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: **580 701 277#.** 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:	June 12, 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: 580 701 277#	**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 • March 20, 2025	**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			

III. Meeting Agenda			
Topic	**Responsible Party**	**Time**	**Vote to approve or Information**
1. Follow-up Items from • March 20, 2025	**Mao Moua** Manager, Cultural and Linguistic Services	3	Information
New Business			
1. Faith-Based Community Engagement	**Yen Ang** Director, Health Equity	12	Information/ Discussion
2. Member Satisfaction Survey	**Loc Tran** Manager, Access to Care	12	Information/ Discussion
3. Population Health Management Strategy	**Linda Ayala** Director, Population Health & Equity **Farashta Zainal** Manager, Quality Improvement **Gil Duran** Manager, Population Health & Equity **Jorge Rosales** Manager, Case Management	15	Information/ Discussion
4. Annual Review of Cultural and Linguistic Services	**Mao Moua** Manager, Cultural and Linguistic Services	12	Information/ Discussion
Alliance Reports			
1. Communications & Outreach	**Alejandro Alvarez** Supervisor, Communications & Outreach	7	Information
CAC Business			
1. CAC Chair Nominations and Voting	**Tandra DeBose** Vice Chair **Linda Ayala** Director, Population Health & Equity	10	Discussion/Vote

III. Meeting Agenda			
Topic	**Responsible Party**	**Time**	**Vote to approve or Information**
2. CAC Membership Recruitment	**Mao Moua** Manager, Cultural and Linguistic Services	5	Information
Open Forum 1. Public Comments 2. Next meeting topics	**Tandra DeBose** Vice Chair	5	Information
Adjournment	**Tandra DeBose** Vice Chair		Next meeting: **September 11, 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:

ALAMEDA Alliance FOR HEALTH

COMMUNITY ADVISORY COMMITTEE (CAC)

Thursday, March 20, 2025, 10:00 AM – 12:00 PM

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

Other Attendees	Organization	Present
Bernie Zimmer	CHME	x
Catalina Valderrama	CFMG	x
Jesus Verduzco	Alameda County	x
Melodie Shubat	CHME	x

Alliance Staff Members	Title	Present
Alejandro Alvarez	Community Outreach Supervisor	x
Alma Pena	Senior Manager, Grievance and Appeals	x
Anne Margaret Macsiljig	Quality Engagement Coordinator	
Dana Patterson	Business Analyst, Incentives and Reporting	x
Danube Serri	Senior Legal Analyst	x
Donna Carey	Chief Medical Officer	x
Emily Erhardt	Population Health and Equity Specialist	x
Farashta Zainal	Quality Improvement Manager	x
Gabriela Perez-Pablo	Outreach coordinator	x
Gil Duran	Manager, Population Health and Equity	x
Isaac Liang	Outreach Coordinator	x

Jennifer Karmelich	Director of Quality Assurance	
Jessica Jew	Population Health and Equity Specialist	
Jorge Rosales	Manager, Case Management	
Katrina Vo	Senior Communications and Content Specialist	x
Krystaniece Wong	Regulatory Compliance Specialist	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	
Mara Macabinguil	Interpreter Services Coordinator	x
Matthew Woodruff	Chief Executive Officer	x
Michelle Lewis	Senior Manager, Communications & Outreach	
Michelle Stott	Senior Director, Quality Improvement	x
Misha Chi	Health Education Coordinator	x
Mohammed Abbas	Outreach Coordinator	x
Monique Rubalcava	Health Education Specialist	x
Peter Currie	Senior Director of Behavioral Health	x
Ronnie Wong	Program Manager, Grants and Incentives	x
Rosa Carrodus	Disease Management Health Educator	x
Shatae Jones	Director, Housing and Community Services Program	x
Stephen Smyth	Director of Compliance and Special Investigations	
Steve Le	Outreach Coordinator	x
Taumaoe Gaoteote	Director of Diversity, Equity, and Inclusion	
Thomas Dinh	Outreach Coordinator	x
Yen Ang	Director of Health Equity	

AGENDA ITEM SPEAKER	DISCUSSION	ACTION	FOLLOW-UP
1. WELCOME AND INTRODUCTION			
T. Debose	T. Debose called the meeting to order at 10:04 am. A roll call was taken, and a quorum was not established. An introduction of staff and visitors was completed.	None	None
2. a. APPROVAL OF MINUTES AND AGENDA – APPROVAL OF MINUTES FROM DECEMBER 5, 2024 and DECEMBER 16, 2024 SPECIAL MEETING.			
T. Debose	The committee was unable to vote on the 12/05/2024 and 12/16/2024 meeting minutes approval as quorum was not established.	None	None

2. b. APPROVAL OF MINUTES AND AGENDA – APPROVAL OF AGENDA			
T. Debose	The committee was unable to vote on the 03/20/25 meeting agenda approval as quorum was not established. T. Debose announced moving the CEO Update and Grievance and Appeals Report towards the end of the meeting.	None	None
3. FOLLOW-UP ITEMS			
L. Ayala	• CAC feedback and questions around the design rationale behind the shapes used in the new logo were shared with the Alliance Leadership team. Updated information was sent to CAC members via email on 01/22/2025. • CAC-recommended organizations were added to the Alliance CAC recruitment efforts. ○ Health and Human Resource Education Center (HHREC)-a candidate has been identified from the organization and an application was received. .	None	None
4. NEW BUINESS – COMMUNITY SSUPPORTS AND HOUSING			

