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 **mchi@alamedaalliance.org.** YOU MAY WATCH THE MEETING LIVE BY LOGGING IN BY COMPUTER. CLICK THE LINK PROVIDED IN YOUR EMAIL OR MAY LISTEN TO THE MEETING BY CALLING IN TO THE FOLLOWING TELEPHONE NUMBER**: 1.510.210.0967**, CODE: **232 186 923#.** 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.

Meeting Name:	**Community Advisory Committee (CAC)**		
Date of Meeting:	March 20, 2025	**Time:**	10:00 AM – 12:00 PM
Meeting Chair and Vice Chair:	Vacant, Chair Tandra DeBose, Vice Chair	**Location:**	Video Conference Call and in-person. Oakland/Hayward Rooms 1240 South Loop Road Alameda, CA 94502
Call In Number:	Telephone Number: **1.510.210.0967** Code: 232 186 923#	**Webinar:**	**Join the meeting now** in Microsoft Teams. Link is also in your email.

Alameda Alliance for Health
Community Advisory Committee Meeting Agenda

I. 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.

II. Members

Name	Title	Name	Title
Natalie Williams	Alliance Member	Jody Moore	Parent of Alliance Member
Valeria Brabata Gonzalez	Alliance Member	Sonya Richardson	Alliance Member
Cecelia Wynn	Alliance Member	Mimi Le	Alliance Member
Tandra DeBose	Community Advocate, Vice Chair	Mayra Matias Pablo	Parent of Alliance Member
Irene Garcia	Alliance Member	Kerri Lowe, LCSW	Alameda County Public Health
Erika Garner	Alliance Member		
Roxanne Furr	Alliance Member		

III. Meeting Agenda

Topic	Responsible Party	Time	Vote to approve or Information
Welcome and Introductions • Member Roll Call • Alliance Staff • Visitors	**Tandra DeBose** Vice Chair	5	Information
Approval of Minutes and Agenda			
1. Approval of Minutes from • December 5, 2024 • December 16, 2024	**Tandra DeBose** Vice Chair	3	Vote
2. Approval of Agenda	**Tandra DeBose** Vice Chair	2	Vote
CEO Update			
1. CEO Report	**Matt Woodruff** Chief Executive Officer	20	Information
Follow-up Items			
1. Follow-up Items from	**Mao Moua**	5	Information

III. Meeting Agenda			
Topic	**Responsible Party**	**Time**	**Vote to approve or Information**
• December 5, 2024 • December 16, 2024	Manager, Cultural and Linguistic Services		
New Business			
1. Community Supports and Housing	**Shatae Jones** Director, Housing & Community Services Program	20	Information
Alliance Reports			
1. Grievances and Appeals • 2024	**Jennifer Karmelich** Director, Quality Assurance	20	Information
CAC Business			
1. CAC Charter	**Mao Moua** Manager, Cultural and Linguistic Services	5	Discussion/Vote
2. CAC Chair Nominations and Voting	**Linda Ayala** Director, Population Health & Equity	15	Vote
3. Confidentiality Statement Updates	**Misha Chi** Health Education Coordinator	3	Information
Open Forum 1. Public Comments 2. Next meeting topics	**Tandra DeBose** Vice Chair	5	Information
Adjournment	**Tandra DeBose** Vice Chair	5	Next meeting: **June 12, 2025**

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 **Misha Chi** 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, December 5, 2024, 10:00 AM – 12:00 PM

Committee Members	Role	Present
Natalie Williams	Alliance Member	x
Valeria Brabata Gonzalez	Parent of Alliance Member	x
Cecelia Wynn	Alliance Member	x
Tandra DeBose	Community Advocate	x
Irene Garcia	Alliance Member	x
Erika Garner	Alliance Member	x
Jody Moore	Parent of Alliance Member	x
Sonya Richardson	Alliance Member	
MiMi Le	Alliance Member	x
Mayra Matias Pablo	Parent of Alliance Member	
Amy Sholinbeck	Asthma Coordinator, Alameda County Asthma Start	x
Irene Garcia	Alliance Member	x
Roxanne Furr	Alliance Member	x
Kerrie Low	Social Worker, Alameda County Public Health Department (ACPHD	x

Other Attendees	Organization	Present
Kellie Knox	City of Berkeley	x
Melodie Shubat	CHME	x
Jennifer Gudiel	ACPHD	x
Carolina Guzman	ACPHD	x
Rebecca Gebhart	Alliance Board of Governors Chair	x
Janice Chin	City of Berkeley	x
Kathrine Shea	Department of Health Care Services	x
Esmail Khaledi	Unknown	

Alliance Staff Members	Title	Present
Matthew Woodruff	Chief Executive Officer	x
Michelle Lewis	Senior Manager, Communications & Outreach	x
Alejandro Alvarez	Community Outreach Supervisor	x
Thomas Dinh	Outreach Coordinator	x
Linda Ayala	Director, Population Health and Equity	x
Mao Moua	Manager, Cultural and Linguistic Services	x

Steve Le	Outreach Coordinator	
Isaac Liang	Outreach Coordinator	x
Rosa Carrodus	Disease Management Health Educator	x
Lao Paul Vang	Chief Health Equity Officer	x
Gil Duran	Manager, Population Health and Equity	x
Emily Erhardt	Population Health and Equity Specialist	x
Gabriela Perez-Pablo	Outreach coordinator	x
Michelle Stott	Senior Director, Quality Improvement	x
Mara Macabinguil	Interpreter Services Coordinator	x
Katrina Vo	Senior Communications and Content Specialist	x
Misha Chi	Health Education Coordinator	x
Farashta Zainal	Quality Improvement Manager	x
Loc Tran	Manager, Access to Care	x
Jorge Rosales	Manager, Case Management	x
Anne Margaret Macsiljig	Quality Engagement Coordinator	
Donna Carey	Chief Medical Officer	x
Peter Currie	Senior Director of Behavioral Health	
Yen Ang	Director of Health Equity	x
Taumaoe Gaoteote	Director of Diversity, Equity, and Inclusion	
Jessica Jew	Population Health and Equity Specialist	x
Jennifer Karmelich	Director of Quality Assurance	
Monique Rubalcava	Health Education Specialist	x
Stephen Smyth	Director of Compliance and Special Investigations	x
Andrea DeRochi	Behavioral Health Manager	x
Oscar Macias	Housing Manager	x
Sean Pepper	Compliance Special Investigator	x
Cecilia Gomez	Senior Manager, Provider Services	x
Yemaya Teague	Senior Analyst of Health Equity	x
Karina Rivera	Senior Manager, Public Affairs and Medica Relations	x
Alma Pena	Senior Manager, Grievance and Appeals	x
Vanessa Suarez	Manager, Vendor Management	x
Adrina Rodriguez	Privacy Compliance Specialist	x

AGENDA ITEM SPEAKER	DISCUSSION	ACTION	FOLLOW-UP
1. WELCOME AND INTRODUCTION			
T. Debose	T. Debose called the meeting to order at 10:03 am.	None	None

	Roll call was taken and a quorum was established. An introduction of staff and visitors was completed.		
2. a. APPROVAL OF MINUTES AND AGENDA – APPROVAL OF MINUTES FROM JUNE 13, 2024			
T. Debose	Motion to approve the September 19, 2024 meeting minutes.	Motion: N. Williams Second: C. Wynn Vote: Approved by consensus	None
2. b. APPROVAL OF MINUTES AND AGENDA – APPROVAL OF AGENDA			
T. Debose	Motion to approve switching the order of the 3rd and 4th agenda items under New Business.	Motion: N. Williams Second: M. Le Vote: Approved by consensus	None
3. CEO UPDATE – ALLIANCE UPDATES			
M. Woodruff	Matthew Woodruff, Chief Executive Officer (CEO), presented on the Alliance updates. • Alliance CEO and Chief Financial Officer (CFO) met with the Department of Health Care Services five (5) times since July 2024, to advocate for increase in rates. • The state usually determines rates by looking at the past 2 to 3 years. Utilization was low in the past 2 to 3 years due to COVID. • Advocated for the state to look at the current utilization instead, from January 2024, since we transitioned from a two-plan model to a single-plan model. Utilization has increased since then. We now have 407,000 members. • The 2024 rates were received in September 2024 and they were not great. We met with the state a few more times to discuss the rates. • Good news: the state notified the Alliance on November 27, 2024, that they will relook at the 2024 rates. No exact timeline for revised rates. • We received the draft 2025 rates on December 2, 2024, with high-level information only, but the rates look much better. • We hope to get more information from the state today (12/05/2024) as our finance report is due tomorrow (12/06/2024) and the finance meeting is on Tuesday (12/10/2024). • In our draft, we are reporting a $125 Million loss for the fiscal year-not final until posted tomorrow (12/06/2024).	None	None

	• The finance team, claims team, and different teams in Healthcare Services have been looking at ways to mitigate in case the state does not help us. • Some utilization controls went to effect last Monday (December 2, 2024) with more to come into effect soon. • With all these measures in place, we will only be able to save $10 million per year, so the state needs to look at current utilization instead of utilization during COVID. • Other cost-saving measures include the hiring freeze, which saved us a total of $1.9 million. This will be lifted once we get more details from the state on our budget. • Overall, our financial outlook is not great, but it appears that the state is taking seriously what we have been asking them to do. ➢ *Member Question-N. Williams: What is the ideal amount, in a perfect world, we can get from the state that you expected?* ➢ *Response-M. Woodruff: I have to break it down by category, but in the largest category, we'll have to get a 20% to 25% raise, and we know that's not realistic with the state budget, but hopefully they can get us close to it.* ➢ *Member Question: T. Debose: Will you hear from them this month or in January?* ➢ *Response-M. Woodruff: For 2025 rates, hoping to hear from them today (12/05/2024), as we need to post our report tomorrow (12/06/2024) for the finance committee meeting next week. For 2024 rates, likely at some point in December, but we will know better in January, where we are financially.* • Preliminary Quality Scores: met 16 out of 18 measures. We will not meet one, which is the lead screening in children. We missed it by 7 members, and we are very close to meeting another, topical fluoride. We are waiting for final numbers. ❖ *Member Comment: So, we are on pins and needles until we hear from the state.* ➢ *Response-M. Woodruff: Pretty much.*		
4. FOLLOW-UP ITEMS - ITEMS FROM 09.20.2024			

M. Moua	Mao Moua, Manager of Cultural and Linguistic Services, presented the updates on the follow-up items. • Online resource survey link was sent via email on 09/19/2024 to CAC members. • Contact information of presenters from Alameda County Public Health Department was sent via email on 09/26/2024 to CAC members. • CEO Report was sent via email on 11/12/2024 to CAC members. • Medicare Program to be presented as a topic at the March or June 2025 CAC meeting. • Behavioral Health to be presented as a topic at the March or June 2025 CAC meeting.	None	None
5. a. NEW BUSINESS – POPULATION NEEDS ASSESSMENT-CITY OF BERKELEY			
G. Duran J. Chin	Gil Duran, Manager of Population Health and Equity provided an introduction on the Population Health and Management Team's work with local health jurisdictions and introduced the presenter from the City of Berkeley. • The Population Health and Management Team uses data and assessments to better understand all our members, then creates strategies for the different services offered. • Based on needs and gaps, work began this year with our local health jurisdictions. • The goal of these collaborations ultimately is to improve health and equity among our members. • G. Duran introduced Janice Chin, Manager for the Public Health Division at the City of Berkeley. Janice Chin, Manager of the Public Health Division, City of Berkeley presented on the City of Berkeley's Population Needs Assessment. . • The Public Health Division is under the Department of Health, Housing, and Community Services (HHCS). • About HHCS: ○ The HHCS Department aims to promote the health of all Berkeley residents by ensuring that they have their basic needs met. ○ Our Vision is for all residents to have affordable housing, a safe community, and the best possible health outcomes.	None	None

	○ HHCS has 6 divisions: Office of the Director, Public Health, Mental Health, Housing and Community Services, Environmental; Health, and Aging Services. • The City of Berkeley is 1 of the 3 cities in the State of California that has its own local health jurisdiction. • The HHCS reports to the City Manager, the City Manager reports to the City Council, and the City Council reports to the Berkeley residents. • The Public Health Division leads the Community Health Assessment (CHA) and the Community Health Improvement Plan (CHIP) for the HHCS Department as a whole. • Berkeley Wellness Blueprint: Project Process Map 1. Landscape Scan-already completed, helped inform which areas that need more deep diving in the CHA. 2. The CHA includes informant interviews, focus groups, and surveys. The CHA is focused on areas with more vulnerable populations or communities, and health disparities seen in the landscape scan. 3. Health Improvement Plan:3 to 4 work groups that will be focusing on 3 to 4 health areas of interest identified in the CHA and will dive even deeper to come up with strategies to address the health issues. Performance measures will be identified to help provide a goal in the improvement plant to guide the next 3 to 5 years. Recruiting has started for the workgroups and the goal is to complete the process by May 2025. • Community Steering Committee: helps drive, assess, and synthesize information being compiled, as well as drive the whole process. • The HHCS works with multiple community partners, as well as support from a consulting group called JSI Research and Training Institute. • Intended Outcomes: ○ A clear community-shaped vision of the most pressing health equity issue in Berkeley. ○ A set of impactful and feasible actions to address the identified issues. ○ Established relationships and partnerships to support collective accountability for the actions. ○ Identification of necessary resources to make the desired change. ➢ *Member Question-N. Williams: Where do you get the people that you're assessing? Are you getting elders, children, or is it across the board? How diversified is it?*		

	➢ *Response-J. Chin- We look at diversity as a key factor. For the Community Steering Committee, it was a month-long process to get people who are interested; we put out a recruitment call for it. About 65 individuals applied, and we went through a vetting process to make sure that each neighborhood was represented. We also looked at diversity within race, ethnicity, socioeconomic status, various types of expertise, and lived experience.*
	
	➢ *Member Question-C. Wynn: Are you dabbing into mental health? I don't see mental health anywhere here, and I know from living in and trying to get on my feet in Berkeley, it's not easy.*
	
	➢ *Response-J. Chin: Mental health has always been on our radar as with many communities and local health jurisdictions. This was identified in our landscape scan as a challenge in our community. It is not surprising that it was identified in our health assessment process as well. Our report is not yet finalized but in the next few slides, I will be presenting a brief overview of what was identified in our health assessment.*
	
	• Landscape Scan Summary: Overall Berkeley Residents appear to be doing fairly well in terms of health and wellness. However, the data masks ongoing inequities and disparities that were highlighted during the pandemic.
	  ○ Life expectancy: 16-year difference in life expectancy between the north most census tract I in the Berkeley Hills-Cragmont neighborhood (93 years), and the southernmost census tract in the South Berkeley -Lorin neighborhood (77 years).
	  ○ Economic environment: poverty rate for children (people under age 18) and among seniors (65 years or older) varies significantly by race. Marginalized groups have been cited by interviewees as experiencing high rates of poverty as well.
	  ○ Physical environment: some Berkeley neighborhoods-including the Berkeley Marina, Downtown Berkeley, and South Berkeley are considered by Federal Emergency Management Agency (FEMA) to be some of the most at-risk places in the state of California.
	• Community Health Assessment Process:
	  ○ Community Steering Committee: provides input regularly on the CHA, as well as how to shape the CHIP. Includes 11 diverse members.		

