, and fraud/waste/abuse. o Quality of Service (254): Complaints against our internal departments, such as G&A, Member Services, Behavioral Health, and Case Management regarding customer service. ➢ *Member Question-L. Harris: Some of the numbers are high for particular vendors. How is that addressed?* ➢ *Response-J. Karmelich: Yes. For certain vendors that are very service based such transportation and DME, there's a lot of touch points there. So that's why we do have a higher number of grievances for these specific vendors. We have what we call a JOM, Joint Operation Meeting, with those vendors on a quarterly basis. We all meet as a group and discuss grievances. We do grievance reports for every single meeting we go to, and we show them where they're at quarter by quarter. That's where we discuss and put actions in place on what they're going to do to try to reduce the number of grievances. It's never going to be 0. That's why we have our process. We look at it per 1000 members, based on utilization. If we see a huge spike or increase, we put actions in place to ensure that we're not going to continue that trend.*		
7. a. CAC BUSINESS – CAC MEMBERSHIP UPDATE (All Lines of Business)			
M. Moua	Mao Moua, Manager of Cultural and Linguistic Services, provided an update on CAC Membership. • Resignation received from Jennifer Gudiel of Alameda County Asthma Start Program, in mid-December 2025.	None	None
7. b. CAC BUSINESS – CONFIFENTIALITY AND CONFLICT OF INTEREST FORM (All Lines of Business)			
M. Chi	Misha Chi, Interpreter Services Coordinator, made an announcement regarding the Confidentiality and Conflict of Interest Form. • M. Chi thanked the CAC members who already completed the form and advised the others to approach her immediately after the meeting to receive the form for completion.	None	None

	• M. Chi advised the people who are attending virtually that she will mail them the form with a prepaid return envelope.		
8. OPEN FORUM			
N. Williams	• M. Lewis announced that CAC members will receive an invitation to attend the Alliance's 30th Anniversary Celebration. It will be held on April 24,2026 11:00 am-2:00 pm. M. Lewis encouraged CAC members to participate in a legacy video that C&O will be creating. • T. Debose gave kudos to the C&O team for creating the new agenda template. She expressed loving the color and formatting. • M. Moua announced that this is the last CAC meeting for Misha Chi due to her role transitioning out of providing on-site support for CAC. M. Moua gave her kudos and thanked her for her amazing work. • M. Moua introduced Osiris Rivas, Cultural and Linguistic Services Specialist, who will take on the role of supporting the CAC. • O. Omotoso raised concern about not having enough Occupational Therapy providers for kids. ➢ *Response-L. Ayala: We will follow up with you individually and then provide an update to the CAC at the next meeting.* • D. Leonard-Pageau recommended that it will benefit members if the Alliance supports the Recipes for Health Program.	None	Alliance staff to follow up with Dr. Omotoso regarding not having enough Occupational Therapy providers for children on the network.
9. ADJOURNMENT			
N. Williams	• Natalie Williams, CAC Chair, announced that the next meeting will be on June 11, 2026. • Meeting adjourned at 12:00 pm.	Motion: C. Wynn Second: D. Leaonard-Pageau Vote: Approved by consensus.	None

Meeting Minutes Submitted by: Mara Macabinguil, Interpreter Service Coordinator Date: 04/16/2026

Approved by: _____ Date:

CEO Update

Matthew Woodruff, Chief Executive Officer

To: **Alameda Alliance for Health Board of Governors**

From: **Matthew Woodruff, Chief Executive Officer**

Date: **June 12th, 2026**

Subject: **CEO Report**

- **Financials:**
  - **April 2026:** Net Operating Performance by Line of Business for the month of April and Year-To-Date (YTD):

	April	YTD
Medi-Cal	$1.46M	$79.1M
Group Care	($77K)	($2.9M)
Medicare	($997K)	($9.3M)
Total	$388K	$67.0M

  - **Revenue was $188.1 million in April and $1.9 billion Year-to-Date (YTD)**.
    - Medical expenses were $179.5 million in April and $1.8 billion for the fiscal year-to-date; the medical loss ratio is 95.5% for the month and 92.3% for the fiscal year-to-date.
    - Administrative expenses were $11.4 million in April and $104.6 million for the fiscal year-to-date; the administrative loss ratio is 6.1% of net revenue for the month and 5.5% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 296% of the required DMHC minimum, representing $156.5 million in excess TNE.
  - **Total enrollment in April was 380,353**, decreased by 5,645 Medi-Cal members compared to March 2026.

- **Alliance Updates**
  - See legislative updates
- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - Member grievances scored 85% processing time for expedited grievances, which is below the 95% compliance mark. The department also scored 75% processing time for standard grievances, which is below the 95% compliance

standard. Currently the department is down 8 positions that they are looking to backfill.

- The Alliance's encounter data reporting fell below the 65% and 80% standards as the Alliance allowed providers to file claims outside of timely filing due to their providers new systems implementations.

- **Non-Regulatory Metrics:**
  - All non-regulatory metrics were met for January.

- **Legislative Updates:**
  - State And Federal Updates

- **IT Workflow Automation - Quarterly Updates**
  - Alliance completed the AI-powered compliance platform to automate regulatory adherence by linking internal documents with requirements. Phase 1 of the work is complete which includes:
    - Access to Readily platform has been provided to all business resources in Compliance, Regulatory affairs, audit Teams
    - Single Sign On (SSO) integration is complete. Users can access the platform with one click from the Alliance Internal portal.
    - Training completed for all modules.

    Our next 3 months plan is complete automation of PolicyTech documents workflow from AAH to Readily platform
  - The AI Governance Framework Policies and Procedures (PnP) have been presented in our Administrative Oversight Committee (AOC) and approved.
  - Alliance has kicked off AI-driven automation to transform software development by enhancing developer productivity, improving code quality, and accelerating delivery across the full software development lifecycle (SDLC) from design and development to deployment, quality assurance, and maintenance. This initiative includes capabilities such as automated code generation, DevOps and Continuous Integration/Delivery (CI/CD) automation, as well as code reviews and testing. The AI transformation is planned as a 12-month level of effort.
  - Alliance developed a high-accuracy (Optical Character Recognition) OCR using OpenAI, automating image interpretation and text extraction from faxes and user prompts, now integrated into key workflows.
    - Automated Phase 2 of Prior Authorization, Health Home, and Pre-Service Authorization in April 2026.
    - ECM end-to-end process redesign is underway.

        - Completed Community Support Referral Forms for DSNP & MediCal in the month of April 2026.
        - 10+ Health Care Services workflow processes are in the pipeline for automation in CY2026 which includes Health Ed Wellness, Behavioral Health care - Autism evaluation form etc.
    - The enterprise-wide implementation of Speech to Text capabilities has been initiated. Following a comprehensive product assessment, Alliance has selected Nuance Dragon as the preferred solution. The procurement of the product took additional timeline due to vendor licensing error. As of now, the procurement is complete and have started implementation to the pilot users.
    - To enhance Claim TAT, our IT Configuration team has pinpointed three main areas for process improvement that could potentially increase our claims auto-adjudication rate from 85% to 92%. As part of the implementation, we have engaged Optum AI to do a pilot program to automate some of the claims manual processing. At the same time, team is design solutioning to automate COB claim workflows.