S. Jones	S. Jones presented an overview of the housing landscape in Alameda County.
	• Housing and Social Determinants of Health (SDOH): social, economic, and environmental factors strongly affect health and well-being.
	• A video on SDOH was presented.
	• California Healthy Places Index: Alameda County is generally considered a very healthy place to reside and ranked in the 94th percentile.
	• City-level data reveals disparities in health rankings tied to SDOH, such as neighborhood conditions, transportation, and education.
	• Alameda County Point-in-time (PIT) Results 2025: mandatory census on people experiencing homelessness on a one-night basis.
	  ○ Single adult males are more likely to experience unsheltered homelessness.
	  ○ Senior individuals are the fastest growing population.
	  ○ Asian Americans are more likely to experience sheltered homelessness.
	  ○ African Americans are more likely to experience unsheltered homelessness.
	  ○ Self-reported disability prevalence in the population experiencing homelessness.
			Alliance staff to send information on Continuum of Care (COC) to CAC members—How to become a voting member.

	• Housing First Model: approach that prioritizes providing stable housing without preconditions such as sobriety and employment.
	• Permanent Supportive Housing (PSH): approach that combines affordable housing, targeted interventions, case management, and referral long-term resources.
	
	Medi-Cal Funded Housing Support: CalAIM benefits are referred to as the Housing Bundle here at the Alliance.
	• CalAIM: multiyear delivery system, intentionally combining social supports with clinical care to support members in a whole-person care model.
	• Fifteen Community Supports (CS) programs at the Alliance, and the Housing Department oversees 4:
	  ○ Housing Deposits: assist with identifying, security, or funding one-time services.
	  ○ Housing Tenancy Sustaining Services: provide tenancy and sustaining services.
	  ○ Housing Transition and Navigation Services: assist members with obtaining and securing housing.
	  ○ Transitional Rent: coming soon
	• Different qualifications for each CS program, but all require medical necessity, and some require prior enrollment in housing navigation.
	• Limits to how long one can receive the services varies.
	• Housing CS Provider: The Alliance is only contracted with Alameda County (AC) Health—serves as administrator, and subcontracts with 23+ housing CS service providers.
	• Members can access housing support through Alameda County Coordinated Entry.
	  ○ Members may call 211 OR
	  ○ Member presents at a Housing Resource Center
	• When a member presents at Housing Resource Center:
	  1. Housing problem solving assessment: connects members to resources upfront.
	  2. If issue/s cannot be resolved in the problem-solving phase, the member will enter the Coordinated Entry system through a screening and assessment. Based on the member responses, members will be prioritized on a waitlist and linked to appropriate resources.
	• Depending on availability, members may be referred to:
	  ○ Interim Housing
	  ○ Permanent Supportive Housing
	  ○ Private Market Housing		

	• Authorization Process 1. AC Health submits an authorization request to the Alliance Housing and Community Supports Department (HCSD). 2. Alliance HCSD reviews authorization and corresponding justification/documentation. 3. Determination is made. 4. Notification is sent to the member, referring provider, rendering provider, and PCP. The Housing team participates in the following: • Alameda County Leadership Board • Alameda County Racial Equity Committee • Alameda County Homeless Management Information System Committee • Alameda County Taskforce for 2030 Home Together Plan • Corporation for Supportive Housing Advisory Workgroups • A Housing staff is the VP of National Association of Housing • Active Alameda County Point-In-Time Count (PIT) programing and planning teams Meet the Housing Team: • Shatae Jones, LCSW: Director of Housing and Community Services • Adrienne Milles, MCP: Housing Coordinator • Michelle Pham, BA: Housing Coordinator • Oscar Macias, MPA: Program Manager S. Jones presented a list of resources which contain information from Coordinated Entry Program, California Health Care Foundation & Corporation Supportive Housing (CSH), Medi-Cal Academy for Homeless Service Providers, and Department of Healthcare Services. ➢ Member Question-T.Debose: Commented that the 94th percentile for Alameda County looked wonderful, but when it changed to 17th percentile for Oakland, it seemed more reasonable. She asked what impact the Alliance is making and how might the Alliance work with the Cit of Oakland. Certain areas of the city are cut off because of debris, and efforts are not making a difference to make the city healthier. She asked what can we do as CAC to affect that. ➢ Response-S.Jones: Responded that the built environment and social determinants of health are important to understand. Some of the “why” of		

	homelessness was designed that way. The audio book called the Color of Law discusses the structural racism in the way built environments are. Different areas of Oakland, above and below 580, were resourced differently. The CAC can use their voices. There are public meetings with your Board of Governors and Board of Supervisors, COC, and the housing development meetings that are open to the public around new affordable housing developments and wanting to hear community feedback. The leadership at the Alliance is dedicated to making sure that the Alliance resources are allocated throughout the county in a meaningful way. She recommended inviting Danny to talk about how we have invested as a community to lift those disparities that you have shared with us. The Alliance got the bundle out to the community as quickly as possible and is now serving both top and the bottom of the corridor. The Alliance also needs to show in our data how targeted intervention strategies that contributed to someone's health getting better. We want to share information on how you can get involved in community activities that impact Alameda County. ➢ Member Question-T.Debose: Asked how the funding supports employment so they can keep their housing. You can give someone first and last month's rent, however, if you can't maintain it, you end up in the streets again. ➢ Response-S.Jones: Anyone who is linked to a coordinated entry resource is also linked to permanent supportive housing model or maybe even transitional housing like rapid rehousing. The good news is that those resources are subsidized, to maintain the unit, it's 30% of their income which can be from Social Security or employment. ➢ Member Question-N Williams: Asked what permanent housing is available for elders or senior citizens. How long would it take for a homeless person to receive housing benefits? ➢ Response-S.Jones: Responded that nationally, it takes about 9 to 24 months. Now, that can change as we've seen with Covid. It depends on the resources available in each county. ➢ Member Question-N Williams: *If it takes 9 to 24 months, are these individuals provided with temporary housing or are they prioritized in any kind of way?* ➢ Response-S.Jones: Responded "yes, in some cases, but it is very individual. For example, if you presented at a coordinated entry location,		