	○ We do lots of quantitative and qualitative data gathering. The Community Steering Committee takes that and synthesizes, assesses, reflects upon it, and helps is identify priority populations, as well as 10 health, safety, and equity issues to explore. ○ Based on the reflections, community surveys were completed. ○ Survey findings were then looked at and assessed through the Community Steering Committee to narrow down to the 6 key findings. • City of Berkeley Demographic Overview ○ Race/ethnicity: ▪ White: 51.9% ▪ Asian: 20.7% ▪ Hispanic or Latino: 12.1% ▪ Black Two or More Races: 6.6%. ○ Population total: increase in population in 2020, anticipating a dip going into 2025, and projecting rise again in 2030. ○ Educational attainment: the population is fairly educated based on their degrees and level of education. • Key priority areas from the CHA: ○ Housing ○ Community Safety ○ Environmental Health Hazards ○ Health Disparities ○ Mental Health • Next Steps: The CHIP & Beyond ○ The CHA is to be finalized by the end of the month (December 2024). ○ Two key questions that will be investigated in the CHIP ▪ What strategies have the greatest potential to be both impactful and feasible, and address the priorities that emerged from the assessment? ▪ Who can advance the strategies and with what resources? • Our Shared Goal with Managed Care Plans		

	○ Improve access to care for at least one priority population in the City of Berkeley (LGBTQ+), adolescent, older adults, or perinatal residents.		
5. b. NEW BUISINESS – ALLIANCE LOGO AND DSNP NAME FEEDBACK			
M. Lewis K. Rivera	This agenda item was not covered as the meeting was abruptly ended due to a building evacuation in response to a tsunami warning.		
5. c. NEW BUISINESS – PROVIDER MANUAL			
C. Gomez M. Lewis	This agenda item was not covered as the meeting was abruptly ended due to a building evacuation in response to a tsunami warning.		
5. d. NEW BUISINESS – NON-SPECIALTY MENTAL HEALTH SERVICES			
A. DeRochi	This agenda item was not covered as the meeting was abruptly ended due to a building evacuation in response to a Tsunami Warning		
6. a. CAC BUSINESS – CAC SELECTION COMMITTEE			
L. Ayala	This agenda item was not covered as the meeting was abruptly ended due to a building evacuation in response to a tsunami warning.		
6. b. CAC BUSINESS – CAC MEMBERSHIP RECRUITMENT			
L. Ayala	This agenda item was not covered as the meeting was abruptly ended due to a building evacuation in response to a tsunami warning.		
7. ALLIANCE CARE BAGS			
M. Lewis	This agenda item was not covered as the meeting was abruptly ended due to a building evacuation in response to a tsunami warning.		
8. OPEN FORUM			
T. Debose	This agenda item was not covered as the meeting was abruptly ended due to a building evacuation in response to a tsunami warning.		
9. ADJOURNMENT			

M. Woodruff	The meeting was abruptly concluded at 11:02 am due to an emergency. Matthew Woodruff, Chief Executive Officer, instructed the attendees to evacuate the building due to a tsunami warning	None	None

Meeting Minutes Submitted by: Mara Macabinguil, Interpreter Service Coordinator Date: 12/30/2024
Approved by: Date:

COMMUNITY ADVISORY COMMITTEE (CAC) Special Meeting

Thursday, December 16, 2024, 12:00 PM – 1:30 PM

Committee Members	Role	Present
Natalie Williams	Alliance Member	
Valeria Brabata Gonzalez	Parent of Alliance Member	
Cecelia Wynn	Alliance Member	x
Tandra DeBose	Community Advocate	x
Irene Garcia	Alliance Member	x
Erika Garner	Alliance Member	x
Jody Moore	Parent of Alliance Member	
Sonya Richardson	Alliance Member	
MiMi Le	Alliance Member	x
Mayra Matias Pablo	Parent of Alliance Member	
Amy Sholinbeck	Asthma Coordinator, Alameda County Asthma Start	
Irene Garcia	Alliance Member	x
Roxanne Furr	Alliance Member	
Kerrie Lowe	Social Worker, Alameda County Public Health Department (ACPHD)	x

Other Attendees	Organization	Present
Melodie Shubat	CHME	x
Kathrine Shea	Department of Health Care Services	x
Jesus Verduzco	ACPHD	x
Preston Poon	Department of Health Care Services	x

Alliance Staff Members	Title	Present
Matthew Woodruff	Chief Executive Officer	x
Michelle Lewis	Senior Manager, Communications & Outreach	x
Alejandro Alvarez	Community Outreach Supervisor	x
Thomas Dinh	Outreach Coordinator	
Linda Ayala	Director, Population Health and Equity	x
Mao Moua	Manager, Cultural and Linguistic Services	x
Steve Le	Outreach Coordinator	x
Isaac Liang	Outreach Coordinator	x
Rosa Carrodus	Disease Management Health Educator	x
Lao Paul Vang	Chief Health Equity Officer	x

Gil Duran	Manager, Population Health and Equity	x
Emily Erhardt	Population Health and Equity Specialist	x
Gabriela Perez-Pablo	Outreach coordinator	
Michelle Stott	Senior Director, Quality Improvement	x
Mara Macabinguil	Interpreter Services Coordinator	x
Katrina Vo	Senior Communications and Content Specialist	x
Misha Chi	Health Education Coordinator	x
Farashta Zainal	Quality Improvement Manager	x
Loc Tran	Manager, Access to Care	
Jorge Rosales	Manager, Case Management	
Anne Margaret Macsiljig	Quality Engagement Coordinator	
Taumaoe Gaoteote	Director, Diversity, Equity, Inclusion	
Donna Carey	Chief Medical Officer	x
Peter Currie	Senior Director of Behavioral Health	x
Yen Ang	Director of Health Equity	
Taumaoe Gaoteote	Director of Diversity, Equity, and Inclusion	
Jessica Jew	Population Health and Equity Specialist	x
Jennifer Karmelich	Director of Quality Assurance	
Monique Rubalcava	Health Education Specialist	x
Stephen Smyth	Director of Compliance and Special Investigations	x
Andrea DeRochi	Behavioral Health Manager	x
Sean Pepper	Compliance Special Investigator	x
Debbie Spray	Manager, IT Governance and Incident Management	x
Yemaya Teague	Senior Analyst of Health Equity	x
Karina Rivera	Senior Manager, Public Affairs and Medica Relations	x
Cecilia Gomez	Senior Manager, Provider Services	x
Oscar Macias	Housing Manager	x
Stephen Smyth	Director of Compliance and Special Investigations	x
Krystaniece Wong	Regulatory Compliance Specialist	x

AGENDA ITEM SPEAKER	DISCUSSION	ACTION	FOLLOW-UP
1. WELCOME AND INTRODUCTION			
T. Debose	T. Debose called the meeting to order at 12:03 pm. Roll call was taken of the CAC members and a quorum was not established.	None	None

	An introduction of staff and visitors was completed.		
2. APPROVAL OF MINUTES AND AGENDA – APPROVAL OF AGENDA			
T. Debose	The CAC was unable to approve the agenda as a quorum was not established at the time of roll call.	None	None
3. a. NEW BUISINESS – ALLIANCE LOGO AND DSNP NAME FEEDBACK			
M. Lewis K. Rivera	Michelle Lewis, Senior Manager of Communications and Outreach introduced the video which presents the proposed new logo for the Alliance and proposed names for the upcoming D-SNP product. • The video was played, and a QR code for a survey was displayed at the end. • The QR code did not work, however, the online survey link worked which could be accessed by the virtual attendees. In-person attendees were asked to complete the paper survey. ❖ *Member Feedback-T. Debose: The shapes were odd. The arch was shaped like a home and the circle encompassed everything. While it looks colorful, the different shapes don't seem to represent people. Maybe do something with the shapes so they mean something. The 4 shapes look weird to me.* ➢ *Response-K. Rivera: Part of it represents diversity of the community, they look like two little people. The pictorial marks and colors represent the different lines of service.* ❖ *Member Feedback-T. Debose: The ball on top of the house is weird. I like the colors.* ➢ *Response-M. Lewis: We will take back to the team these questions about why these shapes were selected.* ❖ *Member Feedback: M. Le: First thing that comes to mind is that service is for everybody. Different backgrounds, races, and ethnicities. Services are for all.* ❖ *Member Feedback- C. Wynn: Are there no more logo choices? I just wish there were more choices.*	None	M. Lewis and K. Rivera to take back to the Alliance team the questions around the new logo-why the shapes were selected.

	➢ *Response-M. Lewis: No, there are no other choices at this time.* ❖ *Member Feedback-T. Debose: As far as the DSNP name, Well+ is trendy, but for most people, they want it to be straightforward, Wellness.* ❖ *Member Feedback-M. Le: + is recognizable, + means better.* • M. Lewis thanked the CAC members for the feedback and acknowledged T. Debose's background in marketing. • The paper surveys were collected by Alliance staff.		
3. b. NEW BUISINESS – PROVIDER MANUAL			
C. Gomez M. Lewis	Cecilia Gomez, Senior Manager of Provider Services, presented on the Alliance Provider Manual. • Current: The Alliance Provider has been available for many years now. It includes important information such as services, benefits, requirements, and contacts for network providers and facilities. • Future: The Alliance will review the Provider Manual with CAC for suggestions or feedback. • Requirements: o Must be reviewed on an annual basis. o Must solicit feedback from contractor committees, including CAC. o Provider Manual was reviewed by the Quality Improvement Health Equity Committee (QIHEC) on 11/15/24. • Plan staff who are Subject Matter Experts (SMEs) are consulted to make sure information is accurate. • Discussion: How can the Alliance improve information that is available in our Provider Manual? ❖ *Member Feedback-T. Debose: The updated version looks really good. The layout is clear and straightforward, nothing to completely change.* • M. Lewis: The provider manual is available online. Similar to the member handbook, we do have a printed version. ➢ *Member Question-T. Debose: Does the 11/15/24 have the most recent changes?*	None	None

	➢ *Response-M. Lewis: Yes* ❖ *Member Comment-T. Debose: You did a great job.* ➢ *Member Question: Will the Care Books be incorporated?* ➢ *Response-M. Lewis: No, they will not be.* ➢ *Response-L. Ayala: But there is a connection, the members get the Care Books, and the Provider Manual goes to the providers. The Provider Manual provides information to providers on health education information like the care books, available to members, as well as immunizations are required, and how to document for billing.*		
3. c. NEW BUISINESS – NON-SPECIALTY MENTAL HEALTH SERVICES			
A. DeRochi	Andrea DeRochi, Behavioral Health Manager presented on Non-Specialty Mental Health Services (NSMHS). • Problem: mental health symptoms are undertreated, which is a problem across the country, but worse in the Medi-Cal population. • Solution: Senate Bill 1019 requires plans to develop and conduct outreach to members and primary care providers regarding covered non-specialty mental health services. • Requirements: o Align with cultural and linguistic appropriateness. o Apply best practices in stigma reduction. o List more than one point of contact for member access. o Involve stakeholder engagement, including the CAC. • Discussion: How can the Alliance encourage more members to use mental health services? ➢ *Member Question: T. Debose: How easy is it to access information and to talk to someone if they have a problem?* ➢ *Response-A. DeRochi: It is very easy to call Member Services. We also have a Behavioral Health team doing referrals. County Behavioral Health is also available. The challenge is capacity, identifying who has appointments available. We have care managers and coordinators. Primary care providers can also refer.* ➢ *Member Question-T. Debose: What happens after the first contact? Do you help them get connected?*	None	None

	➢ *Response-A. DeRochi: We ask them if they want assistance in connecting with a provider. The challenge is that members don't usually call us back after they are connected to care.* ➢ *Member Question-T. Debose: Do you do anything to make sure that the member gets connected because a person with mental health issues may not be as consistent. If you leave it to them, they may not follow through.* ➢ *Response-A. DeRochi: People want different things; some people prefer more help than others.* ➢ *Guest Question-J. Verduzco: Do you have information that we can provide? We will be happy to share.* ➢ *Response-A. DeRochi: We are developing promotional materials right now. We have a large network of mental health providers, largely telehealth. Our goal is to engage more providers to do in-office services.* ➢ *Member Question-K. Lowe: Can you clarify the self-referral process? What happens if they are pending PCP assignment?* ➢ *Response-A. DeRochi: PCP referral is not required, no prior authorization is needed, and there is also no need for PCP assignment. We complete assessments over the phone.* ❖ *Staff Comment- M. Lewis: We have the No Wrong Door messaging to let the members know that there is no wrong door to access mental health services.* • Discussion: Do you think people respond to social media? ❖ *Guest Comment-J. Verduzco: We definitely use social media (at Alameda County Public Health Department (ACPHD), we partner with wellness influencers.* ❖ *Member Comment- E. Garner: I don't follow ACPHD social media, I follow more community-based organizations. We don't usually know unless we ask.* • Discussion: What do you think about QR codes and posters?		