- **Alliance in the Community – Quarterly Updates**

- **Community Relations Reinvestment Sponsorships - Quarterly Updates**

- **Medicare Overview**
    - Successfully launched the Medicare D-SNP product, **Alameda Alliance Wellness**, on January 1, 2026—marking a significant milestone that coincides with the Alliance's 30th anniversary and reinforces our strategic growth trajectory in Medicare.
    - The **CY2027 Medicare Bid** remains on track for June 1, 2026, submission deadline:
        - Plan Benefit Package (PBP) successfully submitted via CMS HPMS with Compliance validation completed.
        - Milliman has confirmed successful submission of the Benefit Pricing Tool (BPT), substantiation, and cost-sharing justification.
        - MedImpact, our selected pharmacy benefit manager (PBM) for CY2027, has completed submission of all required pharmacy files.
    - Strengthened Medicare sales capacity and structure:
        - Approved updated **Medicare Field Sales & Community Agent** role (non-bilingual) to enhance market reach.
        - Authorized hiring of four (4) additional licensed Medicare Field Sales and Community Agents to support growth objectives.

- Advanced key Medicare operational initiatives:
    - Initiated implementation of MedImpact as our new PBM, including execution of the Letter of Agreement (LOA) and formal project kickoff on May 5th, 2026.
    - Commenced CHCN delegation activities on May 21, 2026, positioning the organization for expanded delegated capabilities.
- Progressed **Medicare marketing vendor selection**:
    - Finalists narrowed to two (2) qualified vendors currently developing comprehensive go-to-market proposals.
- On track to select a preferred vendor during the week of June 1st, with onboarding targeted to ensure readiness for July implementation.

- **Member Advisory Committee**
    - Budgeting for Behavioral Health - how does the plan allocate money for these services? – There currently are no limits on the use of MH services. All services are based on whether they are medically necessary, not on receiving a maximum number of services or appointments.
    - Care giver support - what options are available for members? We have a community support specifically for caregivers – Caregiver Respite. This CS helps to provide short term, temporary, intermittent relief for a caregiver. Limitations:, maximum time is 336 hours per calendar year. The respite care can be in-home or in-facility. Per policy guide (April 2025):
    - Respite Services can include any of the following:
        1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.
        2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.
        3. Services that attend to the Member's basic self-help needs and other activities of daily living (ADL), including interaction, socialization, and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.
    - Additional support for caregivers: Personal Care and Homemaker Services. This service helps to fill the time gap between an IHSS application or re-assessment and approval for those services.

    - Lastly, I would point to our benefits that can relieve the caregiver of some of the heavy-lifting duties:

- Transportation – can provide rides to and from appointments, pharmacy
- CM (CCM, ECM) – provide support with care coordination, scheduling appointments, etc.
- Behavioral Health – provide emotional support via therapy for the caregiver

Follow-up Items

Follow-up Items from 03/12/2026

Follow-up Item	Outcome(s)	Status
Send CEO, Matt's presentation to CAC members	• Presentation was sent to CAC members via email on 03/13/2026.	Completed
Clarify youth PCP change issue	• Auto PCP change may have occurred because the member exceeded the provider's age eligibility criteria ("aged out"). • The member would then have been auto assigned to a PCP and need to be referred to specialists who accept adults.	Completed
Occupational Therapy (OT) capacity for children	• Shared concern with the Provider Services (PS) team. • PS is expanding OT contracting. • The following process was shared with Dr. Omotoso when there are no available OT providers: -Submit an authorization request to approve treatment with an out-of-network provider.	Completed

Community Health Improvement Plan (CHIP) Implementation Overview

Carolina Guzman, Program Performance and Accreditation Director

Andrea Wise, Program Specialist

Quality Improvement and Accreditation Division

June 11, 2026

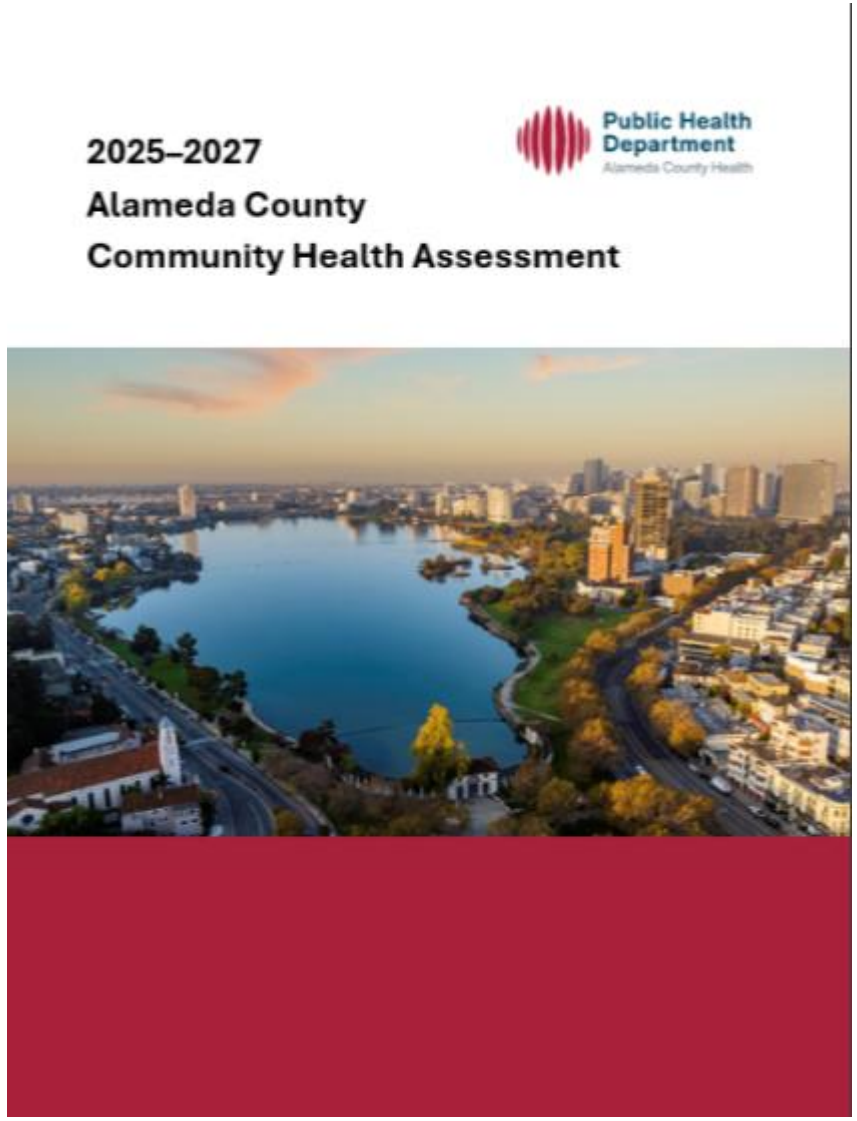
Public Health Department
Alameda County Health

Where We are Headed

- Overview Community Health Assessment (CHA)
- Describe purpose and goals of Community Health Improvement Plan (CHIP)
- Overview accomplishments of 2023-2025 CHIP
- Describe next steps of 2025-2027 CHIP
- Q&A

Public Health Department
Alameda County Health

Community Health Assessment (CHA) Purpose



A CHA is the foundation to improve Alameda County's health

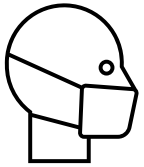
- Serves as basis for:
  - priority setting
  - program development
  - policy changes
  - resource coordination
  - identifying disparities and factors that contribute to them
  - supporting efforts to achieve health equity

Public Health Department
Alameda County Health

2026 Community Health Assessment – Health Needs

Social Determinants of Health: Economic and environmental factors

Chronic Diseases: Screening, timely treatment



Communicable Diseases: Awareness and education

Behavioral Health: Access, culturally relevant

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Alameda County Health

Where can I find the CHA?