	and you made a personal decision of going into a shelter opportunity before permanent supportive housing opportunity, that could be available. But again, as we know, homelessness is not a people issue, it is literally a production of housing issue and there's not nearly enough affordable housing or housing resources in the community.		
5. CEO UPDATE– CEO Report			
M. Woodruff	M. Woodruff presented the following updates: Homelessness • The Alliance has 15,000 homeless members currently. • Only about 2,000 out of the 15,000 are enrolled in ECM, which is now at full capacity. ➢ Member Question-T.Debose: Asked if members coming from other states. ➢ Response-M. Woodruff responded that although he didn't know the answer to that question, he has seen in the news. What we do know is that the street teams in Alameda County are seeing the same people for many years ,and understand their needs. ❖ Member Comment-T.Debose: Yes, but some people have been homeless for over five years or more. ➢ Response-M. Woodruff: When speaking to a Street team medical director, they have been treating some of the same couples and people for 15 to 20 years. ❖ *Member Comment-N. Williams:,* Some people can't even live in the house now, they've been outside so they can't function inside. CEO Report • Financials o January financials are not as good as hoped for but is due to reasons that are very different than what we've been going through. o Longterm care and operations cost came down. In-patient hospital went flat. o Main reason for loss is $8 Million in potential fraud payments. • D-SNP o Getting ready for Medicare: multiple work plans and work streams, second provider town hall next month.	None	None

	○ A decision was made to start small with Medicare so not going to actively recruit for the first 6 to 9 month, will instead work with a couple of community partners to start with. ○ Medicare has rules and requirements that are different from Medi-Cal, so the goal is to make sure that we set that up to put us in a good path. ▪ Coding: if the provider does not enter the member's diagnoses at least once a year into the member's chart, we get less money. ▪ Stars program (Medicare's quality program): involves members rating their providers. • DHCS and DMHC Audit ○ Dual audit during the first 2 weeks of March 2025. ○ DHCS audit happens yearly, findings will likely be 3 or 4. ○ DMHC audit happens every 3 years, findings will likely be around 20 due to a longer look-back period. • Potential Changes to Medi-Cal Program ○ Disenrollments: after 07/01/25, all protections in place under Covid will be discontinued. ▪ Asses test returns. ▪ Reenrollment on anniversary month, no longer automatic. ▪ People enrolled in CalFresh or SNAP are no longer automatically enrolled to Medi-Cal. ○ Projection of 12,000 to 13,000 disenrollments. ○ Ninety-day protection stays in place. ○ Potential funding changes: the state has taken $6 Billion loan from the general fund to keep what's current in Medi-Cal going. ○ The federal government might take action towards the undocumented population whether making it illegal to give them coverage or other forms of backlash. ○ In Alameda County, 80,000 undocumented people would have to go back to HealthPAC (county program). Providers are Community Health Center Network (CHCN) or Alameda Health System (AHS). ○ Result will be a $700 Million revenue loss to the Alliance. • Community Supports ○ Centers for Medicare and Medicaid Services (CMS) retroactively took back the guidance on community supports. ○ Community Supports stays as it is, nothing is going away.		

	○ The federal government stated that they will make it harder for any social determinants of health programs to be funded in the future. ○ The Alliance's waiver ends on 12/31/2026, so the new waiver will be in 2027 if we get a new one. ○ Enhanced Care Management (ECM) stays even though it's under the CalAIM umbrella, but still waiting to see what happens with transitional rent due to potential lack of funding. ➢ *Attendee Question-B. Zimmer, CHME: Asked what happens to those 80,000 members if they lose Medi-Cal, and if they go to HealthPAC. They are utilizing equipment from CHME. How is the continuity of care extended if they move?* ➢ *Response-M. Woodruff: I don't know what's covered in HealthPAC. HealthPAC never went away, it was kept intact, although they only now have 2,200 lives, whereas it used to be up to 130,000 lives. The hope is that Alameda County can keep funding the HealthPAC, but what we fund right now is much higher under Medicaid than what the county can afford under HealthPAC. I don't know if they cover DME. We're going to lose 12,000 to 13,000 members next fiscal year, so we're essentially doing a side-by-side budget of what happens if the undocumented members go back to HealthPAC, so they're no longer covered by us. Those are obviously going to be very big changes to our budgets, and for the community supports, if these go away in 2027. Are there any programs that we could keep? Could we go out and get grants? So that's the conversation that I started having with the county.* ➢ *Member Question-V. Gonzalez: For people that are in the process of seeking asylum, are they considered undocumented? Who's considered documented and who's considered undocumented?* ➢ *Response-M. Woodruff: I'm not sure how to answer that right now. I'd have to exactly see what the Medi-Cal definition is of undocumented, but I'm assuming it's anybody not born in the United States that doesn't have legal residency.* ❖ *Member Comment-N. Williams: It's very sad there's such a big gap in the undocumented member's healthcare and disparities, as well as the homeless. Then you have all these facets of the homeless. There's the mentally ill, elderly, and families. You have to approach these all at once.*		