	❖ *Member Feedback- E. Garner: I hate automated systems. It works best when my doctor refers me. I'm not good with the internet, I get frustrated, a phone call is better for me.* ➢ *Member Question-T. Debose: Have you partnered with a sports team to take away stigma from mental health?* ➢ *Response-M. Lewis: No, we have not worked with sports teams, but I know they make public service announcements (PSAs) all the time. In the past, we were contacted by the Warriors for a health fair night, but that was before COVID. We now have digital well-child ads at the DMV.*		
4. a. CAC BUSINESS – CAC SELECTION COMMITTEE			

L. Ayala	Linda Ayala, Director of Population health and Equity provided updates on the CAC Selection Committee (CAC SC).
	• CAC SC: new committee that makes sure that CAC represents our community.
	• 1st meeting was held on 09/30/2024.
	• Kerri Lowe, Alameda County Public Health Department was approved as a new CAC member.
	• CAC SC Guidance: The CAC SC provided guidance on the following CAC member recruitment focus areas:
	  ○ Limited English Proficient (LEP)
	  ○ Men
	  ○ Ages 19-44
		None	None

4. b. CAC BUSINESS – CAC MEMBERSHIP RECRUITMENT			

L. Ayala	Linda Ayala, Director of Population Health and Equity provided updates on CAC Membership Recruitment.
	• The Alliance has connected and presented information about the CAC to the following groups:
	  ○ First 5 Alameda County Fathers Corps:
	  ▪ Father-Friendly Provider Network Members (FFPN) on 11/15/2024.
	  ▪ Healthy Relationships Learning Community (HRLC) on 11/21/2024.
	  ○ Health and Human Resource Education Cener (HHREC):
	  ▪ We received interest from the Senior Program Manager.
	  ○ Alameda County Public Health Fatherhood Initiative:
		None	L. Ayala to explore the organizations suggested for recruitment.

	▪ We received interest to support recruitment and connect the Alliance with interests. ➢ *Member Question-E. Garner: How are you outreaching?* ➢ *Response-L. Ayala: It is easier through community organizations. I believe we also put it in the newsletter.* ➢ *Response-M. Moua: Yes, we did. We now have an updated flyer that we can share. Also, we would like to leverage CAC members support and you can refer interests to us.'* ❖ *Guest Comment: I can connect you with Brighter Beginnings, a community-based organization in the Latino community.* ❖ *Member Feedback-C. Wynn: Health and Human Resource Education Center (HHREC) is another good organization to reach out. Black Men Speak came out of it.* ❖ *Staff Feedback-M. Lewis: It would also be good to reach out to Peralta Colleges, it would be good to have their voices as well. We can also potentially explore holding our meetings on weekends as not everyone can attend on weekdays.* ❖ *Member Feedback-E. Garner: It would be good to reach out to Black Infant health as well. They have a connection to the Men's Group.* ❖ *Staff Feedback-M. Lewis: Churches as well.*		
5. ALLIANCE CARE BAGS			

M. Lewis	Michelle Lewis, Senior Manager of Communications and Outreach presented on the Alliance Care Bags.
	
	• This project was started by CAC members, Ms. Mello and Ms. Williams, a small and thoughtful thing that we do as helpers in the community.
	• The Alliance created 5,000 care bags this year. The bags include the following items:
	  ○ socks
	  ○ masks
	  ○ first aid kit
		None	None

	○ hand sanitizer ○ personal hygiene items ○ non-perishable food items. • The bags given to the shelters do not contain non-perishable food items as it causes issues for them. ➢ *Member Question-E. Garner: Why do shelters not like non-perishables?* ➢ *Response-M. Lewis: Community partners usually reach out to us for care bags, but they request no food items as it causes issues, such as rodents when they are storing them.* ➢ *Member Question-E. Garner: Is there an updated shelter list? And does it include family size?* ➢ *Response-M. Lewis: Yes, the county list is updated yearly. Some places do not allow children, and we include that information there. We also recommend calling 211 as they can look for shelter beds.* • 2024 Care Bag Distribution: ○ Alliance CAC members ○ Local Alameda County shelters ○ Local churches ○ Street medicine teams ○ Warming centers ❖ *Staff Comment-A. Alvarez: The Alliance Outreach team gathered in conference rooms to assemble them, 120 minutes total spent.* ❖ *Member Comment-T. Debose: I would like to share some with my church. Staff Response-M. Lewis: Of course, we can get those ready for you.*		
6. OPEN FORUM			
	❖ *Member Comment-M. Le: Thanks for this meeting, we got to finish the items we were not able to cover during the last meeting.*	None	None
7. ADJOURNMENT			

T. Debose	Tandra Debose, CAC Vice Chair adjourned the meeting at 1:20 pm.	None	None

Meeting Minutes Submitted by: Mara Macabinguil, Interpreter Service Coordinator Date: 12/31/24
Approved by: Date:

To: **Alameda Alliance for Health Community Advisory Committee**

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

Date: **March 20th, 2025**

Subject: **CEO Report**

- **Financials:**
  - **January 2025:** Net Operating Performance by Line of Business for the month of January 2025 and Year-To-Date (YTD):

	January	**YTD**
Medi-Cal	($5.7M)	($97.9M)
Group Care	($656K)	($893K)
Medicare	($371K)	($5.0M)
Total	($6.7M)	($103.9M)

  - **Revenue was $190.7 million in January 2025 and $1.2 billion Year-to-Date (YTD)**.
    - Medical expenses were $191.1 million in January and $1.3 billion for the fiscal year-to-date; the medical loss ratio is 100.2% for the month and 104.8% for the fiscal year-to-date.
    - Administrative expenses were $8.9 million in January and $66.5 million for the fiscal year-to-date; the administrative loss ratio is 4.6% of net revenue for the month and 5.6% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 186% of the required DMHC minimum, representing $70.2 million in excess TNE.
  - **Total enrollment in January 2025 was 412,828**, an increase of 602 Medi-Cal members compared to December 2024.

- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - Nothing to report
  - **Non-Regulatory Metrics:**
    - Nothing to report

- **Medicare Overview**

    - **<u>D-SNP Readiness</u>**

        - Alameda Alliance for Health (AAH) Medicare Advantage (MA) Duals Eligible Special Needs Plan (D-SNP) will begin serving members on January 1st, 2026. Currently, there are 17 different departmental workstreams and a total of 112 projects, of which 58 are active, 50 requested, and 4 are on hold.
        - Submitted CMS Application via HPMS on February 12th, 2025, which included Part C (MA), Part D, SNP Attestations, supporting documentation, Model of Care (MOC), Model of Care (MOC) Matrix, and Provider Network Adequacy report.
            - Submitted to DHCS the Model of Care (MOC), CA Specific Model of Care (MOC) Matrix, and Health Risk Adjustment Tool (HRAT).
            - PBM, MTM, Call Center Overflow, and Marketing Contracts are all complete.
        - AAH participated in CHCF Joint D-SNP Planning with CHCN on February 28th, 2025, which was facilitated by El Cambio Consulting.
        - Continued Sales System, Hearing, and FlexCard implementation with Nations vendor. Choose a vendor for the Health Risk Assessment Tool (HRAT) and demoing 4 different vendors for Risk Adjustment.
        - The Medicare Operations Department is interviewing for 8 positions. 69 policies have been submitted to PolicyTech for review and approval by leadership.
        - Continuing to collaborate with IT in updating Core Claims / Medical Management Systems and identified 321 requirements collected within Microsoft List.

- **Department of Health Care Services**
    - The Alliance audit completed on March 14, 2025.

- **Potential Changes to the Medi-Cal Program**
    - What we know today
        - Community Supports
        - Disenrollment beginning July 1, 2025
        - Potential Funding Changes
        - Other

Follow-up Items

Mao Moua

ALAMEDA Alliance FOR HEALTH

FOLLOW-UP ITEMS FROM 12-05-2024 AND 12-16-2024

Follow-up Item	Outcome(s)	Status
Share CAC feedback and questions around the design rationale behind the shapes used in the new logo	• Feedback and questions were shared with Alliance Leadership team. • Updated information was sent CAC members via email on 01/22/2025.	Completed
Explore suggested organizations for CAC member recruitment	• Added CAC recommended organizations to the Alliance CAC Recruitment Tracker. • Health and Human Resource Education Center (HHREC)- A candidate has been identified from this organization and application was received.	Completed

Housing Is Healthcare:

A high-level Introduction to Housing-Related Community Supports

ALAMEDA Alliance FOR HEALTH

Goals & Objectives

1. Overview of Housing Landscape
2. Discuss Alameda County Housing Landscape
3. Integration of CalAIM Housing Related – Community Supports
4. Housing Bundle Overview

Social Determinants of Health
“HOUSING”

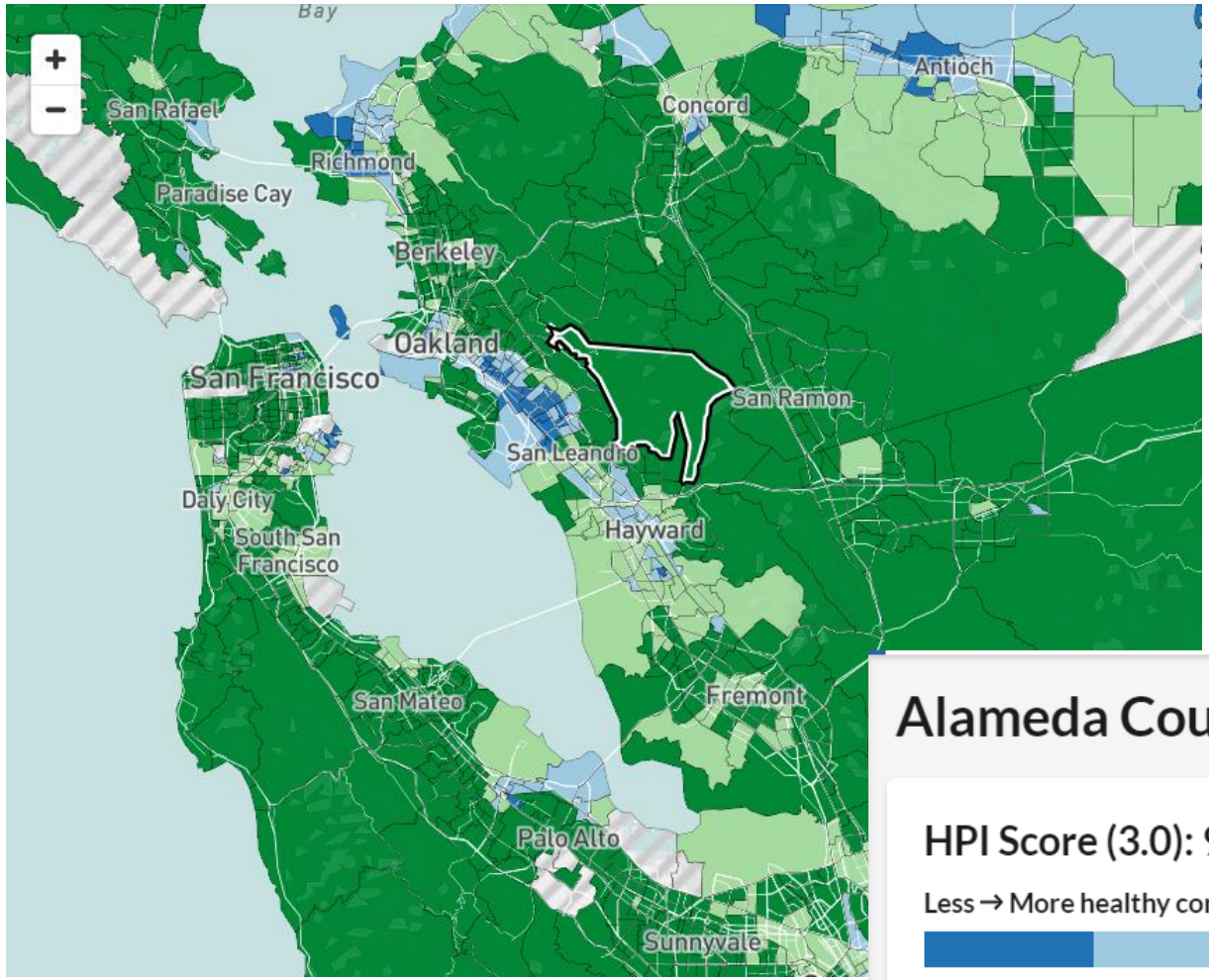
ALAMEDA Alliance FOR HEALTH

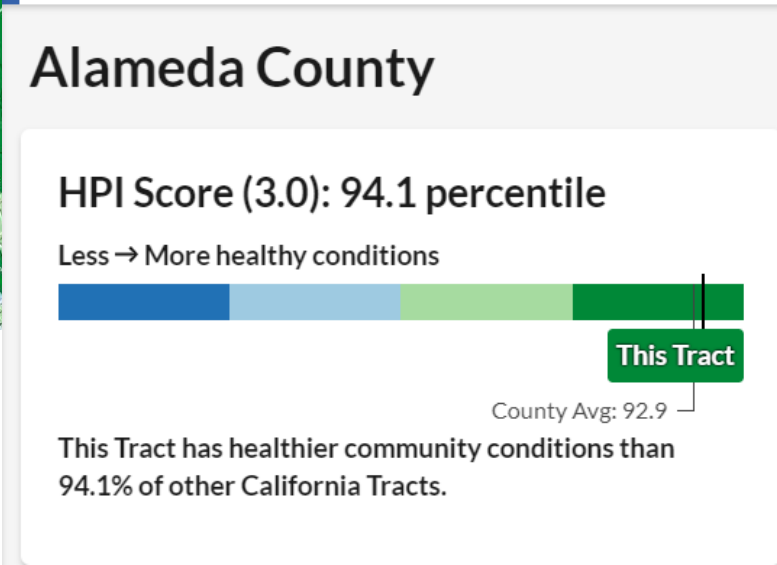
Housing & Social Determinants of Health

- Health and well-being are strongly influenced by social, economic and environmental factors known as Social Determinants of Health (SDOH)
- HOUSING = A critical component to wellness
- Social Determinants of Health Video Link

According to the California Healthy Places Index, we can see from the diagram below that Alameda County is generally considered a very healthy place to reside.