- Website: temporarily posted here

Alameda County Public Health Department 2026 CHA | Actionable Insights

- Website: future link here

Community Health Needs Assessment and Community Health Improvement Plan | Public Health Department | Alameda County Health

- One pagers forthcoming
- Bluesky | Instagram | Facebook

Community Health Improvement Plan (CHIP)

A CHIP is an **action-oriented plan** for addressing pressing health needs across Alameda County by:

- Using CHA data to inform priority areas
- Collaborating with:
  - community organizations
  - hospitals
  - managed care plans
  - community members
- Coordinating and utilizing community partnership to see **measurable health outcomes**

"The distinguishing factor of the CHIP is that it relies on collaborative participation and community engagement."

Source: Healthy Marin Partnership: A Community Health Improvement Plan.

Public Health Department
Alameda County Health

2023-2025 CHIP Impacts | Internal Signature Programs

Three Priority Areas: Access to Care, Economic Security & Opportunities, Promoting Peaceful Families & Communities

	Key Achievements
Doula Program	Advanced birth justice, trained 98 doulas, served 176 families, expanded reimbursement for doulas and access to doula services through MCPs: Alameda Alliance and Kaiser Permanente
Front Door	Piloted asthma care partnership with multilingual outreach and culturally responsive staffing, receiving over 1,500 referrals from Alameda Alliance
Immunization Program	Piloted school-based outreach for the Human Papillomavirus (HPV) vaccine. Advanced efforts to improve data sharing with MCPs to target outreach efforts

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2023-2025 CHIP Impacts | Internal Signature Programs

Three Priority Areas: Access to Care, Economic Security & Opportunities, Promoting Peaceful Families & Communities

Key Achievements

Office of Violence Prevention

Invested $5.74M in 19 grantees for hospital and community-based violence prevention initiatives; strengthened collaboration and data sharing. Developed Countywide gun violence report.

Sexual & Reproductive Health

Established long-term STI screening and prevention at Santa Rita Jail through provider training and inmate outreach. Provided leadership development and capacity building for LGBTQ men of color at the LGTBQ+ Center.

Women, Infants, and Children (WIC) Program

Launched Pregnancy Day events, now provided at all full-time WIC offices, and increased attendance by African American clients. Partnered with MCPs to improve referrals.

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2025-2028 CHIP Priority Areas

Access to Care

- Health, dental, and behavioral health care access and delivery that is high quality, comprehensive, affordable, and culturally and linguistically appropriate.

Economic Security & Opportunities

- Economic security and opportunity that support the ability of all residents to be able to pay for basic needs, build wealth, and strengthen community resilience.

Peaceful Families and Communities

- Ensuring neighborhood safety through violence prevention and promoting community resilience in the face of disasters and emergencies.

Public Health Department
Alameda County Health

Building Blocks for the CHIP

Engage community

- Disseminate CHA
- Engage hospitals, MCPs, steering committee, community leaders, residents

Identify Strategies for CHIP Outcomes

- Convene implementation strategy meeting with key stakeholders
- Work with CHIP RFP Partners
- Solidify benchmarks for each strategy

Evaluate

- Conduct evaluation efforts that identify and quantify policies and impacts

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Alameda County Health

CHIP RFP

- Awards $2.0 million to three awardees
- CHIP Priority Areas: Access to Care, Economic Security and Opportunities, Promoting Peaceful Families and Communities
- The contract period begins **October 1, 2026**, for an initial 12-month pilot.
- Bidders must propose activities aligned with one Community Health Improvement Plan (CHIP) Priority.
- Bidders must attend Bidders conference in May. (completed on 5/20 & 21)

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2026 CHIP Timeline

Jan - May

- **Preparation Phase**
  - Distribute CHA, share CHA results
  - Review hospital CHNA implementation strategies and identify data benchmarks by hospitals
  - Prepare CHIP RFP
  - Identify community assets across Alameda County

May - July

- **Planning Phase**
  - Host hospital/MCP convening to establish CHIP strategies
  - Narrow and develop CHIP strategies
  - Select CHIP Implementation Partners

July - Sept

- **Strategy Identification Phase**
  - Convene implementation strategy meeting with key stakeholders (steering committee, hospitals/MCPs, residents, nonprofits)
  - Solidify benchmark data and program performance data for each CHIP implementation strategy

Public Health Department
Alameda County Health

Discussion & Questions

Public Health Department
Alameda County Health

Contact

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Andrea Wise, Program Specialist
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Quality Improvement Health Equity (QIHE) Program

Quality Improvement Health Equity
Overall Objectives

Advance Health Equity
Everyone gets fair, equal access to quality care

Support Communities
Address social factors that affect health

Whole-Person Care
Treat the full person — body, mind, and social needs

Track Quality
Measure and improve how care is delivered

Close the Gaps
Reduce differences in health outcomes across all populations

Keep Improving
Use continuous quality improvement to raise standards over time

*Aligned with the DHCS Comprehensive Quality Strategy | *NCQA QI 1, Health Outcomes 7*

Quality Improvement Health Equity
Program Components

Member Experience & Access to Care

Safe care

Community Health Strategy
Community Health Workers as trusted connectors

Quality Performance
Top quality scores

Population Health & Equity
Address Social Drivers of Health and reduce disparities in health outcomes

NCQA Accreditation
Achieve high standards and excellence

How do we monitor quality?

- **Feedback** from members, providers, and the community!
- **Managed Care Accountability Set (MCAS)/STARS** – preventive care, chronic disease
- **Key Performance Indicators** (examples)
  - Initial Health Appointments
  - Emergency Visits
  - Inpatient Visits
  - Behavior health utilization
- **Surveys**
  - Member Experience
  - Timely access
- **Grievances and Potential Quality Issues**
- **Facility site and medical chart review**

Managed Care Accountability Set (MCAS)

ALAMEDA Alliance FOR HEALTH

Quality Measures: 17 out of 18 above the 50th percentile

Below 50th (1 measure)

- Controlling High Blood Pressure

50th percentile (9 measures)

- Lead Screening
- Well-child visits (0-30 mo)
- Child/Adolescent Well Care (WCV)
- Asthma Medication Ratio (AMR)
- Glycemic Status >9.0% (GSD)
- Breast Cancer Screening (BSC)
- Cervical Cancer Screening (CCS)
- Colorectal Cancer Screening (COL)

75th percentile (6 measures)

- ED Follow-Up: Mental Illness (FUM)
- Developmental Screening (DEV)
- Chlamydia Screening (CHL)
- Postpartum Care (PPC-Pst)
- Topical Fluoride (TFL)

90th percentile (3 measures)

- ED Follow-Up: Alcohol/Drug Dependence (FUA)
- Childhood Immunizations (CIS-10)
- Immunization for Adolescents (IMA-2)

Our Commitment: Driving high-quality care and better health outcomes for our members.

Challenges we are hearing about

Lack of awareness regarding preventive care requirements
It's not always clear which preventive care services I should get or why they matter.

Members not going to their assigned primary care providers
It's hard to connect with my assigned provider or I don't understand why it's important.

Incorrect member contact information
My contact info changes, so I miss important calls, letters, or reminders.