	➢ *Member Question-V. Gonzalez: Do they have the capacity to take people back under HealthPAC?* ➢ *Response-M. Woodruff: When those 80,000 lives came into Medi-Cal they did not just have AHS or CHCN anymore, they could go to anyone in our provider network. With HealthPAC they will be limited back to those two. I'm sure we could get the data, but I don't know how many people left those two networks and how many stayed.* ❖ *Member Comment-C. Wynn: Mr. Matthew, I want to thank you for this report that you've done diligently this morning for us. What I'm going to do on my next appointment is to make sure my new doctor has all my diagnoses entered, so that the funding can keep coming. Since they finally stopped deporting my doctors. One year, I got a doctor that got deported. Second year, I got another doctor who also got deported. I have a doctor for 3 years now, and so I'll make sure my information is well updated, to turn it over to where it needs to go to keep the money coming. I'm not speaking much today because I'm very proud of the work we're doing around here lately.*		
6. ALLIANCE REPORTS – GRIEVANCE AND APPEALS 2024			

A. Pena	A. Pena presented on the 2024 Grievance and Appeals Report.
	
	Medi-Cal
	• Number of grievance cases:
	  ○ Standard Grievance: 17,114
	  ○ Expedited Grievances: 30
	  ○ Exempt Grievance: 23,557
	  ○ Standard Appeal: 478
	  ○ Expedited Appeal: 12
	  ○ Total cases: 41,191
	• All cases have been resolved within compliance timeframes.
	• 7.56 complaints per 1,000 members (goal: 1 per complaint per 1000 members
	• 32,276 unique grievance cases; 40,701 total grievance cases including all shadow cases
	• Grievances related to quality of care were forwarded to the Quality Improvement Department as Potential Quality Issue (PQI).
	• Grievances related to discrimination, fraud, waste, and abuse were forwarded to the Compliance Department for further investigation.
		None	None

	• Grievances against delegates/vendors have been reported during quarterly joint operation meetings with each entity.
	• Overturn rate: 22% (goal: 25% or below)
	• Number of grievance cases by type:
	  ○ Access to Care: 17,850
	  ○ Coverage Dispute: 4,342
	  ○ Other: 6,799
	  ○ Quality of Care: 944
	  ○ Quality of Service: 10,701
	  ○ Total cases: 40,701
	• Grievances filed against delegates/vendors:
	  ○ Delegates: 412
	  ○ Vendors: 2,048
	  ○ Total cases: 2,460
	
	In-Home Support Services (IHSS)
	• Standard Grievance: 258
	• Expedited Grievances: 0
	• Exempt Grievance: 150
	• Standard Appeal: 21
	• Expedited Appeal: 0
	• 2024 Total cases: 429
	• 20.1 complaints per 1,000 members (goal: 1 per complaint per 1000 members).
	• 349 unique grievance cases; 408 total grievance cases including all shadow cases
	• Grievances related to quality of care were forwarded to the Quality Improvement Department as Potential Quality Issue (PQI).
	• Grievances related to discrimination, fraud, waste, and abuse were forwarded to the Compliance Department for further investigation.
	• Grievances against delegates/vendors have been reported during quarterly joint operation meetings with each entity.
	• Overturn rate: 28.5% (goal: 25% or below)
	• Number of grievance cases by type:
	  ○ Access to Care: 174
	  ○ Coverage Dispute: 93
	  ○ Other: 23
	  ○ Quality of Care: 16
	  ○ Quality of Service: 102		

	○ Total cases: 408 • Grievances filed against delegates/vendors: ○ Delegates: 10 ○ Vendors: 9 ○ Total cases: 19 Top 3 categories of grievances filed against the plan: • Access to Care: 58 • Quality of Services: 43 • Coverage Disputes: 29 ➢ *Member Question-T. Debose: Do you compare number of complaints or grievances between quarters?* ➢ *Response-A.Pena: Yes, the Alliance reports quarterly to internal committees and tracks quarterly all the incoming grievances and appeals.* ➢ *Member Question-T. Debose: So, do you feel like 4th quarter is more versus summertime when people are more happy?* ➢ *Response-A.Pena: Yes, I'd like to think so, right? There was a jump in the 4th quarter and next year when we see the 1st quarter of this year, you'll see a jump also there. There was a jump due to the transition into the Alliance. Usually, we see that 4th quarter is a little lower because people are vacationing or going on holidays, but most of the time, it is the 1st quarter and last year, we did see a little spike because of the transition.* ❖ *CEO Comment-M. Woodruff: Our phone calls usually go down in May through August and then pick up when kids go back to school and needing to get to appointments. You see an uptick August through March and then it drops.*		
7. a. CAC BUSINESS – CAC CHARTER			
L. Ayala	L. Ayala reminded CAC members that the meeting packet includes a tracked version of the charter. Brief description of changes: • 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.	None	CAC Planning Team to move voting on the CAC Charter approval to the next meeting.