In fact, Alameda County was ranked in the 94.1 percentile as a healthy community.

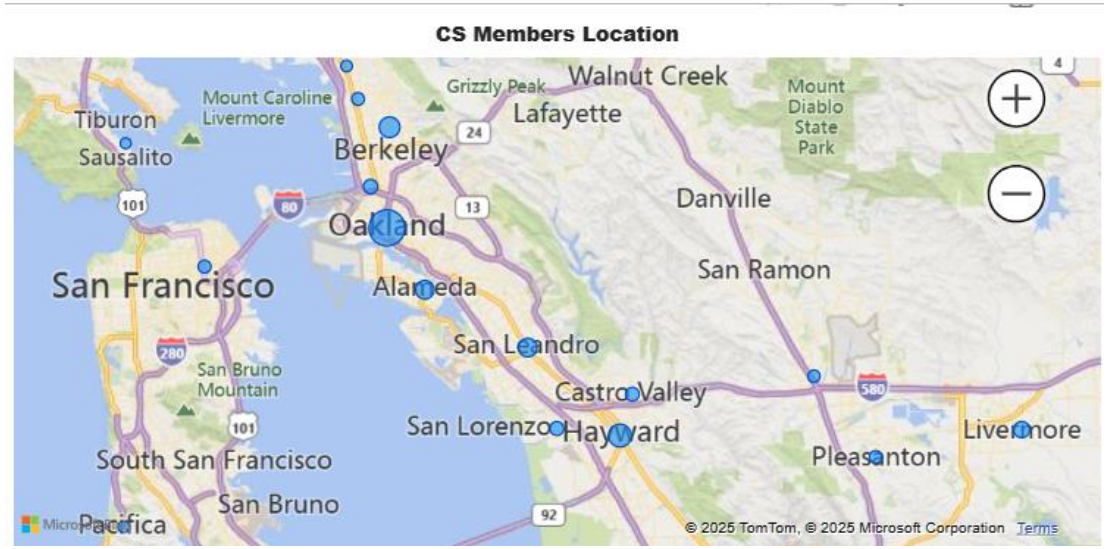


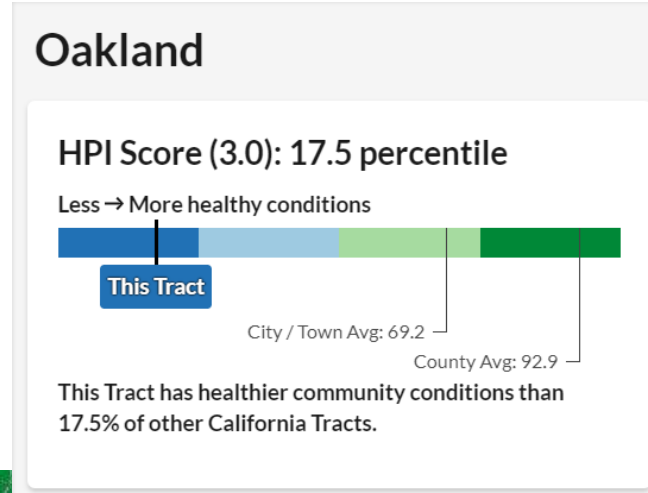


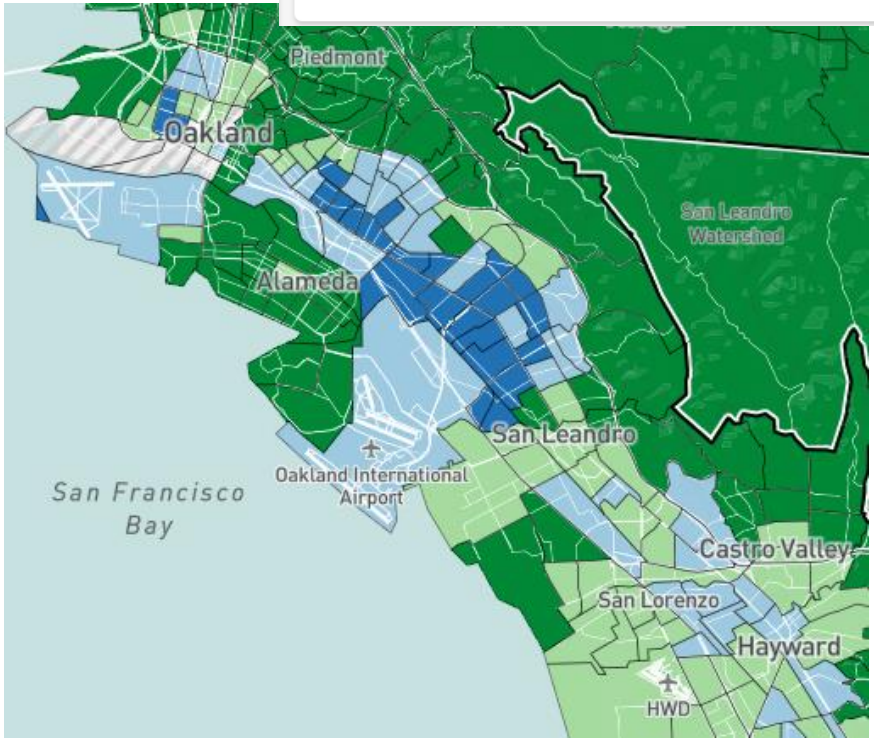
Housing & Social Determinants of Health

Zooming into Alameda County at the city level reveals disparities in health rankings tied to social determinants of health (SDOH), such as neighborhood conditions, transportation, and education.

As a health plan we can stratify our data to better understand population health nuances and deploy health education and housing and health strategies to support integrated care that honor health equity for our members







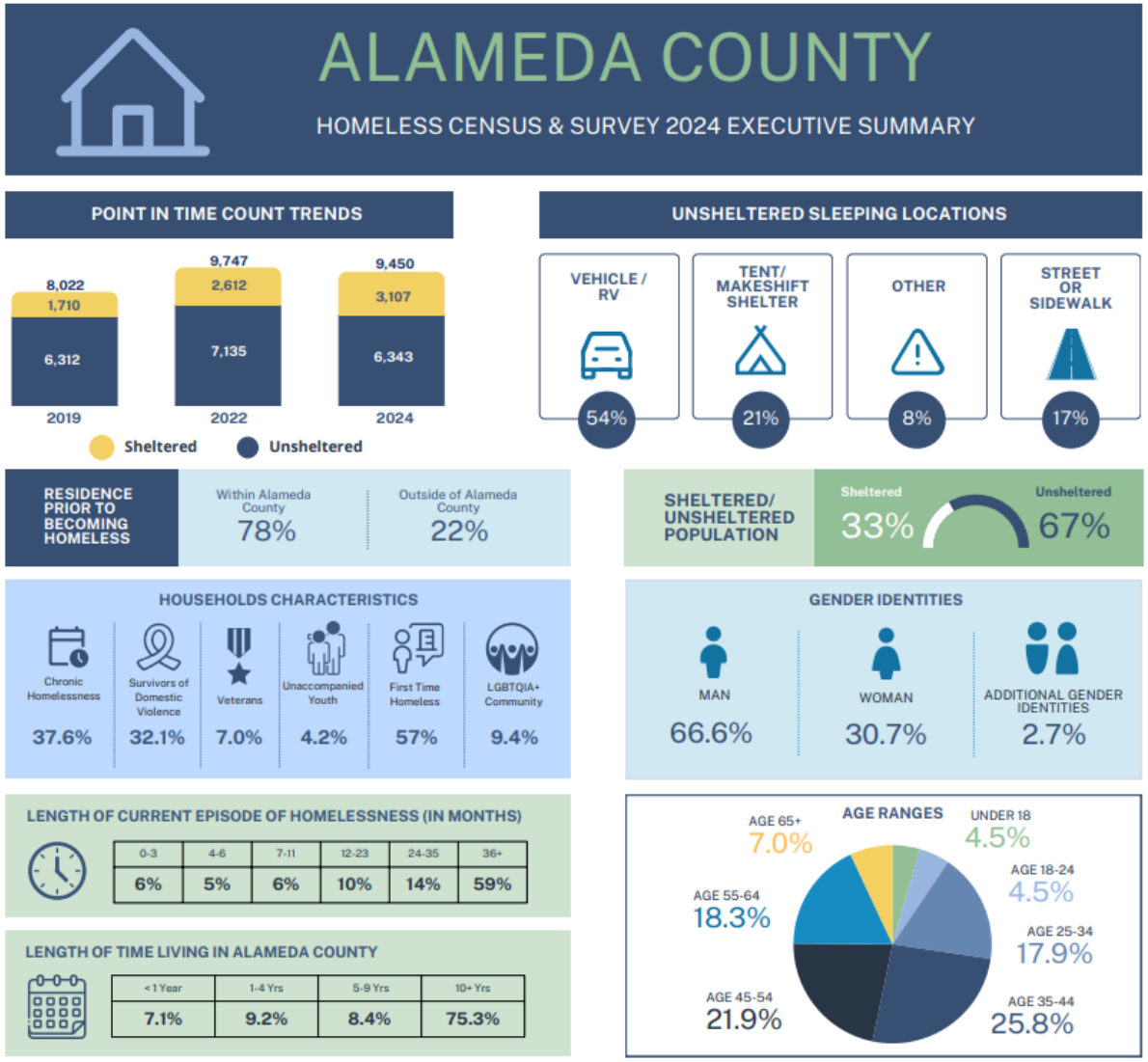
Alameda County PIT Results -2025

The annual Point-in-Time (PIT) Count is a mandatory census for communities that receive homelessness funding from the US Department of Housing and Urban Development (HUD). This one-night survey aims to enumerate individuals experiencing homelessness.

Beyond its primary purpose, the PIT Count serves multiple important functions:

1. It sheds light on the diverse challenges faced by homeless populations.
2. It provides a platform for direct communication with those affected by homelessness.
3. It helps identify inequalities within the homeless community.
4. It showcases crucial aspects of the local response to homelessness.