Managing multiple chronic conditions
It's overwhelming to manage more than one health condition at the same time.

Access and appointment availability
It's hard to get appointments that fit my schedule or are available soon enough.

No show
Sometimes I forget about appointments or something comes up and I can't make it.

Health disparities in certain populations
Some groups in our community face more barriers and have worse health outcomes.

What we are working on

- **Population Health strategies**
- **Better outreach through trusted partners**
  - Alliance staff (i.e. QI Engagement Coordinators)
  - Community Health Workers (CHW)
  - Pharmacist outreach
- **Chronic care management**
  - Blood pressure remote monitoring
- **Access to care**
  - Extended Office Hours provider incentive
  - Care Options document
  - Network expansion: doulas, CHWs, vendors
- **Stronger community partnerships**
  - First 5
  - Community events and health fairs
- **Internal cross-collaboration**

What success looks like

Quality Improvement Health Equity

- **Top quality scores across all quality measures:**
  - Children
  - Maternal Health
  - Chronic Disease management
  - Behavioral Health

- **Low rates for emergency room (ER) visits**

- **Better preventive care strategies**

- **Timely access to care**

- **Reduced care gaps across communities**

Thank you.

Questions?

Medi-Cal for Kids & Teens:

Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) Services

June 11, 2026

What is Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)?

Also known as “Medi-Cal for Kids and Teens”

- Children, Teens, and Young Adults (under 21) enrolled in the Alliance qualify for free services and support to stay or get healthy

Goal: Ensures that children get the Right Care at the Right Time in the Right Place

- Comprehensive age-appropriate health care services
- Preventive screenings, diagnostic services, and treatment services
- Screenings, covered benefits, and services of medical necessity

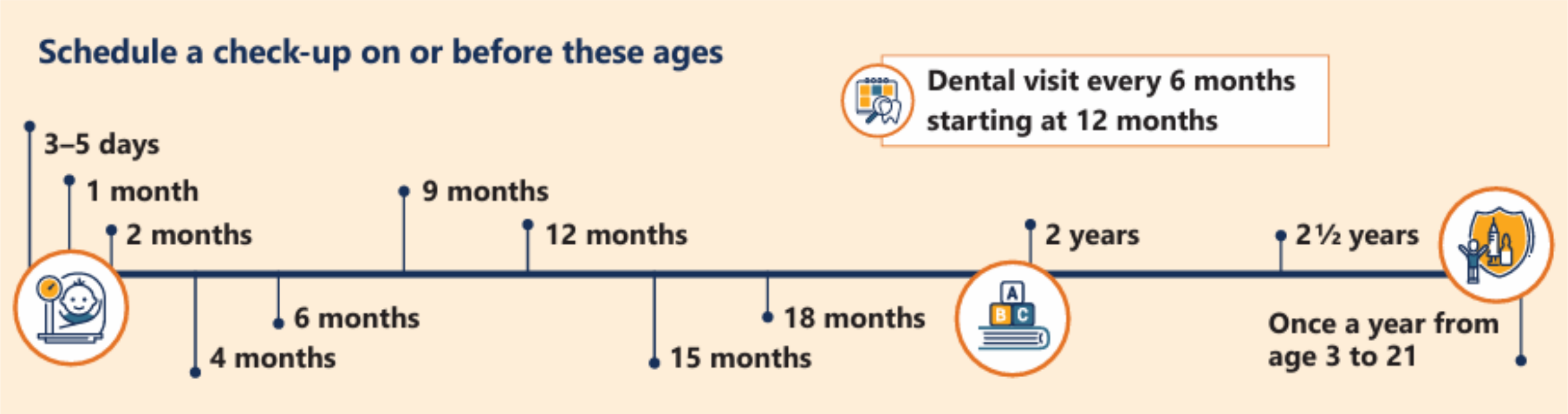
Well-Child Visits

Free Check-Ups

- Physical Exam
- Social and family health history
- Immunizations
- Dental Health and Fluoride varnish
- Hearing and Vision
- Behavioral/Mental Health Needs
- Lead Screening
- Developmental milestones
- And other preventive care services and topics based on the child's age!

Well-Child Visits

- Based on Bright Futures/American Academy of Pediatrics



periodicity_schedule.pdf

How do we monitor care for children?

- Managed Care Accountability Measures – Children's Health
- Claims data and encounter data
- Surveys
  - Member Experience
  - Timely Access to Care
- Facility and medical record reviews
- Utilization of services
  - Emergency room visits
  - Inpatient visits
  - Behavioral health visits
  - Care Management referrals
- Grievances and Potential Quality Issues

Managed Care Accountability Measures – Children's Health

HEDIS PERFORMANCE HIGHLIGHTS

90th
Childhood & Adolescent Immunization Rates 90 %tile National HEDIS Benchmarks

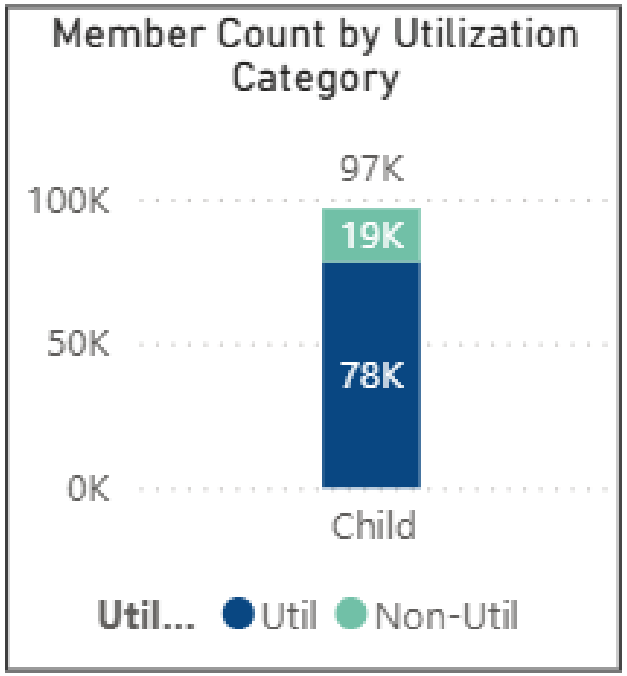
65%+
Children 0–30 Months Completed Required Number of Well Visits