	○ Removed review of population needs Assessment (PNA) findings from CAC duties. • Under Officer of the CAC: ○ Updated voting process. The committee was unable to vote on the charter approval as a quorum was not established.		
7. b. CAC BUISNESS – CAC CHAIR NOMINATIONS AND VOTING			
L. Ayala	L. Ayala thanked Tandra Debose for chairing the meetings as the CAC Chair position is currently vacant. L. Ayala discussed the roles and responsibilities. • CAC Chair Roles and Responsibilities: ○ Collaborate with the CAC Planning team to develop meting agendas. ○ Lead and facilitate CAC meetings. ○ Ensure meeting follows Robert's Rules of Order and ground rules. ○ Start the meeting and review the agenda with CAC members. ○ Guide discussion on agenda topics. ○ Set aside off-topic issues for future discussion (Parking Lot). ○ Decide whether to extend discussions on the topics that go into overtime. ○ Encourage all members to participate in discussions. ○ Involve all CAC members in the decision-making process. • CAC Chair Selection Process ○ Inform members of Chair elections. ○ Request nominations (self-nomination are welcome). ○ Nominees share brief statement on their interest. ○ Motion and roll call to vote. ○ Alliance staff record votes and announce selection during the meeting. ➢ *Member Question-N. Williams: To which email address do we send our nominations to?* ➢ *Response-L.Ayala: We will actually do the nomination at the meeting, in this public forum. So, you'll be able to verbally make that nomination.* The committee was unable to nominate and vote for a new chair as a quorum was not established.	None	CAC Planning Team to move the CAC Chair Nominations and Voting to the next meeting.

7. c. CONFIDENTIALITY STATEMENT UPDATES			
M. Chi	M. Chi requested that the members sign the yearly confidentiality statement and submit it to her at the end of the meeting. M. Chi also informed members attending virtually via Teams, that she had sent them a packet containing the document with a return envelope.	None	None
8. OPEN FORUM			
T. Debose	• L. Ayala announced that the Alameda County Behavioral Health Department is going through a planning proceed that helps them determine where funding goes, to ensure that they are dedicating funding to types of services needed by Alameda County residents. Misha Chi will send an email with the survey link to the CAC members after the meeting. There will be a $25 gift card raffle for people who participate. • T. Debose asked if it would be possible for an email to be sent to CAC members with the dates of the next 2 to 3 meetings. • N. Williams requested that the Initial Health Assessment be added as a topic in a future meeting.	None	M. Chi to send an email with the Alameda County SH Department survey link to CAC members. CAC Planning Team to send an email to CAC members with the dates of the next 2-3 meetings. CAC Planning Team to add the Initial Health Assessment as a topic in a future meeting.
9. ADJOURNMENT			
T. Debose	T. Debose announced that the next CAC meeting is on 06/12/2025. T. Debose adjourned the meeting at 11:43 am.	None	None

Meeting Minutes Submitted by: Mara Macabinguil, Interpreter Service Coordinator Date: 4/16/2025
Approved by: _____ Date:

CEO Update

Matthew Woodruff, Chief Executive Officer

ALAMEDA Alliance FOR HEALTH

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

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

Date: **June 13th, 2025**

Subject: **CEO Report**

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

	April	**YTD**
Medi-Cal	$5.7M	($85.4M)
Group Care	$585K	$389K
Medicare	($375K)	($7.3M)
Total	$5.9M	($92.4M)

  - **Revenue was $193.0 million in April 2025 and $1.8 billion Year-to-Date (YTD)**.
    - Medical expenses were $181.2 million in April and $1.8 billion for the fiscal year-to-date; the medical loss ratio is 93.9% for the month and 101.1% for the fiscal year-to-date.
    - Administrative expenses were $8.7 million in April and $95.5 million for the fiscal year-to-date; the administrative loss ratio is 4.5% of net revenue for the month and 5.4% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 202% of the required DMHC minimum, representing $82.2 million in excess TNE.
  - **Total enrollment in April 2025 was 410,784**, decreased by 1,846 Medi-Cal members compared to March 2025.

- **BUDGET UPDATES**
  - **State and Federal – See Presentation**

- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - The G&A team currently faces challenges in managing a high volume of cases along with staffing shortages. During the month of April, the team missed the expedited case criteria for both grievances, 83% (5 out of 6 were compliant), and appeals, 75% (3 out of 4 were compliant). The criteria are that these cases be resolved in 3 calendar days. The staffing shortages resulted in the team's being noncompliant on these two metrics.

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

- **Alliance Updates:**
  - **Demographics**
    - Please see the attached PowerPoint describing the demographics of the Alliance employees.
- **COMMUNITY SUPPORTS**
  - There will be a Board discussion
- **STRATEGIC PLANNING**
  - July Board meeting
- **AUTOMATION AND AI**
  - There will be an update at a future Board meeting
- **ALLIANCE IN THE COMMUNITY**
  - This will be a new section focused on partnership work the community
- **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 111 projects, 69 of which are active, 37 requested, and five (5) on hold.
  - Final QA of 2026 CMS Formulary and Bid Submission (Benefit Determination) was completed on Friday, May 30th, 2025, and on track for submission on Monday, June 2nd, 2025.
  - CMS Account Manager assigned on Friday, May 30th.
- Onsite with CHCN was conducted on Tuesday, May 27th, 2025, to review operational readiness and discuss continued collaboration/partnership.
- Sales scripts, enrollment letters, & enrollment form are all complete. Nations SOW fully executed for Sales System, Hearing, and FlexCard OTC benefit. D-SNP elements added to Utilization Management Committee (UMC) and Community Advisory Committee (CAC).
- Stars strategy continues to gain momentum with full staff and focusing on EMR care gap closure opportunities, enhancing data feed capabilities, and implementing pay for performance. Future opportunities include concierge care cap program, annual wellness visit program, and health awareness campaign.
- PBM implementation is on track. Core systems implementations are underway with EMR upgrades at 60% complete. Sprint sessions are in full swing.