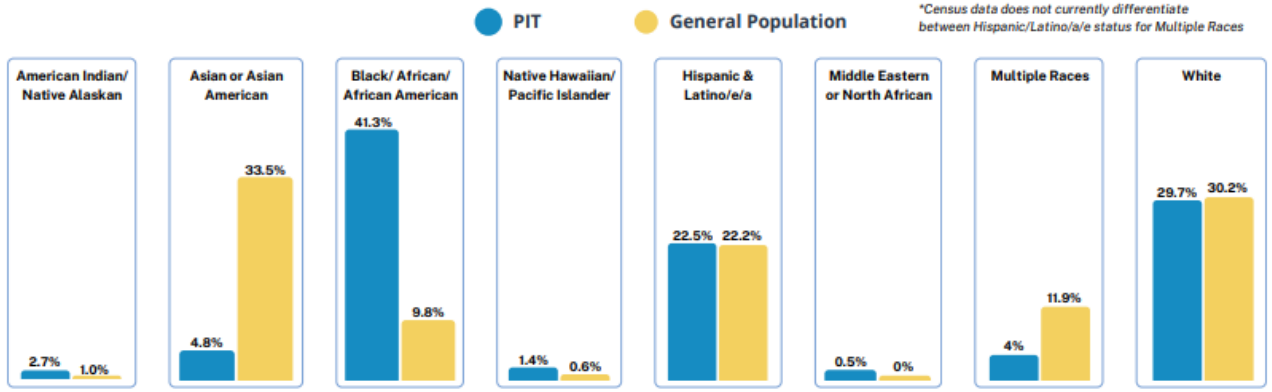
By fulfilling these objectives, the PIT Count not only meets federal requirements but also plays a vital role in increasing public awareness and understanding of homelessness issues



** Information gathered from: 2024 Point-in-Time Count Report for Alameda County*

Alameda County PIT Results -2025

RACE IDENTITIES COMPARED TO GENERAL POPULATION



SELF-REPORTED DISABILITY PREVALENCE

Substance Use Disorder	Serious Mental Illness	Chronic Health Issues	Physical Disability	Developmental Disability	HIV/Aids Related Illness	Any Disabling Condition
28.5%	34.8%	30.4%	32.5%	17.4%	2.7%	60%

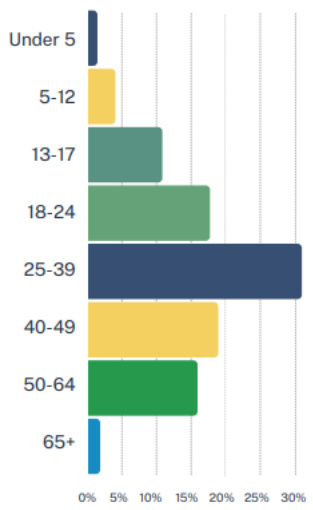
PRIMARY CAUSES OF HOMELESSNESS

Housing Loss Related	Job Loss/ Income Related	Health Related Issues	Household Loss/ Breakup Related
35.4%	22%	18.1%	18%

ADDITIONAL HOUSEHOLD CHARACTERISTICS

Pregnant or Expecting a Child	Interaction with Criminal Justice in Past Year	Unsheltered People with Employment	Unsheltered People with a Pet
1.8%	32.5%	10%	30.1%

AGE AT FIRST EXPERIENCE OF HOMELESSNESS



HOUSEHOLD BREAKDOWN

Single Adults	Families	Unaccompanied Youth
29% | 71%	85% | 15%	49% | 51%
8,725 People in 8,398 Households	699 People in 237 Households	398 People in 388 Households

Sheltered | Unsheltered

SELECT POPULATION LOCATIONS

Chronic Homelessness	Unaccompanied Youth and Young Adults	Veterans
36% | 64%	49% | 51%	26% | 74%
3,832 People	398 People	527 People

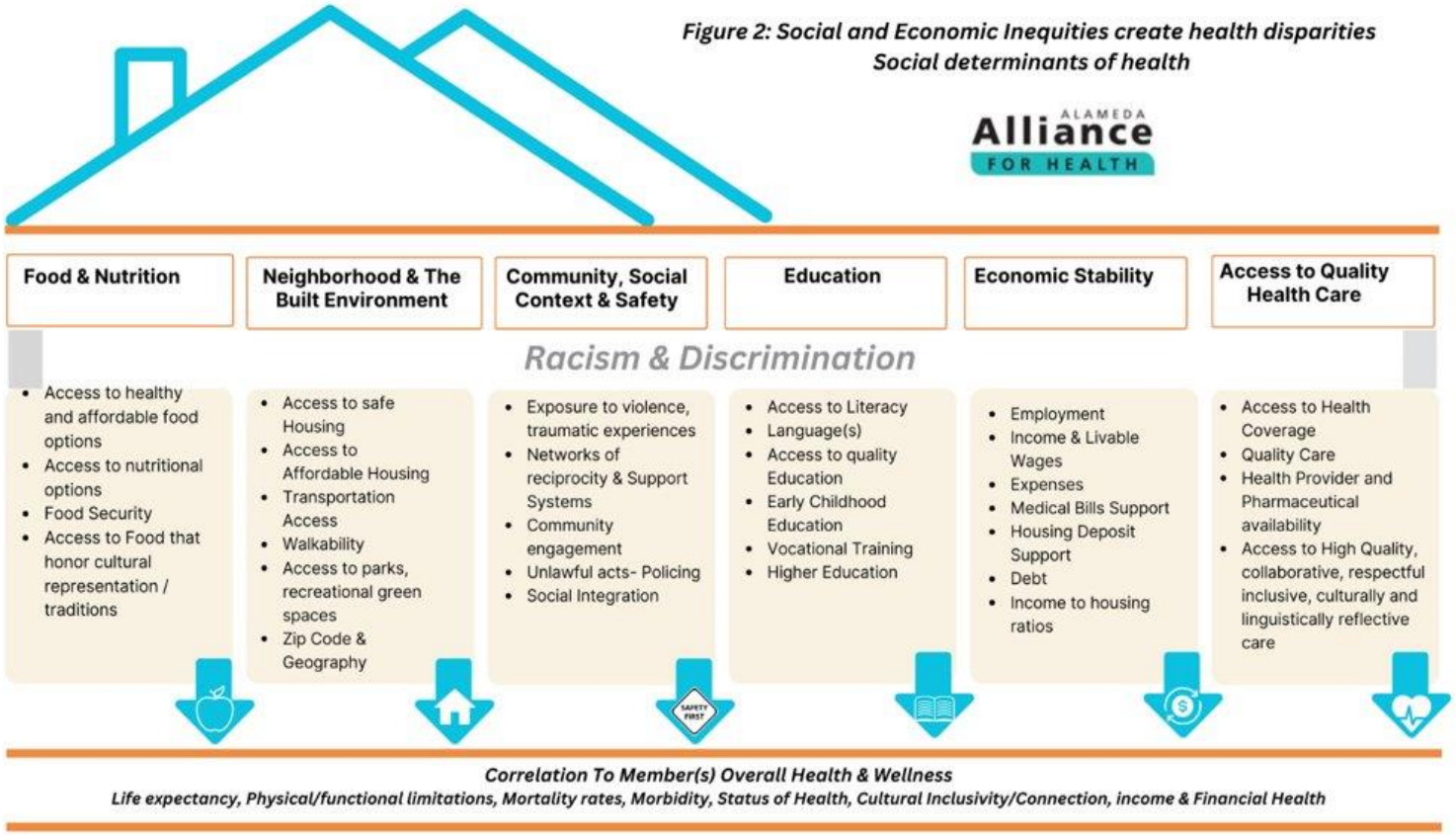
Sheltered | Unsheltered

Housing is Healthcare

- Stable, safe and affordable housing directly impacts physical and mental wellbeing. Without it, individuals face higher risks of poor health outcomes.
  - Key Examples:
    - **Prevents Chronic Illness and Disease:** Unstable housing exposes individuals to stress, poor nutrition, and environmental hazards, increasing the risk of asthma, hypertension, and heart disease.
    - **Enhances Medication Adherence & Chronic Disease Management**
      - Managing conditions like diabetes, HIV/AIDS, or hypertension requires regular medication and follow-ups, which are difficult without stable housing.
      - Stable housing provides a secure environment for storing medications and maintaining healthy routines.
  - Approaches that support this model:
    - **Housing First Model:** This approach prioritizes providing stable housing without preconditions like sobriety or employment. It has been shown to rapidly reduce homelessness and improve health outcomes.
    - **Permanent Supportive Housing (PSH): PSH** combines affordable housing with targeted case management interventions, referrals and social services to support long-term stability for vulnerable populations

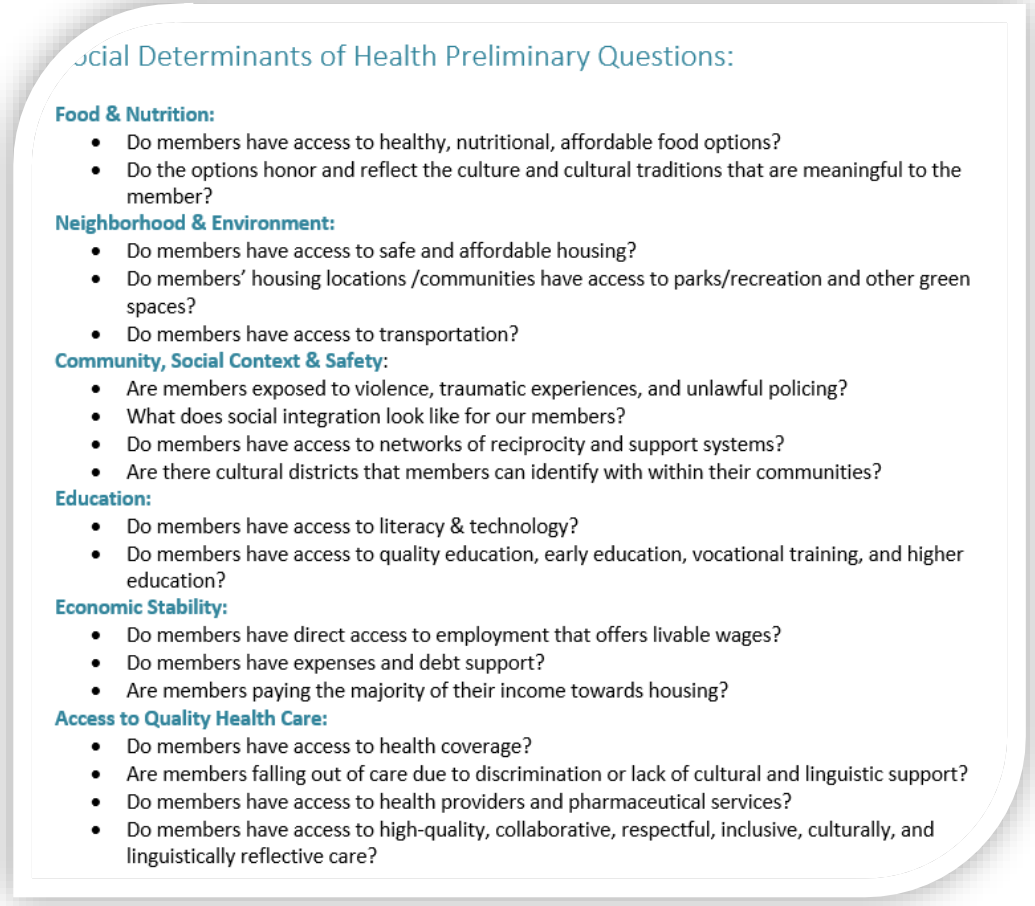
Housing is Healthcare

- **Medi-Cal Funded Housing Support:** Also known in some states as Medicaid provides funds to cover Housing related services for individuals with complex health needs and is extremely critical to the movement of Housing as healthcare because for the first time ever, we now have a dedicated integration of services to support Medi-Cal Members
- At Alameda Alliance, we refer to theses CalAIM benefits as **The Housing Bundle**



CalAIM At A Glance

- The Department of Health Care Services (DHCS) courageously launched California Advancing and Innovating Medi-Cal known as CalAIM.
- CalAIM is a multiyear care delivery and repayment reform initiative that focuses deeply on improving health equity, quality of care, SDOH, and well-being for millions of California Medicaid (Medi-Cal) enrollees.
- CalAIM is intended to intentionally, create a seamless integration of Medi-Cal with other social services that enhance population health through deepening member access to coordinated, whole-person care-related social needs that are rooted in addressing social determinants of health
- CalAIM is dedicated to deploying culturally and linguistically appropriate services for Medi-Cal recipients, especially those with complex needs.
- Housing is healthcare, by improving quality outcomes for transformational value-based initiatives, modernization payment reforms and systems



ɔcial Determinants of Health Preliminary Questions:

Food & Nutrition:
- Do members have access to healthy, nutritional, affordable food options?
- Do the options honor and reflect the culture and cultural traditions that are meaningful to the member?

Neighborhood & Environment:
- Do members have access to safe and affordable housing?
- Do members' housing locations /communities have access to parks/recreation and other green spaces?
- Do members have access to transportation?

Community, Social Context & Safety:
- Are members exposed to violence, traumatic experiences, and unlawful policing?
- What does social integration look like for our members?
- Do members have access to networks of reciprocity and support systems?
- Are there cultural districts that members can identify with within their communities?

Education:
- Do members have access to literacy & technology?
- Do members have access to quality education, early education, vocational training, and higher education?

Economic Stability:
- Do members have direct access to employment that offers livable wages?
- Do members have expenses and debt support?
- Are members paying the majority of their income towards housing?

Access to Quality Health Care:
- Do members have access to health coverage?
- Are members falling out of care due to discrimination or lack of cultural and linguistic support?
- Do members have access to health providers and pharmaceutical services?
- Do members have access to high-quality, collaborative, respectful, inclusive, culturally, and linguistically reflective care?