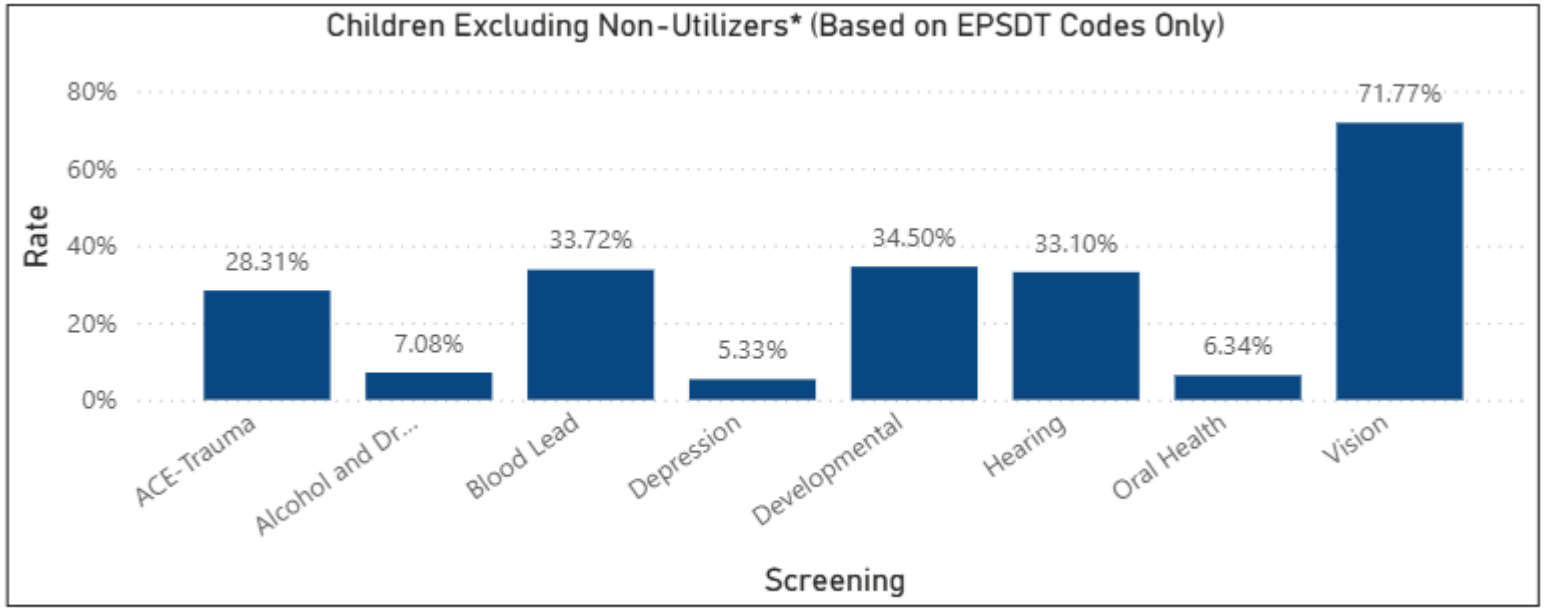
8 / 8
Childhood Measures Above the 50th %tile National HEDIS Benchmarks

ALL 8 TRACKED MEASURES

- ✓ **Childhood Immunization** (0–2 years)
- ✓ **Immunization for Adolescents** (9–13 years)
- ✓ **Developmental Screening** (First 3 Years of Life)
- ✓ **Lead Screening in Children**
- ✓ **Topical Fluoride for Children**
- ✓ **Well Child Visit 6+** (0–15 months)
- ✓ **Well Child Visits 2+** (15–30 months)
- ✓ **Child & Adolescent Well Care Visits** (3–21 years)

EPSDT Quality Monitoring: Non-utilizer





*Non-utilizer: no paid or medical rx claims during the service date period.

Dates of Service: 2/2025 – 1/2026

No PCP Visits

- Black or African American children had the highest % No PCP Visits with a moderate % Non-Utilization.

Subgroup	No PCP Visits	Non-Utilization
Children and Adolescents	**41.3%**	**16.3%**
Ages 11-20	46.2%	18.8%
SPD	50.4%	9.8%
Filipino	51.7%	29.0%
White	53.9%	26.4%
American Indian/Alaska Native	54.4%	15.6%
Black/African American	59.7%	18.1%

Well Child Activities

- Population Health & Equity
  - Patient identification & dashboards
  - Stakeholder input on root causes and actions
  - Health Education
- Community Driven
  - Community Health Workers (CHW)
    - First 5
    - Pediatric practices
  - Outreach at community events (e.g. health fairs, cultural events)
- Care Management
  - Care coordination
- Access
  - Timely Access to Care
  - Outreach for post-emergency room visits and alternative care options to obtain care

Well Child Initiatives

- Member Driven
  - Well Child Birthday Cards/Letters
  - Incentives
  - Outreach
  - Well Visit Campaigns
- Provider Driven
  - Provider Meetings – data sharing & QI project initiatives
  - Education – webinars, tip sheets
  - QI coaching to improve clinic workflows
  - QI funding
- Data Approach
  - Provider care gap reports

Discussion

- How can the Alliance encourage more children/parents to get well-child visits with their PCPs?
  - Race/Ethnicity or Cultural considerations
    - Black/African American
    - Filipino
    - American Indian/Alaska Native
    - White
  - Time span:
    - During pregnancy and at birth
    - Middle school years (9-11 years old)
    - Young adults (18-21 years old)

Questions?

Alliance Wellness: Model of Care and Medicare Stars Performance

Allison Lam, Executive Director, Health Care Services
Kayla Williams, Manager of Member Experience and Program Management

Model of Care (MOC) Key Components

The **Model of Care (MOC)** is the foundation for how a Dual Eligible Special Needs Plan (D-SNP) delivers coordinated, high-quality, and person-centered care to its members. It is required by CMS and is the **guiding framework** for identifying and addressing the unique medical, behavioral, functional, and social needs of dually eligible individuals.

Description of the D-SNP Population

Care Coordination

Specialized Provider Network

Quality Measurements and Performance Improvement

Care Coordination

Health Risk Assessment (HRA)

Face to Face Encounter

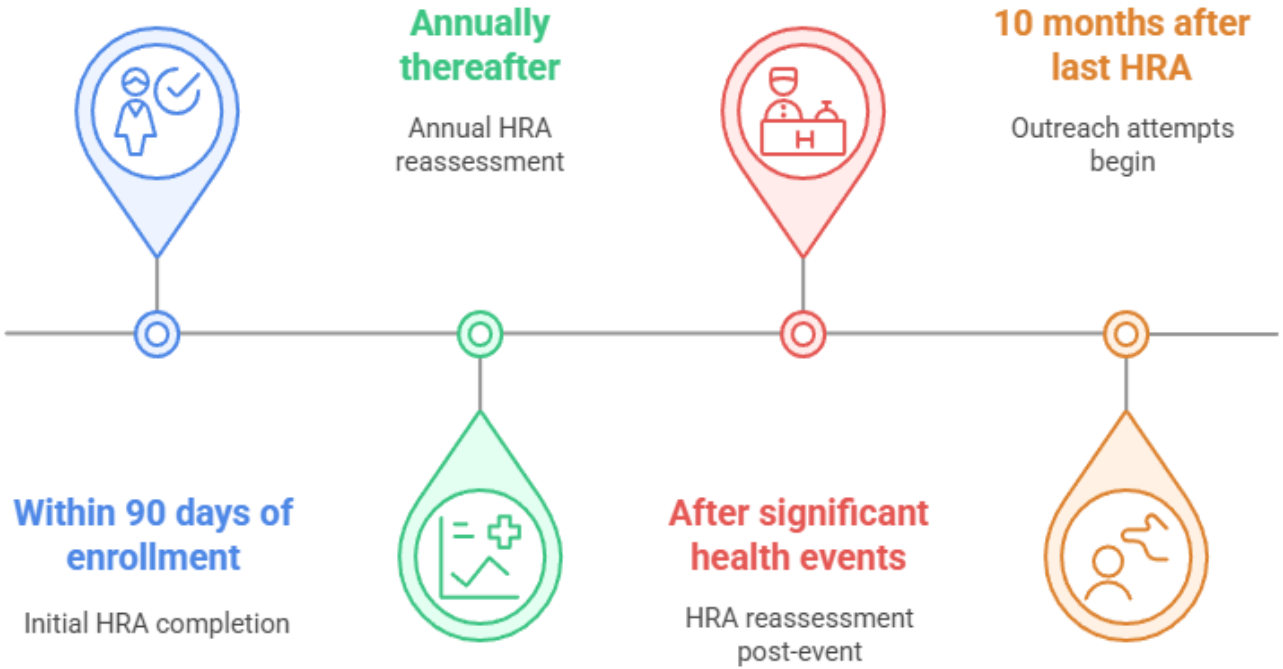
Individualized Care Plan (ICP)