Summary of Medicaid Related Provisions in the Federal Reconciliation Package and California's May Revise (Budget)

Alliance Public Affairs Department

June 13th, 2025

ALAMEDA Alliance FOR HEALTH

House Reconciliation Package

- On May 22nd, the House of Representatives passed its reconciliation package (H.R. 1) by a 215-214 vote.
- The Congressional Budget Office (CBO)estimates that under provisions within Energy and Commerce, the national uninsurance rate would increase by 10.9 million by 2034 with 7.8 million related to the Medicaid provisions (1.4 million of those individuals are estimated to lose coverage due to citizenship or immigration status).
- Medicaid provisions are organized under the following sections:
  - Fraud Reduction and Enrollment Gaming
  - Wasteful Spending Reduction
  - Reducing abuse practices
  - Personal Accountability

Major Provisons in the House Reconciliation Bill

- Citizenship/Immigration Status
  - → No federal match if immigration status is not verified. Removes the 90-day period in which states can enroll individuals and receive FFP while verifying immigration status. Effective: December 31, 2026.
- FMAP Penalty
  - → Reduction in federal match by 10% for expansion states that provide Medicaid coverage for undocumented individuals – from 90% to 80%. Effective: October 1, 2027.
- Work Requirements/Community Engagement
  - → 80 hours for 19-64 age group (without dependents), with exemption for medically frail as defined by state. Eliminates the discretion of future administrations to waive work requirements for various populations. Effective: December 31, 2026, with guidance for states to adopt as soon as December 31, 2025.

Major Provisons in the House Reconciliation Bill

- Supplemental Payments
  - → Freeze on state provider tax rates; prohibits states from increasing the amount or rate of an existing provider tax and/or establishing new provider taxes. Effective: Upon enactment.
  - → Provider Tax Requirements: tightens requirements for uniform taxes, requires states to modify models to comply with requirements. Effective: Upon enactment. Subject to transition period as determined by HHS Secretary, not to exceed 3 years.
  - → State Directed Payments: limits new state-directed payments (SDPs) for services provided to 100% of Medicare rates (for expansion states).

    *According to CHA, could result in cuts of $10 billion (2% of total hospital Medicaid revenue)
- Redeterminations
  - → Requires Redeterminations for adults in expansion population (19-64) every 6 months. Effective: December 31, 2026.

Major Provisons in the House Reconciliation Bill

- Gender Services
  - → No federal match for gender transition procedures for children and adults. Effective: Upon enactment.
- Assets
  - → $1M ceiling for permissible home equity values for LTSS eligibility. Effective: January 1, 2028.
- Retroactive Coverage
  - → Restricted to 1 month (currently 3 months) before application. Effective: December 31, 2026.
- Provider Screening
  - → Requires states to conduct monthly checks to determine whether HHS or another state has already terminated a provider/supplier in Medicaid and to disenroll them from the program. Effective: January 1, 2028.

Major Provisons in the House Reconciliation Bill

- Cost Sharing for Expansion Adults (19-64 age group)
  - → Cost sharing for adults over 100% FPL. Effective: October 1, 2028.
  - → Max $35 copay/service
  - → No cost share for primary care, prenatal care, pediatric care, or emergency room care (except for non-emergency care provided in an emergency room).
- Beneficiary Addresses
  - → Requires states to obtain correct member addresses. Effective: October 1, 2029.
  - → Requires states to submit Social Security Numbers and other information to HHS to prevent duplicate enrollment. Effective: October 1, 2029.

Next Steps in Reconcilation Process

- Senate Amends the House Package (H.R. 1, the One Big Beautiful Bill Act)
- Senate Reconciliation Package goes through “Byrd Bath” to determine whether any provisions need to be excluded.
- Senate votes on Reconciliation Package
- House and Senate resolve differences and vote on a final reconciliation bill that goes to the president.
- President signs bill into law. Current goal is to have it to the president by July 4th.

Reconciliation Bill and Impacts to California

- Medicaid (Medi-Cal) coverage could be stripped from up to 3.4 million Californians and cost the state over $30 million in lost federal funding.
  - → Redetermination provision (every 6 months) could cause up to 400,00 Californians in expansion population to lose their coverage.
  - → Work requirement provision could lead to a loss of up to $22.3 billion in federal funding and cause up to 3 million to lose coverage.
  - → FMAP penalty for covering undocumented population could lead to loss of $4.4 billion.
  - → State funding tools:
    - Freezing provider taxes
    - Provider tax requirements
    - State directed payments

State Budget: Governor's May Revise and Legislature's Proposals

ALAMEDA Alliance FOR HEALTH

Revised Budget and Shortfall

- On May 14th, Governor Newsom released his 2024-25 $321.9 billion *($226.4 billion GF)* budget proposal, a decrease of $400 million from his January Budget.
- The revised budget projects a deficit of $12 billion, compared to his January budget which forecasted a $16.5 billion surplus.
- The balanced budget proposed the following:
  - $15.7 billion, a decrease of $2.7 billion from the January Budget.
  - $11.2 billion in Budget Stabilization Account, an increase of $300 million from the January Budget.
  - $4.5 billion in Special Fund for Economic Uncertainties, no change from the January Budget.
  - $1.5 billion earmarked in the January Budget for the Public School System Stabilization Account is not reflected in the May Revision.