** SDOH are socio and economic inequities that can create potential health disparities. Understanding that health is wealth, we asked ourselves the following questions as they fit within the model of Housing, Healthcare, and members' access to services that determine their health outcomes.*

Housing Community Supports

- **Community Supports (formerly known as In-Lieu of Services)**: Services that address the social drivers of health for Medi-Cal managed care plans to institute for members. The following services are strongly encouraged by DHCS to provide medically appropriate cost-effective alternatives to the utilization of other services or settings such as skilled nursing facilities or hospitals. Categories of coverage Include: There are a total of 15 community Supports / Housing Oversees 4 Community Supports
  - ***Housing Deposits***
  - ***Housing Tenancy Sustaining Services***
  - ***Housing Transition & Navigation Services***
  - *Transitional Rent – coming soon*

Community Supports (CS) – Housing Bundle

Housing Transition Navigation Services

Housing transition services assist members with obtaining and securing housing

Housing Deposits

Housing Deposit Services assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household

Housing Tenancy and Sustaining Services

Provide tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured

Community Supports (CS) – Housing Bundle - Continued

Housing Transition Navigation Services

*Service duration can be as long as/as many times as necessary

*Meets medical necessity and the HUD definition of homelessness, or at risk of homelessness, or prioritized for a PSH unit or rental subsidy through the CES or similar system (PHAs)

Housing Deposits

*Once in a lifetime

*$5,000 limit

*Meets medical necessity and has been enrolled or had prior enrollment in housing navigation, or meets the HUD definition of homelessness, or prioritized for a PSH unit or rental subsidy through the CES or similar system (PHAs)

Housing Tenancy and Sustaining Services

*Service duration until services are no longer necessary

*Once in a lifetime

*Meets medical necessity and has been enrolled or had prior enrollment in housing navigation, or meets the HUD definition of homelessness, or at risk of homelessness, or prioritized for a PSH unit or rental subsidy through the CES or similar system (PHAs)

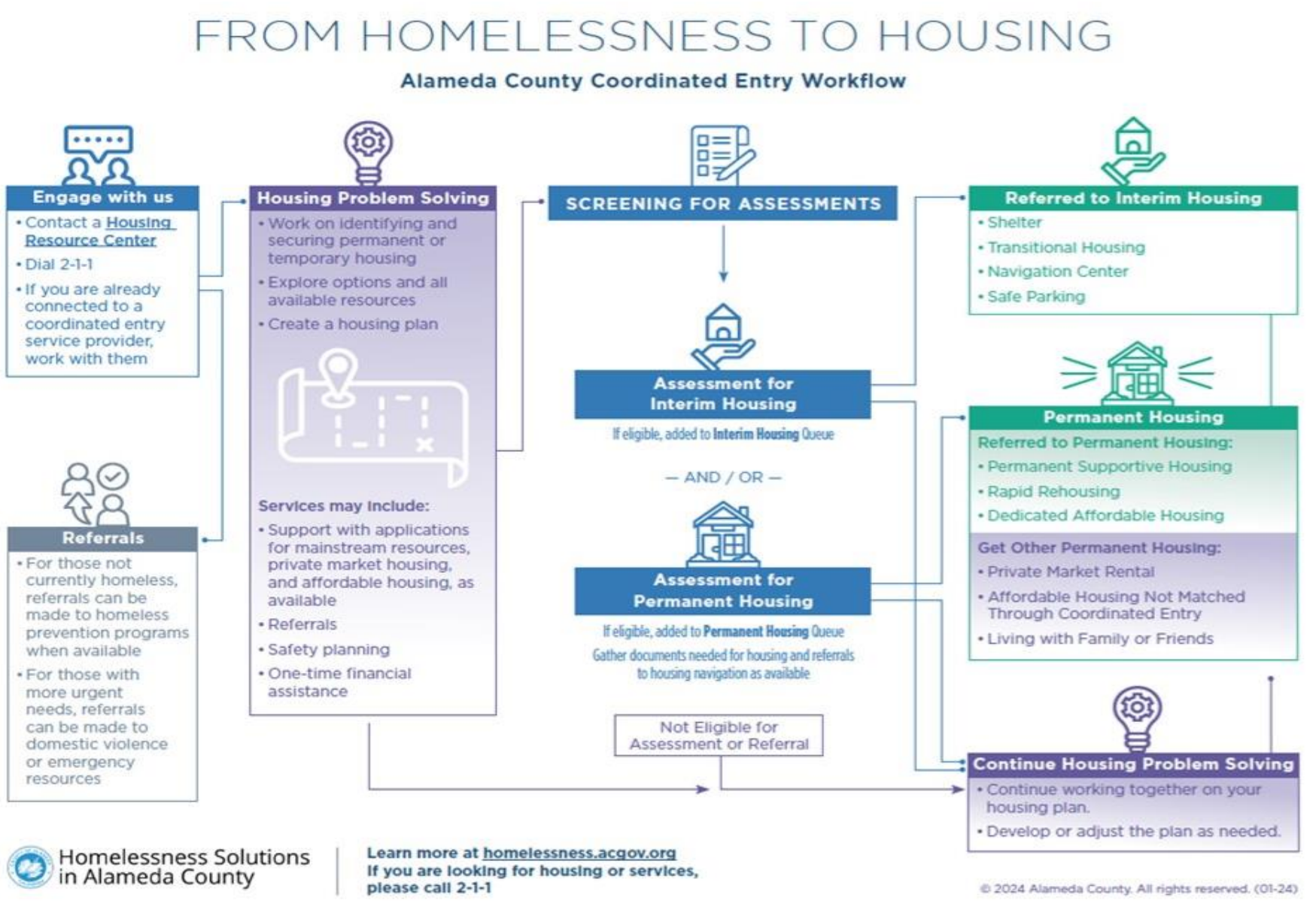
Housing Community Supports Provider Overview

- Currently, AAH is only contracted with Alameda County Health (AC Health) for Housing Community Supports (some exceptions)
- AC Health serves as the administrator, and subcontracts with 23+ providers to deliver Housing CS services

Abode Services	Asthma Start	Bay Area Community Services	Insight Housing	Building Futures with Women and Children	Building Opportunities for Self-Sufficiency
YEAH/ Covenant House	City of Fremont	East Bay Innovations	East Oakland Community Project	La Familia Counseling Service	Five Keys Schools and Programs
Fred Finch Youth Center	Housing Consortium of the East Bay	Lifelong Medical Care	Life STEPS	Recipe 4 Health	Roots Community Health Center
Satellite Affordable Housing Associates	St Mary's Center	Tiburcio Vasquez Health Center	Operation Dignity	Women's Daytime Drop In Center	

Coordinated Entry – Pathway to Housing Community Supports

Member must call 2-1-1
or
Present at a Housing Resource Center



Authorization Process

Housing CS **Providers** (AAH is only contracted with AC Health) **submit authorization request** (AC Health pulls members from coordinated entry) **to AAH** HCSD **department**

AAH HCSD **team reviews authorization request and corresponding justification/documentation**

Determination is made

Notification is sent:

Member	Referring provider	Rendering provider	PCP

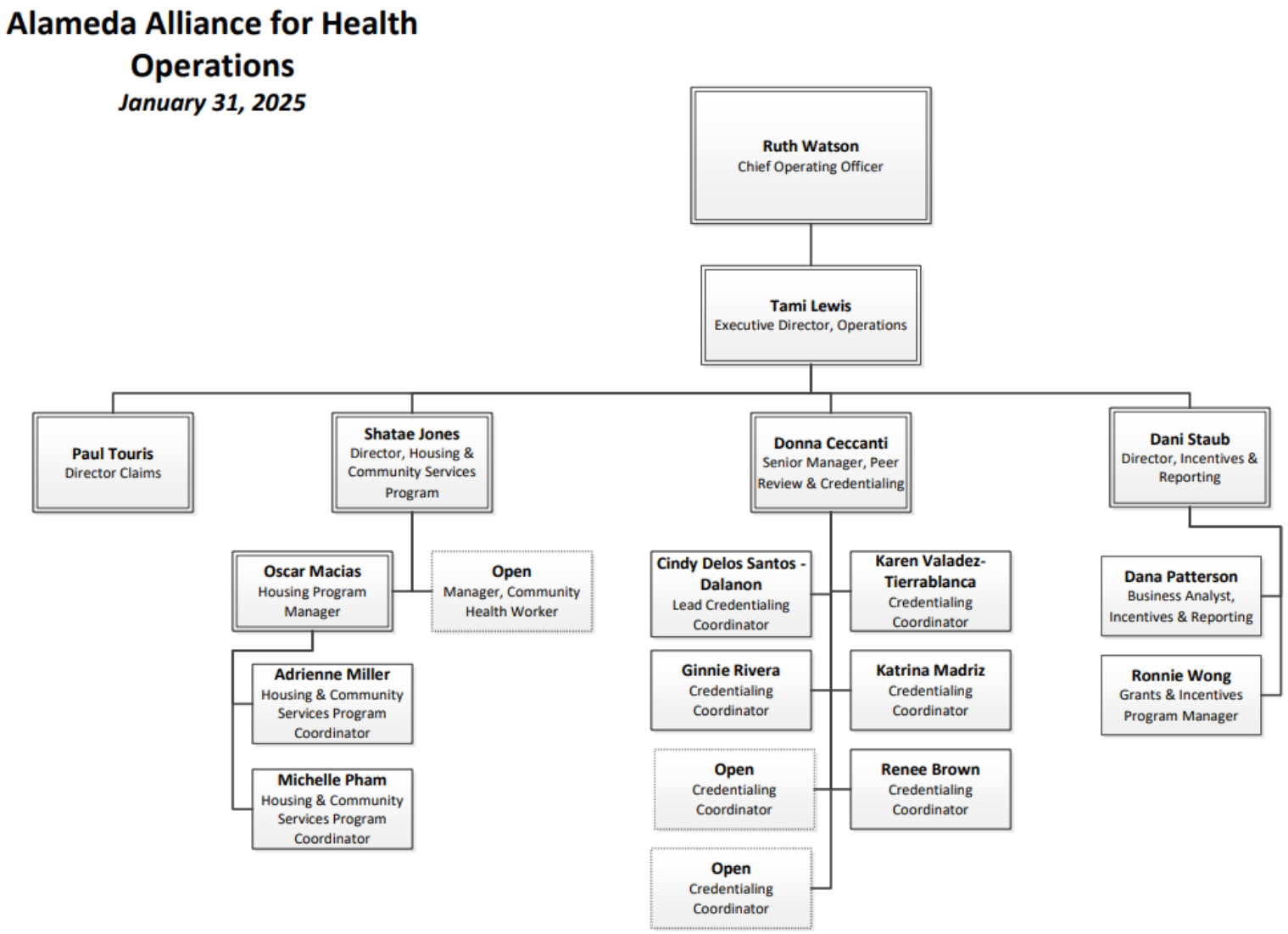
Housing In the Community

- Housing & Community Services Full Team are former Housing Providers and representative of our community at large through both lived and learned experience
- Housing Team sit on both Alameda County Committees to impact local change:
  - Alameda County Leadership Board
  - Alameda County Racial Equity Committee
  - Alameda County Homeless Management Information system Committee
  - Alameda County Taskforce for 2030 Home together plan
- Represent AAH to support our members via Corporation for Supportive Housing Advisory Workgroups
  - Supporting centering member experience through streamlining CalAIM policies and programming
- Active Alameda County Point-In-Time Count (PIT) programming and planning teams
- Housing Staff is VP of National Association of Housing Redevelopment Officials Local Chapter
- Supporting integration of Public Housing authorities to CalAIM
- Streamline Access to additional resources
- Housing Team advocates through participation in the Bringing California Home initiatives which support advocacy on policies for housing through legislative change
- Create Housing Education Cohorts focused on integrating those with lived experience and support resource connection

Meet The Housing Team

ALAMEDA Alliance FOR HEALTH

Housing and Community Services Team



Thank You, From your Housing Team

Shatae Jones, LCSW
Director of Housing & Community Services

Adrienne Miller, MCP
HCSD – Housing Coordinator

Michelle Pham, BA
HCSD – Housing Coordinator

Oscar Macias, MPA
HCSD – Program Manager

Please contact us if you have additional Questions at:
depthousingservices@alamedaalliance.org

Resources

- Coordinated Entry
  - Understanding Coordinated Entry Process
  - Coordinated Entry/ HRC locations
- California Health Care Foundation & Corporation for Supportive Housing (CSH): Medi-Cal Academy for Homeless Service Providers
  - Training Sessions, readings, best practice examples and templates
  - CHCF's YouTube Channel
  - Subscribe to CSH Medicaid/Medi-Cal cohort: Newsletter Sign-up - CSH
- Department of Health Care Services
  - Policy Guides, All Plan Letters, Overview of CalAim
  - Cal Aim Providing Access and Transforming Health Initiative
  - Technical Assistance marketplace PATH
  - Community Supports Descriptions
- Homelessness in Alameda County – PIT Count Data
- Social determinants of Health Full video - Limelight Creative Media

Thank You, please contact us if you have additional questions

You can contact us at:

Housing CS Inbox |
depthousingservices@alamedaalliance.org

2024 Grievance and Appeals

ALAMEDA Alliance FOR HEALTH

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Health care you can count on. Service you can trust.

Grievance and Appeals Report - Medi-Cal

To:	Community Advisory Committee Meeting
Date:	March 19, 2024
From:	Alma Pena – Sr. Manager, Grievance and Appeals
Reporting Period:	Resolved 2024

Purpose: In accordance with Title 28 of the California Code of Regulations §1300.69(f) Enrollees and subscribers participating in establishing public policy shall have access to information available from the plan regarding public policy, including financial information and information about the specific nature and volume of complaints received by the plan and their disposition.

Standards/Benchmark:

Case Type	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	17,114	30 Calendar Days	95% compliance within standard	17,082	99.8%	
Expedited Grievance	30	72 Hours	95% compliance within standard	30	100.0%	
Exempt Grievance	23,557	Next Business Day	95% compliance within standard	23,526	99.8%	
Standard Appeal	478	30 Calendar Days	95% compliance within standard	476	99.5%	
Expedited Appeal	12	72 Hours	95% compliance within standard	12	100.0%	
2024 Total Cases:	41,191		95% compliance within standard	41,126	99.8%	7.56

*Goal is to have less than 1 complaint per 1,000 members, (calculation: the sum of all unique grievances for the quarter divided by the sum of all enrollment for the quarter multiplied by 1000.)

Tracking and Trending:

- There were 36,276 unique grievance cases resolved during the reporting period, with a total of 40,701 grievances including all shadow cases.
- Grievances related to quality of care were forwarded to Quality Improvement Department as Potential Quality Issue (PQI).*
- Grievances related to discrimination, fraud, waste, and abuse were forwarded to Compliance Department for further investigation.

- Grievances against Delegates/Vendors have been reported during quarterly Joint Operation Meetings with each entity.