Interdisciplinary Care Team (ICT)

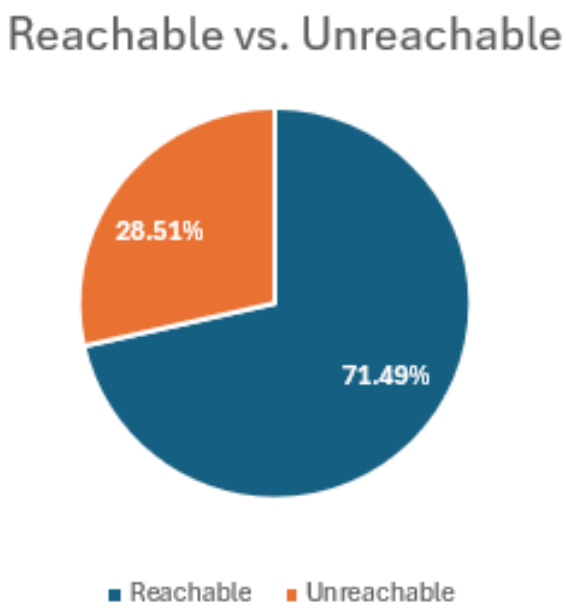
Care Transition Protocols

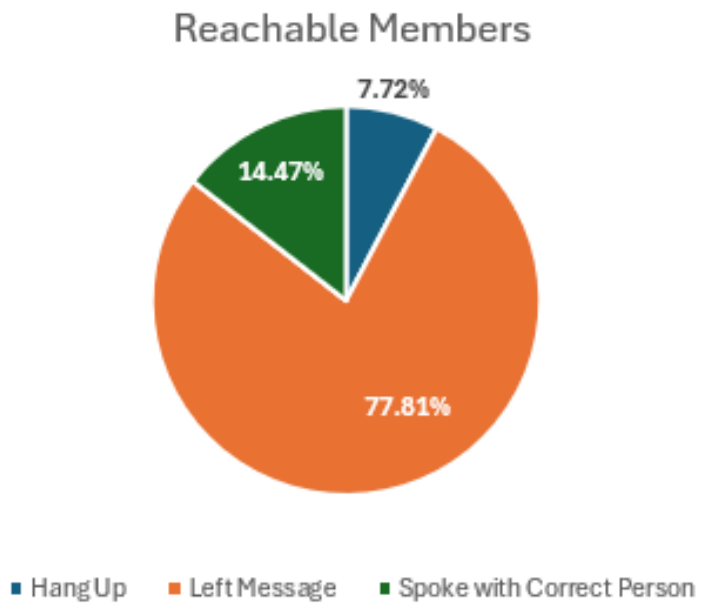
Health Risk Assessment

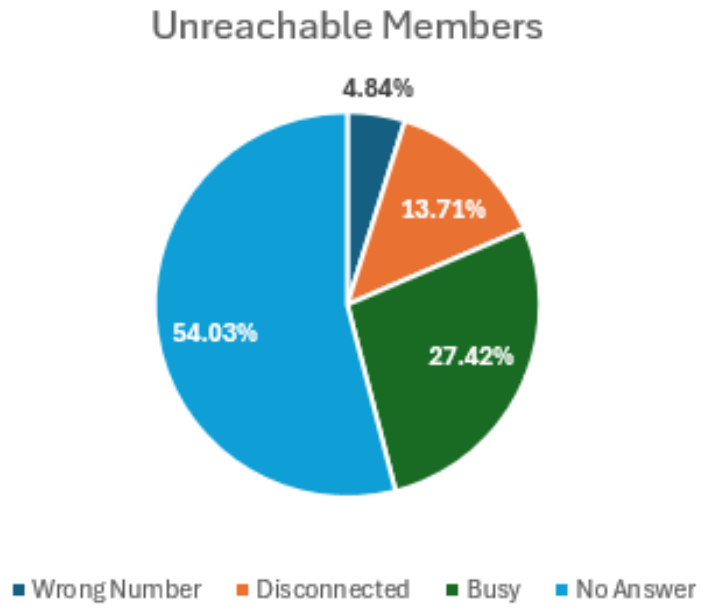
- A **structured tool** used to collect data on:
  - Medical, behavioral, functional, and cognitive needs
  - Social Determinants of Health (SDOH)
  - Member preferences and goals
- Includes **tailored questions** to identify:
  - Cognitive impairments
  - Behavioral health risks
  - Assess caregiver stress and capacity
- Completed within **90 days of enrollment**
  - Attempted on every D-SNP member
  - Annually thereafter
  - After significant health events