Revised Budget and Shortfall

- Medi-Cal is mentioned as a key source of expenditure growth and reason for increased budget shortfall as well federal government policies and proposals that have destabilized the state's economic conditions.
- Medi-Cal expenditures continue to grow and outpace revenues. References the $3.4 billion cash flow loan that DHCS obtained and the additional $2.8 billion approved by the legislature for the Medi-Cal program in March and April 2025.
- Increased costs for the Medi-Cal program are attributed to higher overall enrollment, pharmacy costs, and higher managed care costs. Major cost drivers include:
  - Increase for undocumented members
  - Higher enrollment/utilization resulting from continuation of unwinding flexibilities
  - Repayment of Medical Providers Interim Payment Fund loan
  - Offset reduction related to MCO tax.

Medi-Cal Budget Proposals

- Medi-Cal cuts that would impact the undocumented population:
  - Enrollment freeze for full-scope Medi-Cal for adults, starting 1/1/2026.
  - $100 monthly premiums, beginning 1/1/2027.
  - Elimination of long-term care coverage, starting 1/1/2026.
  - Elimination of dental benefits for adults, starting 7/1/2026.
    - →Does not include restricted-scope emergency dental coverage
  - Reduction in funding for FQHCs and Rural Health Clinics for undocumented population (via elimination of PPS rates) in 2026-2027.
  - Implement a pharmacy rebate aggregator for the undocumented population.

Medi-Cal Budget Proposals

- Medical Loss Ratio (MLR) – increase the minimum MLR for Managed Care Organizations to 90% (from current 85%), beginning 1/1/2026.
- Provider Supplemental Payments
  - Elimination of Prop 56 payments for dental, family planning and women's health providers
  - Elimination of the Workforce and Quality Incentive Program (Skilled Nursing Facility)
- Governor moving MCO tax dollars to offset Medi-Cal budget (lawsuit?)

Medi-Cal Budget Proposals

- Other Medi-Cal Cuts
  - Reinstating Medi-Cal asset limits.
  - Elimination of acupuncture as an optional benefit.
  - Implementation of prior authorization requirements for hospice services.
  - Limiting payments to PACE providers.
- CalAIM
  - Continues to fund ECM and Community Supports (including transitional rent) with estimated $2.4 billion in expenses.
  - $200 million from Prop 35 to support Flexible Housing Pool rental assistance and housing supports over two years.

Pharmacy Budget Proposals

- Includes policies aimed at addressing pharmacy costs within the Medi-Cal program, including:
  - Minimum rebate for HIV/AIDS and cancer drug rebates
  - Elimination of pharmacy coverage for COVID-19 tests (out of network), OTC vitamins, and certain antihistamines.
  - Ongoing implementation of UM and PA policies.
  - Implementation of a step therapy strategy.
  - Elimination of weight loss drugs (GL-Ps).

IHSS Budget Proposals

- Includes reductions to In-Home Supportive Services, including:
  - Reduction to conform IHSS with Medi-Cal asset limit reinstatement
  - Elimination of IHSS benefits for undocumented population.
  - Reduction to conform the IHSS Residual Program coverage, a program available to individuals who are not eligible for full-scope Medi-Cal, with the timing of Medi-Cal coverage.
  - Reduction and ongoing cap on IHSS provider overtime and travel at 50 hours, a decrease from the current 60–70-hour cap beginning 2025-26.

Legislature's Budget Version

- On June 9th, Assembly and Senate Leaders announced a Budget Plan which includes the following budget solutions of note:
  - Modifies Medi-Cal enrollment freeze proposal, applying to UIS 19 years and older, beginning 1/1/2026 and establishes a 6-month re-enrollment grace period for those that fall off the rolls. Clarifies that an individual cannot 'age out' of the program.
  - Modifies $100 Medi-Cal premiums for UIS population by lowering to $30 per month, limits to those aged 19-59, and postpones to 1/1/2027.
  - Delays elimination of dental benefits for UIS population until 7/1/2027.
  - Restores the Medi-Cal Asset Limit to $130k for an individual and $195K for a couple.
  - Approves Governor's proposal on weight loss drugs.
  - Delays implementation of PA for hospice services in Medi-Cal to 7/1/2026.

Legislature's Budget Version

- Assembly and Senate Budget Plan continued:
  - Delays Prop 56 supplemental payments for dental until 7/1/2027 and rejects Prop 56 supplemental payments for family panning and women's health.
  - Delays the proposed $1.1B cuts to Health Centers and Rural clinics until 7/1/2027.
  - Adjusts rebate aggregator for prescription drugs for UIS population.
  - Approves Governor's MCO tax proposal.
  - Rejects proposal to eliminate LTC and IHSS for UIS adults.
  - Rejects proposal to eliminate acupuncture benefit.
  - Approves Governor's proposal to eliminates the Workforce and Quality Incentive Program for SNFs.
  - Proposes the development of a large employer contribution requirement for employers with employees enrolled in Medi-Cal.

What happens next?

- Assembly and Senate leaders vote on and pass a Budget Act by June 15th
- The Governor and the legislature negotiate to reach a three-party deal on the Budget Package.
- The Governor signs the Budget Package and any accompanying budget bill jrs. and trailer bills.
- If the federal reconciliation bill passes, legislators will have to come back for a special budget session in the fall.