Appeal Data/Analysis:

Prior Authorization Appeals				Grand Total
	CFMG	CHCN	Plan	
Inpatient Appeal	0	2	45	47
Outpatient Appeal	3	125	277	405
Pharmacy Appeal	0	0	1	1
Retro Appeal	0	2	35	37
Grand Total:	**3**	**129**	**358**	**490**
Overturned %:	**66.7%**	**21.7%**	**21.8%**	**22.0%**

- The overall overturn rate was within our goal of 25.0% or below, at 22%.

Grievance Data/Analysis:

Filed Against:	Grievance Type					Grand Total
	Access to Care	Coverage Dispute	Other	Quality of Care	Quality of Service	
Ancillary	532	1388	24	24	324	2292
Clinic	6,175	697	98	454	2062	9486
Delegate	144	62	62	12	141	412
Hospital	208	774	15	118	132	1247
Long-term Care	5	1	0	1	1	8
Mental Health Facility	212	33	9	27	143	424
Mental Health Professional	136	13	4	15	55	223
Other	43	123	9	5	103	283
Out-of-Network	303	640	6	29	121	1099
PCP	1737	27	20	116	655	2555
PCP Non-Physician Medical Practitioner	17	2	0	2	12	33
Plan	7,380	431	6,463	8	4,905	19,187
Skilled Nursing Facility	11	3	0	59	22	95
Specialist	665	100	19	62	375	1249
Specialist Non-Physician Medical Practitioner	9	0	0	1	4	14
Vendor	273	48	70	11	1646	2048
Grand Total	**17,850**	**4,342**	**6,799**	**944**	**10,701**	**40,701**

Grievances filed against the Plan:

- Access to Care (7,380): 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 (431): Disputes related to benefit and reimbursement requests.
- Other (6,463): Complaints about enrollment, eligibility, protected health information, and fraud/waste/abuse.
- Quality of care (8): Complaints about the quality of care received from the plan.
- Quality of Service (4,905): 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:

Filed Against:	Grievance Type					Grand Total
	Access to Care	Coverage Dispute	Other	Quality of Care	Quality of Service	
Delegate	**144**	**62**	**62**	**3**	**141**	**412**
Beacon	5	0	0	0	4	7
CFMG	23	2	0	0	7	32
CHCN	68	6	1	0	59	134
Kaiser	1	16	6	1	3	27
March Vision	47	38	55	2	68	210
Vendor	**273**	**48**	**70**	**11**	**1646**	**2048**
Ansafone	0	1	0	0	0	1
CHME	102	18	3	3	187	313
Crisis Support Center	0	0	0	0	1	1
CyraCom	8	0	0	0	12	20
Hanna	18	0	0	0	11	29
Human Arc	0	0	2	0	4	6
ModivCare	116	23	45	7	1066	1257
Optum	4	1	0	1	7	13
Teladoc	18	5	19	0	17	59
Xaqt	7	0	1	0	341	349
Grand Total	**417**	**110**	**132**	**14**	**1787**	**2460**

Delegated Network is a subcontractor with a Health Plan that has been given authority to perform functions, our delegates are listed below:

- Beacon Health Strategies – Behavioral Health Benefit Provider (through Q1 2023)
- Children First Medical Group (CFMG) – Alliance Provider Network
- Community Health Center Network (CHCN) – Alliance Provider Network
- California Home Medical Equipment (CHME) – DME Benefit Supplier
- Kaiser – Fully Delegated Provider

- March Vision Care Group – Vision Benefit Provider
    - ModivCare had the highest number of complaints out of all vendors in 2024.

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Health care you can count on. Service you can trust.

Grievance and Appeals Report - IHSS Commercial

To:	Internal Quality Improvement Committee
Date:	March 19, 2025
From:	Alma Pena - Senior Manager, Grievance and Appeals
Reporting Period:	Resolved Q4 2024

Purpose: To track and trend all grievance and appeals resolved during the reporting period in order to identify opportunities for quality improvement.

Standards/Benchmark:

Case Type	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	258	30 Calendar Days	95% compliance within standard	255	98.8%	
Expedited Grievance	0	72 Hours	95% compliance within standard	0	N/A	
Exempt Grievance	150	Next Business Day	95% compliance within standard	150	100.0%	
Standard Appeal	21	30 Calendar Days	95% compliance within standard	21	100.0%	
Expedited Appeal	0	72 Hours	95% compliance within standard	N/A	N/A	
Q4 2024 Total Cases:	429		95% compliance within standard	426	99.9%	20.1

*Goal is to have less than 1 complaint per 1,000 members, (calculation: the sum of all unique grievances for the quarter divided by the sum of all enrollment for the quarter multiplied by 1000.)

Tracking and Trending:

- There were 349 unique grievance cases for IHSS members resolved during the reporting period, with a total of 408 grievances including all shadow cases.
- Grievances related to quality of care were forwarded to Quality Improvement Department as a Potential Quality Issue (PQI).*
- Grievances against Delegates/Vendors have been reported during quarterly Joint Operation Meetings with each entity.

Appeal Overturn Analysis:

Prior Authorization Appeals	Filed Against		Overturn %
	CHCN	Plan	
Outpatient Appeal	5	6	33.3%
Pharmacy	0	10	30.00%
Retro Appeals	0	0	0.00%
Grand Total:	**5**	**16**	**21**
Overturned %:	**40.00%**	**6.25%**	**28.5%**

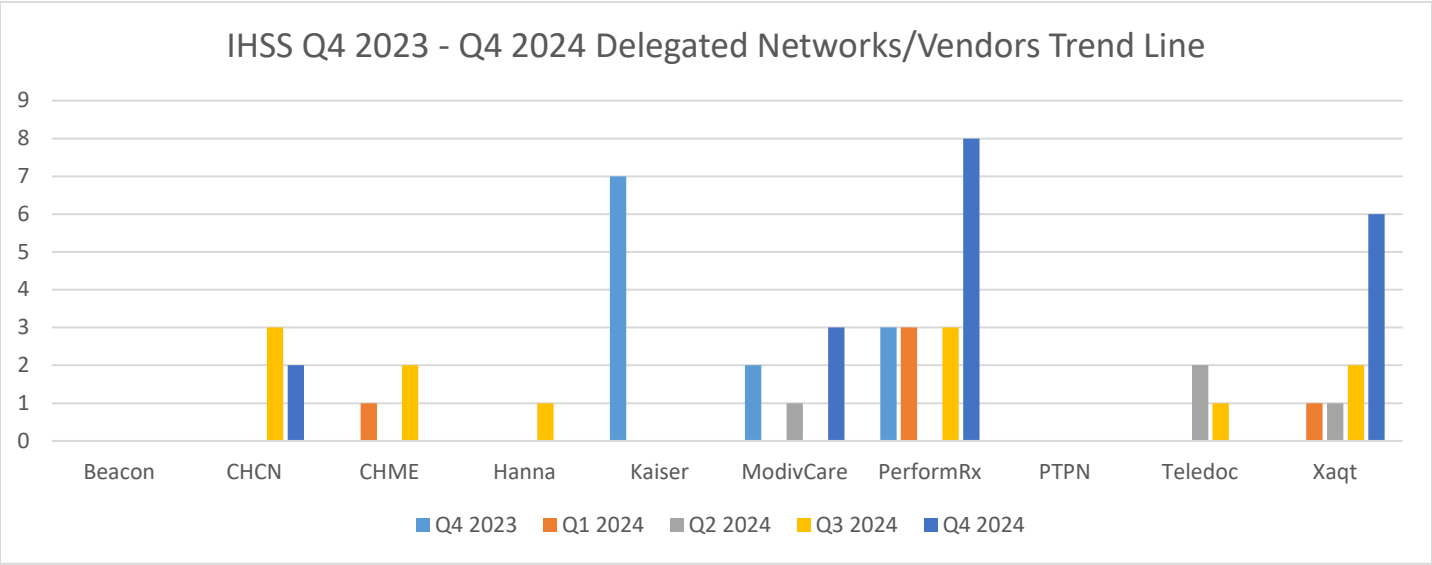
- The internal benchmark rate for overturns in Q4 2024 was not met. The overturn rate for Q4 2024 is 28.5%.

Grievance Data/Analysis:

Filed Against:	Grievance Type					Grand Total
	Access to Care	Coverage Dispute	Other	Quality of Care	Quality of Service	
Ancillary	18	27	0	2	7	54
Clinic	44	13	0	5	13	75
Delegate	6	2	0	0	2	10
Hospital	5	10	0	1	0	16
Other	7	1	1	0	10	19
Out-of-Network	8	5	0	1	1	15
PCP	22	0	0	6	11	39
Plan	58	29	21	0	43	151
Specialist	6	6	1	1	6	20
Vendor	0	0	0	0	9	9
Grand Total	**174**	**93**	**23**	**16**	**102**	**408**

Grievances filed against our Delegated Networks/Vendors:

Filed Against:	Grievance Type					Grand Total
	Access to Care	Coverage Dispute	Other	Quality of Care	Quality of Service	
Delegate	**6**	**2**	**0**	**0**	**2**	**10**
CHCN	2	0	0	0	0	2
PerformRx	4	2		0	2	8
Vendor	**0**	**0**	**0**	**0**	**9**	**9**
ModivCare	0	0	0	0	3	3
Xaqt	0	0	0	0	6	6
Grand Total	**6**	**2**	**0**	**0**	**11**	**19**


IHSS Q4 2023 - Q4 2024 Delegated Networks/Vendors Trend Line
9
8
7
6
5
4
3
2
1
0
Beacon
CHCN
CHME
Hanna
Kaiser
ModivCare
PerformRx
PTPN
Teledoc
Xaqt
Q4 2023
Q1 2024
Q2 2024
Q3 2024
Q4 2024

Grievances filed against our Plan/network:

- **Grievances filed against the Plan; the top 3 categories are:**
  - (58) Access to Care:
    - 30 out of the 58 complaints were related to telephone/technology; 28 of the 30 complaints were related to AAH System Error. Complaints were related to members experiencing delays in receiving their AAH ID cards in the mail, and difficulty logging into the Member Portal accounts.
  - (43) Quality of Service
    - 35 of 43 complaints were made against our internal departments: G&A, Member Services, Behavioral Health, Case Management, and Pharmacy regarding customer service.
  - (29) Coverage Disputes
    - 17 complaints were related to benefit disputes
    - 10 complaints related to reimbursement
    - 2 complaints related to bills

Grievances filed against our contracted facilities/providers:

Filed Against Ancillary Services (5 or more in a rolling 4 quarters)	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024					Q4 2024 Totals	Grand Total
					Access to Care	Coverage Dispute	Other	Quality of Care	Quality of Service		
NorCal Imaging (multiple locations	4	5	10	20	4	3	0	0	0	7	27

  - NorCal Imaging (multiple locations): Coverage disputes where members are being billed for covered services.

Filed Against Clinic - excluding AHS (5 or more in a rolling 4 quarters)	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Grand Total

					Access to Care	Coverage Dispute	Other	Quality of Care	Quality of Service	
No providers met the threshold										

Filed Against Hospital – excluding AHS (5 or more in a rolling 4 quarters)	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024					Grand Total
					Access to Care	Coverage Dispute	Other	Quality of Care	Quality of Service	
No providers met the threshold										

Filed Against PCP (5 or more in a rolling 4 quarters)	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024					Grand Total
					Access to Care	Coverage Dispute	Other	Quality of Care	Quality of Service	
No providers met the threshold										

Filed Against Specialty Services (5 or more in a rolling 4 quarters)	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024					Grand Total
					Access to Care	Coverage Dispute	Other	Quality of Care	Quality of Service	
No providers met the threshold										

Issues/Recommendations:

Action Items:

Action Item:	Responsible Party:	Completed:

* Upon further investigation, the PQI nurse and Alliance MD assign severity levels, action codes and outcome codes as deemed appropriate.

CAC Business

ALAMEDA Alliance FOR HEALTH

CAC
Charter

ALAMEDA Alliance FOR HEALTH

CAC CHARTER UPDATES

Brief Description of Change(s)
• Under Policy/Scope, ▸ Added "hard-to-reach populations". ▸ Expanded on CAC duties to include review of the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) and Non-Specialty Mental Health Services Outreach (NSMHS) and Education Plan. ▸ Removed review of Population Needs Assessment (PNA) findings from CAC duties. • Under Officers of the CAC: ▸ Updated voting process.

CAC Chair Nominations and Voting

CHAIR ROLES AND RESPONSIBILITIES

- Provide guidance to the CAC so its members identify, discuss, and make recommendations on issues of concern for Alliance members.
- The Chair will:
  - Collaborate with the CAC Planning team to develop meeting agendas.
  - Lead and facilitate CAC meetings.
  - Ensure meetings follow Robert's Rules of Order and ground rules.
  - Start the meeting and review the agenda with CAC members.
  - Guide discussions on agenda topics.
  - Set aside off-topic issues for future discussion (Parking Lot).
  - Decide whether to extend discussions on topics that goes into overtime.
  - Encourage all members to participate in discussions.
  - Involve all CAC members in the decision-making processes.

CHAIR SELECTION PROCESS

1. Inform members of Chair elections.
2. Request nominations (self-nominations are welcome).
3. Nominees share brief statement on their interest.
4. Motion and roll call to vote.
5. Alliance staff record votes and announces selection during the meeting.

Confidentiality Statement Updates

ALAMEDA Alliance FOR HEALTH

ALAMEDA ALLIANCE FOR HEALTH
COMMUNITY ADVISORY COMMITTEE (CAC) CHARTER

Purpose

The purpose of the Community Advisory Committee (CAC) is to provide a link between Alameda Alliance for Health (Alliance) and the community. The policy/scope, structure, and functions of the CAC, as outlined in this charter, shall be in accordance with the Alliance's Department of Health Care Services (DHCS) contract. In addition, pursuant to Title 22, California Code of Regulations, Section 53876(c), the CAC reflects the Alliance's member population and advises the Alliance on the development and implementation of policies and procedures that affect cultural and linguistic access, quality, and health equity.