Health Risk Assessment – Initial Outreach Outcomes*

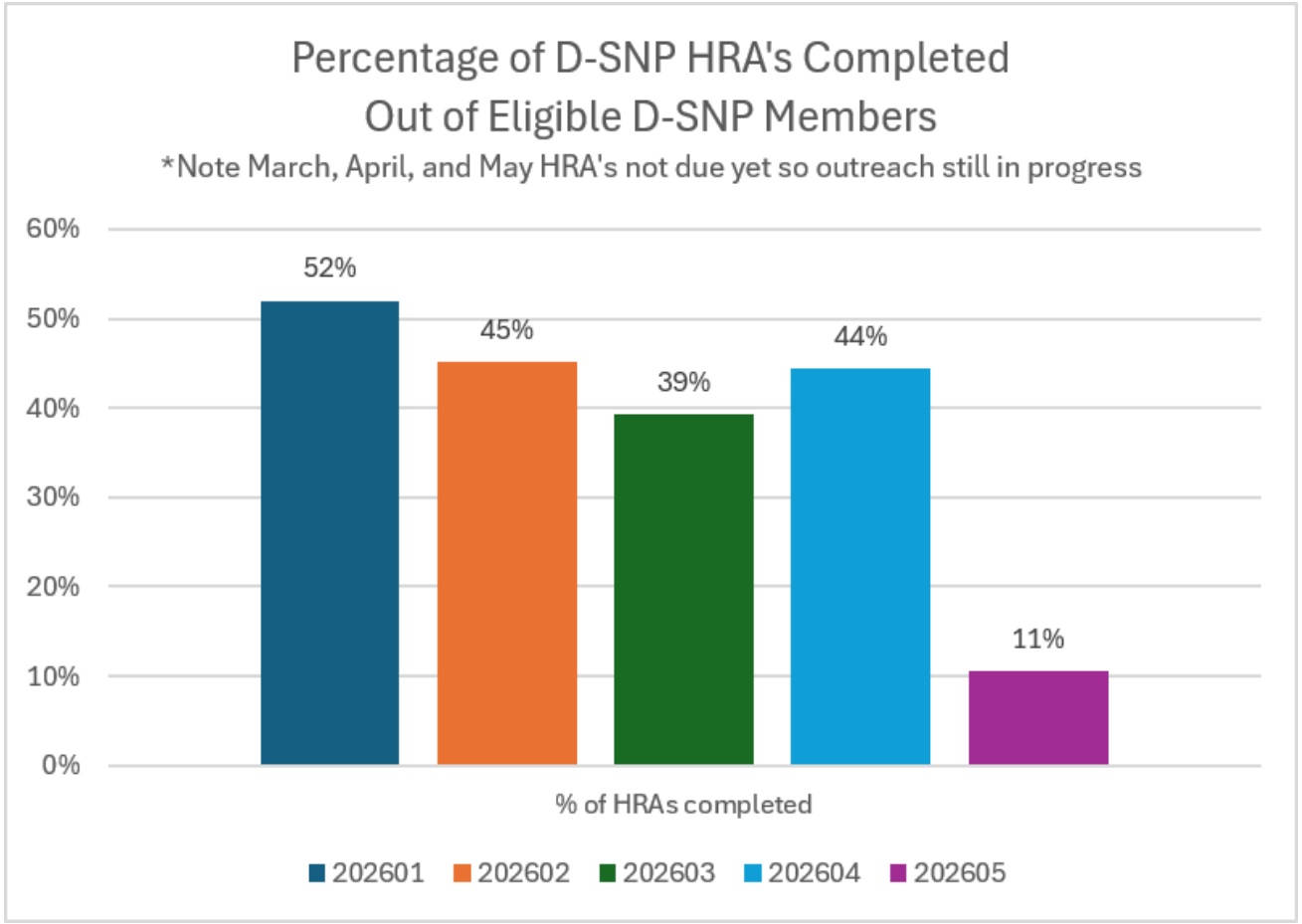






**initial attempts made by live representatives within 21 days of enrollment*

Health Risk Assessment – Completion Rate



Medicare Stars Program

The health plan's Medicare Star Rating:

- Reflects the quality of care, safety, and experience members have.
- Is published on Medicare's websites for eligible members to use when choosing their insurance.
- Impacts the plan's funding to expand benefits and provide the D-SNP plan to more community members.

5 Stars: Excellent

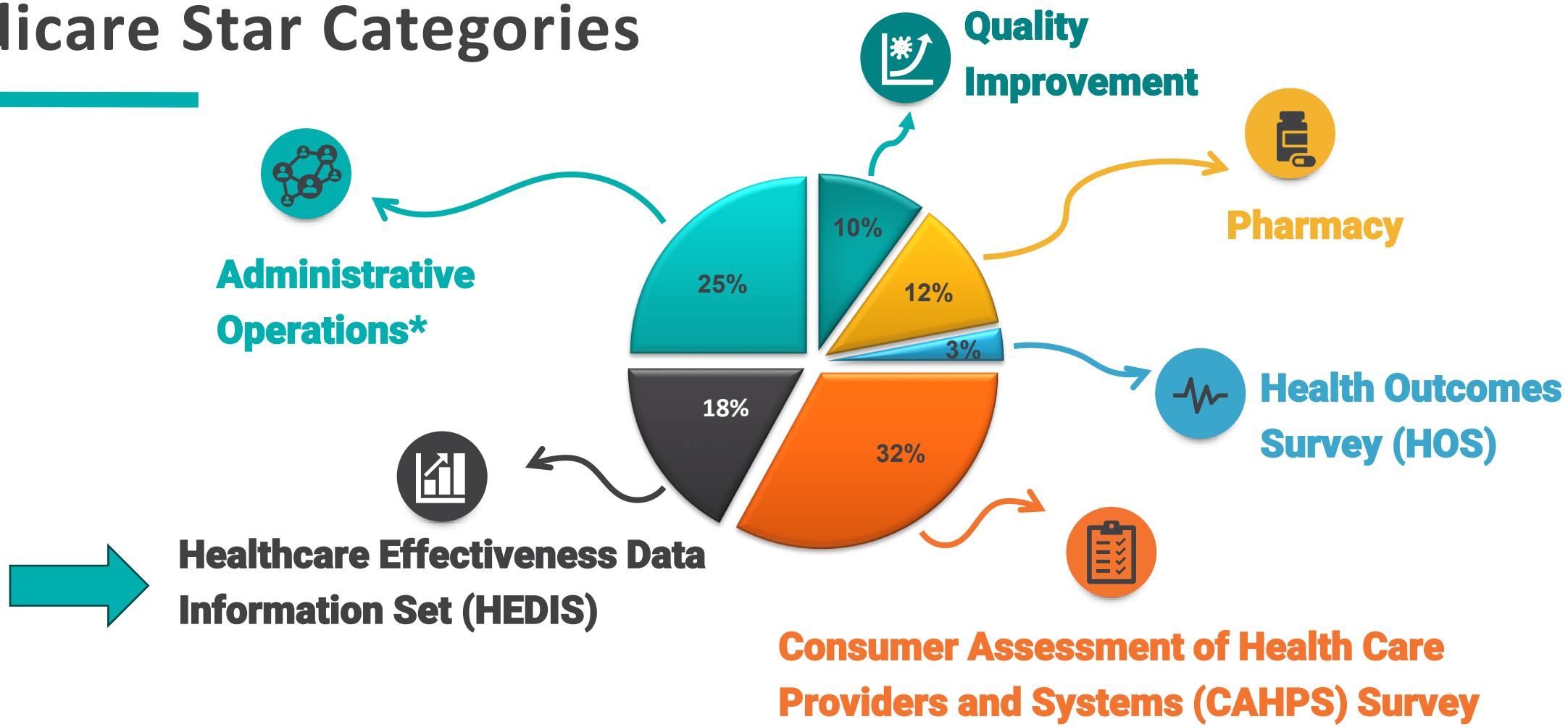
4 Stars: Above Average

3 Stars: Average

2 Stars: Below Average

1 Star: Poor

Medicare Star Categories



**Administrative Operations will be eliminated by the end of Measurement Year 2027*

Sample of Current Stars Performance

Medicare Star Measure		Percent of eligible members with service complete
	Care for Older Adults: Functional Status Assessment	14%
	Blood Pressure in Control for Patients with Hypertension	36%
	A1c Control for Patients with Diabetes	17%
	Kidney Health Evaluation	17%
	Eye Exam for Patients with Diabetes	56%
	Transitions of Care: Patient Engagement	63%

D-SNP Member Incentive Program

D-SNP Flex Card	$	Healthy Activity	Population
	$50	Initial Preventive Physical Exam, Annual Wellness Visit, or In Home Assessment	All members
	$25	Influenza Vaccine	All members
	$25	Colorectal Cancer Screening	Members 45-75
	$25	Breast Cancer Screening	Women 40-74
	$25	A1c Test	Members up to 75 with diabetes (type 1 or 2)
	$25	Diabetes Eye Exam	Members up to 75 with diabetes (type 1 or 2)

Committee Input

- Ideas to **improve initial outreach & engagement** of D-SNP members within 90-days of enrollment
  - *How do you prefer to be notified of program offerings? (telephone, flyer, text, etc.)*
- Ideas to **increase completion rate** of Health Risk Assessment
  - *How do you prefer to respond to health-related questionnaires? (over the phone, online, mail, etc.)*
- Ideas to **increase caregiver participation** in Health Risk Assessment
- Ideas to encourage **members to stay connected with their case manager** after the Health Risk Assessment is complete
- Ideas to **support members manage their chronic conditions**
  - *Example: Diabetes, hypertension, chronic kidney disease, dementia*

Thank you.

Questions?

You can contact us at:
deptcmdm@alamedaalliance.org
stars@alamedaalliance.org

Brown Act Meeting Update

Danube Serri JD, Esq.,
Supervisor, Legal Services

Annual CAC Charter Update

Mao Moua
Manager, Cultural and Linguistic Services

CAC CHARTER Updates

Area	Description of Change(s)
Voting	• Removed requirement to have virtual attendance approved by vote.
Meeting Schedule and Special Participation	• Updated CAC member meeting participation to align with new Brown Act provisions and Senate Bill 707 and Welfare & Institutions Code requirements. • Added the following provisions: → CAC meetings may be held in person, virtually, and/or hybrid format. → CAC meetings will continue to be held in person based on operational/business needs and accessibility considerations. → CAC members are expected to participate regardless of meeting format.
Other Updates	• Minor grammar and formatting updates.

Review CAC Membership: Terms of Service and Attendance

Mao Moua
Manager, Cultural and Linguistic Services

CAC CHARTER: Membership Terms of Service

- **Membership Terms of Service and Attendance:**
  - "New CAC members will be invited to serve based on the membership criteria and with the approval of the CAC Selection Committee.
  - The term of service for each CAC member shall be two (2) years.
  - Committee members may serve more than two (2) terms, at the discretion of the CAC Selection Committee.
  - The CAC Selection Committee may dismiss a member from the CAC if they do not attend at minimum two (2) quarterly meetings of the committee within one (1) year.
  - Members shall notify the Alliance of expected absences."

CURRENT MEMBERSHIP REVIEW

- Total Current CAC Members: 25
- Membership Changes:
  - Welcomed six (6) new CAC Members
    - Diana Janeth Espinel
    - Darcell Davis
    - Iris Abarca
    - Nacerddine Azeb
    - Tee Kimmons
    - Jie Feng
  - Three (3) CAC Members did not meet the minimum attendance requirement and are no longer serving on the CAC.

Thank you.

Questions?

COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2025 - 2026 | **3RD QUARTER (Q3) OUTREACH REPORT**

ALLIANCE IN THE COMMUNITY

FY 2025 - 2026 | 3RD QUARTER (Q3) OUTREACH REPORT

Between January 2026 and March 2026, the Alliance completed **1,654** member orientation outreach calls among net new members and non-utilizers and conducted **146** net new member orientations and **9** non-utilizer member orientations (**23%** member participation rate). In addition, the Outreach team completed **31** Alliance website inquiries, **22** service requests, **13** community events, **11** member education events and **1** Community Meeting/Presentation events in Q3. Our sponsorships for the OCCC Chinatown Lunar New Year event and the Black Joy Parade were $5,000 and $6,000, respectively, engaging more than **20,000** and **120,000** participants through these two events. We also participated in the Black Joy Parade for the first time, walking in the parade to celebrate Black History Month and 30 years of the Alliance serving the community.

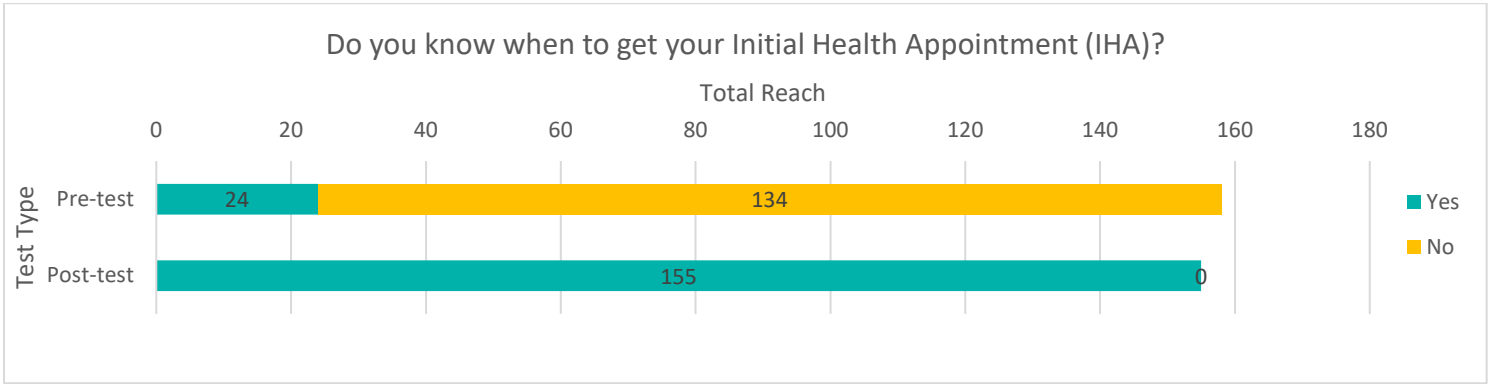
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, approximately **45,650** self-identified Alliance members have been reached during outreach activities.

On **Monday, March 16, 2020**, the Alliance began assisting members by telephone only, following the statewide Shelter-in-Place (SIP) guidance to protect the general public from the Coronavirus Disease (COVID-19). As a result, the Alliance proactively postponed all face-to-face member orientations and community events until further notice.

On **Wednesday, March 18, 2020,** the Alliance began conducting member orientations by phone. As of **Tuesday, March 31, 2026**, the Outreach Team has completed **56,267** member orientation outreach calls and conducted **10,390** orientations, achieving a **18.5%** participation rate.

The Alliance Member Orientation (MO) program has been in place since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Appointment, by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between March 18, 2020, through March 31, 2026, **10,390** members completed our MO program by phone.

After completing a MO, **100%** of members who completed the post-test survey in Q3 FY 25-26 reported knowing when to get their IHA, compared to only **15.2%** of members knowing when to get their IHA in the pre-test survey.



All report details can be reviewed at: **W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Outreach Reports\FY 25-26\Q3\March 2026**

ALLIANCE IN THE COMMUNITY

FY 2025 - 2026 | 3RD QUARTER (Q3) OUTREACH REPORT

Q3 FY 2025-2026 TOTALS

13	COMMUNITY EVENTS	142406	TOTAL REACHED AT COMMUNITY EVENTS
11	MEMBER EDUCATION EVENTS	1773	TOTAL REACHED AT MEMBER EDUCATION EVENTS
155	MEMBER ORIENTATIONS	155	TOTAL REACHED AT MEMBER ORIENTATIONS
1	MEETINGS/ PRESENTATIONS	75	TOTAL REACHED AT MEETINGS/PRESENTATIONS
31	TOTAL INITIATED/INVITED EVENTS	2063	TOTAL MEMBERS REACHED AT EVENTS
180	TOTAL EVENTS	144409	TOTAL REACHED AT ALL EVENTS

ALAMEDA
ASHLAND
BERKELEY
CASTRO VALLEY
DUBLIN
FREMONT
HAYWARD
LIVERMORE
NEWARK
OAKLAND
PLEASANTON
SAN LEANDRO
SAN LORENZO
UNION CITY

TOTAL REACH 17 CITIES

Cities represent the mailing addresses for members who completed a Member Orientation by phone. The following cities had <1% reach during Q3 2026: Albany, Emeryville, and Fairview. The C&O Department started including these cities in the Q3 FY21 Outreach Report.

$11150.00

TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

** Includes refundable deposit.*

Presentation Questions and Feedback
June 11, 2026

1. **Do you have any feedback and/or questions about the following topics presented today:**
    a. ACPHD: Community Health Improvement Plan Evaluation

    b. Quality Improvement Program

    c. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

    d. STARs/MOC Outcomes

2. **Please share other questions or ideas you may have:**

Name (optional, please include if you want us to contact you)**:**

Best way to contact (optional):

Questions? Please email livehealthy@alamedaalliance.org