Policy/Scope

The Alliance maintains a diverse CAC as a part of its implementation and maintenance of member and community engagement with stakeholders, community advocates for hard-to-reach populations, ~~traditional and Safety Net~~ providers and Members. The CAC encourages Alliance members and others to participate in public policy of the health plan to ensure the comfort, dignity, and convenience of members.

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

a) Identify and advocate for preventive care practices to be used by the Alliance.
b) Develop and update cultural and linguistic policy and procedures related to cultural competency issues, educational and operational issues affecting seniors, people who speak a primary language other than English, and people who have a disability.
c) Advise on Alliance member and provider-targeted services, programs, and trainings.
~~d)~~ Provide and make recommendations about the cultural appropriateness of communications, partnerships, and services.
d)
e) Advise on how to use findings from the CHAs/CHIPs to influence Alliance strategies and workstreams related to the Department of Healthcare Services

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Bold Goals, wellness and prevention, health equity, health education, and cultural and linguistic needs.

~~e) Review findings from the Population Needs Assessment (PNA) and discuss improvement opportunities on Health Equity and Social Drivers of Health and provide input on selecting targeted health education, cultural and linguistic, and Quality Improvement (QI) strategies.~~

f) Provide input and advice, including, but not limited to, the following:
   i. Culturally appropriate service or program design
   ii. Priorities for health education and outreach program
   iii. Member satisfaction survey results
   iv. ~~PNA~~ Population Needs Assessment findings
   v. Marketing materials and campaigns
   vi. Communication of needs for network development and assessment
   vii. Community resources and information
   viii. Population Health Management
   ix. Quality
   x. Health delivery systems to improve health outcomes
   xi. Carved out services
   xii. Coordination of care
   xiii. Health Equity
   xiv. Accessibility of services
   xv. Development of the provider manual and clarification of new and revised policies and procedures in the manual~~.~~
   ~~xv.~~xvi. Development of covered, Non-Specialty Mental Health Services (NSMHS) outreach and education plan.

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The Alliance shall ensure the fulfillment of the following requirements in accordance with Title 28, California Code of Regulations, Section 1300.69.:

a) The CAC shall receive information from the Alliance on public policy issues, including financial information and data on the nature and volume of grievances and their disposition.
b) The CAC's activities and recommendations shall be regularly reported to the Alliance Board of Governors (BOG) at board meetings.

Structure

1) CAC Selection Committee:

There will be a CAC Selection Committee established, tasked with selecting members of the CAC that reflect the general Medi-Cal and Group Care member populations,

hard to reach populations, and those that experience health disparities in Alameda County. The CAC Selection Committee will report to the Alliance Board of Governors.

The CAC Selection Committee shall consist of persons who sit on the Alliance BOG, which include representation in the following areas:

a) Safety-Net Providers (including, Federally Qualified Health Centers, behavioral health, regional centers, local education authorities, dental providers, Indian Health Service facilities, home, and community-based service providers).
b) Persons and community-based organizations that represent Alameda County.

2) <u>Membership of CAC:</u>

The CAC shall consist of voting members (including the chair and vice-chair) and regular/ad hoc guests of the committee. Membership on the committee must be changed as the Alliance's beneficiary population changes.

The CAC membership and representation must reflect the Medi-Cal and Group Care populations in Alameda County, and representation must include the following:

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

To ensure the CAC membership is representative of the communities in the Alliance service areas, the Alliance shall complete and submit annually to DHCS, an Annual CAC Member Demographic Report by April 1st of each year.

If a CAC member resigns, is asked to resign or is unable to serve on the CAC, the Alliance must replace the vacant seat within 60 calendar days. All new CAC candidates must follow the selection process with the CAC Selection Committee.

All CAC members shall complete a Conflict of Interest (COI) Form relating to any financial or other relationship to an Alliance competitor. A member's links with outside interests shall not impair the responsible exercise of his or her duties as a CAC member.

The CEO shall not vote at CAC meetings.

At least one (1) CAC member will serve on the Alliance BOG. The Alliance Chief Executive Officer (CEO) will select CAC members to serve on the BOG.

3) Regular/Ad-hoc Guests (non-voting):

Regular/subcommittee guests shall not be counted towards a quorum or be subject to term limits. Non-voting guests may include:

a) CAC candidates
b) Any persons from the public
c) Guests who will present information being discussed at a meeting

4) Officers of the CAC:

Officers of the CAC shall consist of the following:

a) Chair
b) Vice-Chair.

The CAC Chair and Vice-Chair shall be recommended by the CAC members by majority vote and ~~approved by the CEO~~announced in an open session meeting.

If both the Chair and Vice-Chair of the CAC are absent or unable to act at a meeting where a quorum is present, the Committee will select one of the attending committee members or Alliance staff to act as Chair pro tempore, with all the authority appurtenant thereto, if the Chair has not selected someone to preside at the meeting.

5) Meeting Agendas and Minutes:

a) CAC meeting agendas shall be developed with input from CAC members.
b) At least 72 hours prior to a regular meeting, an agenda and meeting materials shall be posted on the Alliance website in a centralized location.
c) The agenda shall be posted at the main entrance of the Alliance's principal offices and/or any other location freely accessible to members of the public.
d) An agenda and meeting materials, including minutes of the previous meeting, shall be sent to the CAC members at the same time they are posted on the website.
e) Meeting minutes shall be posted on the Alliance website and submitted to

DHCS no later than 45 calendar days after each meeting.

f) The minutes, including any CAC findings and/or activities are reported to the Quality Improvement Health Equity Committee (QIHEC).

6) Non-Agenda Items:

a) Prior to discussing a matter which was not previously placed on an agenda, the item must be publicly identified so that interested members of the public can monitor or participate in the consideration of the item in question.

b) The CAC may discuss a non-agenda item at a regular meeting if, by simple majority vote, the CAC determines that the matter in question constitutes an emergency pursuant to §54956.5. (§ 54954.2(b)(1).) or that it should be discussed at a future meeting.

7) Voting:

a) A simple majority (50% of voting members + 1) shall mean an approval of the proposed action.

b) Absent CAC members may not vote by proxy.

c) Electronic voting may be an option if attending a regular meeting, virtually is an option for a meeting attendance and approved.

8) Quorum:

a) A quorum, defined as a simple majority (50% + 1) of voting members, must be present for the CAC to vote on any matter.

b) If a quorum is not met at a regular scheduled meeting, the meeting shall continue as informational only.

9) Meeting Schedule and Special Participation:

a) The Alliance shall hold regular scheduled CAC meetings at least four (4) times per year.

b) The Alliance makes the regular scheduled CAC meetings open to the public.

c) The Alliance may request special participation from the CAC members to provide input on topics such as, but not limited to, advancing member targeted efforts.

10) Public Comment:

a) Every agenda for a regular meeting shall provide an opportunity for members of the public to directly address the CAC on any agenda items.

b) Where a member of the public raises an issue which has not yet come before the committee, the item may be briefly discussed and put on the next meeting agenda for further discussion, but no action may be taken at that

meeting.

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) term, at the discretion of the CAC Selection Committee.

The CAC Selection Committee may dismiss a member from the CAC if they fail to attend two (2) meetings of the committee within one (1) year without an excused or approved absence. Members shall notify the Alliance of expected absences. Members can request a leave of absence if needed for up to one (1) year for health or personal reasons.

Alliance Support

The Alliance will provide the following to the CAC:

a) Adequate staff support for committee meetings and activities.
b) Maintenance of meeting minutes and records.
c) Organizational updates and relevant materials.
d) Interpretation: The Alliance will arrange for a bilingual interpreter to assist CAC members whose preferred language is not English. CAC members shall make a request for an interpreter at least 72 hours before a regularly scheduled meeting.
e) Accommodations: CAC meeting location is wheelchair accessible. CAC members may call to request agendas and/or handouts in an alternative format, or any other disability-related accommodation needed to take part in the meeting. CAC members shall make a request for accommodation at least 72 hours before a regular scheduled meeting.
f) Stipend: CAC members shall receive a stipend for each meeting attended. CAC members may choose not to accept the stipend.
g) Transportation: The Alliance covers transportation costs. Members who cannot use regular transit because of a disability or disabling health conditions may request assistance from the Alliance to arrange for services from East Bay Paratransit.
h) Childcare: CAC members will be reimbursed for the cost of childcare. A reimbursement will be sent once a childcare invoice has been received and confirmed.
i) The Alliance will provide support for CAC candidates to attend one (1) meeting prior to becoming a member for the purpose of observation.

j) Sufficient resources, within budgetary limitations, to support CAC activities, member outreach, retention, and support.

COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

2024 | **ANNUAL OUTREACH REPORT**

ALLIANCE IN THE COMMUNITY

2024 | ANNUAL OUTREACH REPORT

Between **January 2024** and **December 2024**, the Alliance initiated and/or was invited to participate in **103** events throughout Alameda County. The Alliance completed **29** community events, **30** member education events, **1** community meeting/presentation, more than **12,796** live member orientation outreach calls among net new members and non-utilizers and completed **1,482** member orientations by phone. The Alliance reached a total of **10,468** people and spent **$2,987.55*** on donations, fees, and/or sponsorships in 2024. In addition, during 2024, the Outreach team completed **655** Alliance website inquiries, **98** service requests, and **11** social media inquiries.

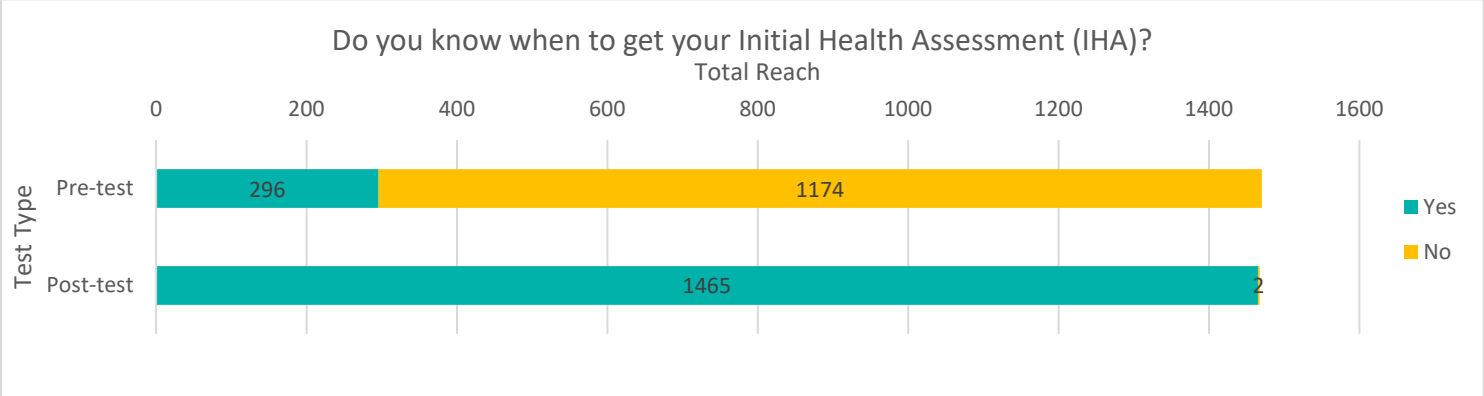
The majority of people reached at member orientations (MO) are Alliance Members. Approximately 30% of the people reached during community events are covered by Medi-Cal, and approximately 80% of people with Medi-Cal coverage have Alliance Medi-Cal based on Managed Care Enrollment Reports. Additionally, the Outreach Team began tracking Alliance members at community events in late February 2018. Since July 2018, **35, 857** self-identified Alliance members were 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).

On **Wednesday, March 18, 2020,** the Alliance began conducting member orientations by phone. As of December 31, 2024, the Outreach Team completed **45,067** member orientation outreach calls and non-utilizer calls and conducted **9,279** member orientations (**20.6%** member 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 Assessment (IHA), 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 December 31, 2024 – **9,279** members completed our MO program by phone.

After completing a MO **99.86%** of members who completed the post-test survey in 2024 reported knowing when to get their IHA, compared to only **20.1%** 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 24-25\Q2\3. December 2024**

ALLIANCE IN THE COMMUNITY
2024 | ANNUAL OUTREACH REPORT

2024 TOTALS

29	COMMUNITY EVENTS
30	MEMBER EDUCATION EVENTS
1482	MEMBER ORIENTATIONS (By Phone)
1	MEETINGS/ PRESENTATIONS
103	TOTAL INITIATED / INVITED EVENTS
1542	**TOTAL EVENTS**

7059	TOTAL REACHED AT COMMUNITY EVENTS
3396	TOTAL REACHED AT MEMBER EDUCATION EVENTS
1482	TOTAL REACHED AT MEMBER ORIENTATIONS
13	TOTAL REACHED AT MEETINGS/PRESENTATIONS
6373	TOTAL MEMBERS REACHED AT EVENTS
11950	**TOTAL REACHED AT ALL EVENTS**

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

TOTAL REACH 39 CITIES

**Cities not listed represent the mailing addresses for members who completed a Member Orientation by phone and Community Events. The italicized cities are outside of Alameda County. The C&O Department started including these cities in the FY20 Q3 Outreach Report. Please see event details for complete listings of cities.*

$2,987.55

TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

** Includes refundable deposit.*