Follow -up Items

Mao Moua

ALAMEDA Alliance FOR HEALTH

FOLLOW-UP ITEMS FROM 03/20/2025

Follow-up Item	Outcome(s)	Status
Share additional Housing and Community Supports resources	• Information was sent CAC members via email on 03/20/2025.	Completed

HEALTH EQUITY ROADMAP: Community Engagement

Presented by:
Yen Ang, Director of Health Equity
DrPH, MS, MPH, RD, FAND
Community Advisory Committee meeting June 12, 2025

ALAMEDA Alliance FOR HEALTH

Vision:

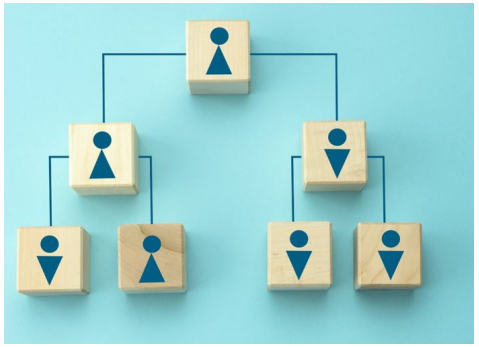
A world where every Alliance member, regardless of race, ethnicity, religion, gender-sexual identity, or social economic status, has equitable access to care

Mission:

To dismantle institutional racism and systemic inequities in healthcare practices, strengthen intersectoral collaboration and community engagement to achieve and sustain health equity for all members.

Health Equity Roadmap: Six Milestones

1. Organization



4. Communication

2. Data Driven

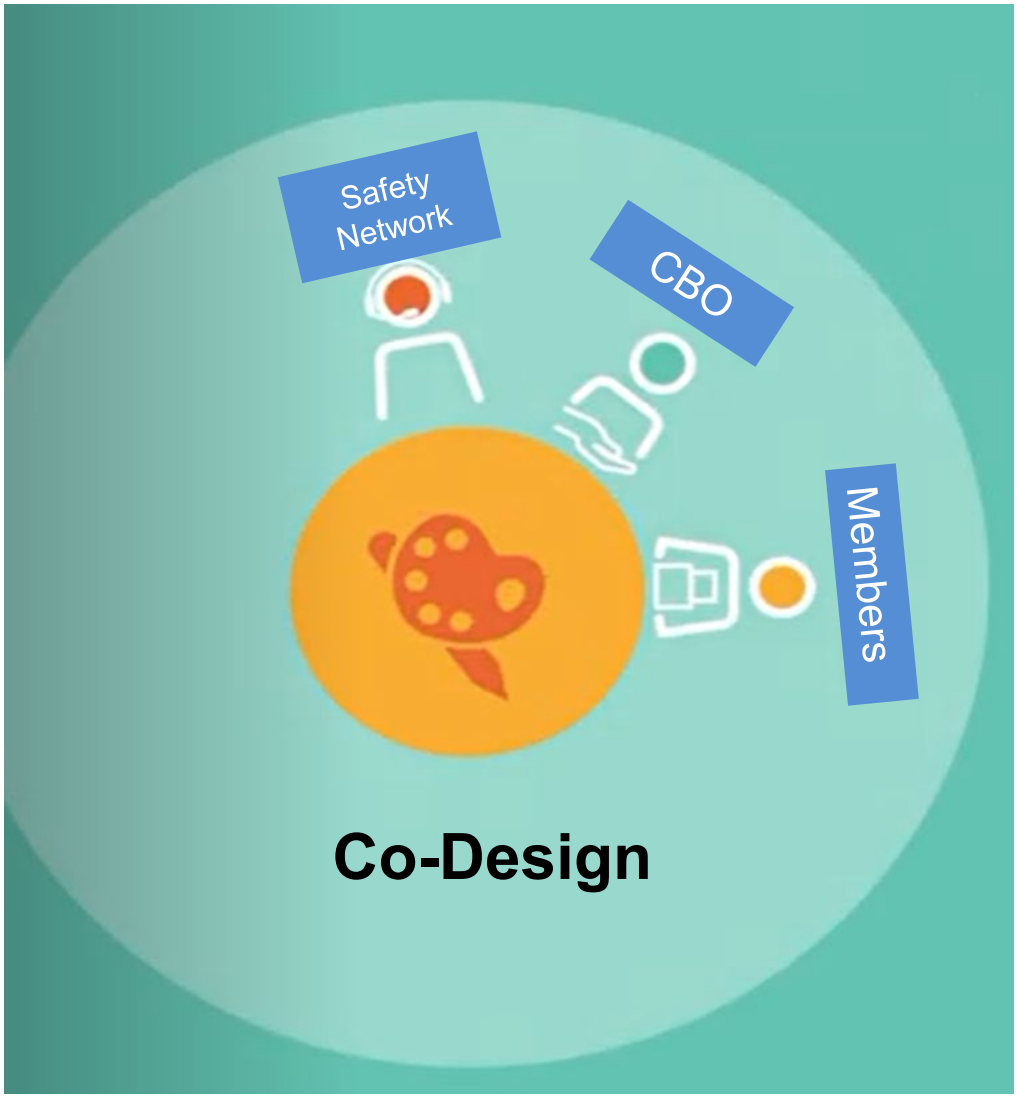
5. Community Engagement

3. Education

6. Social Determinant of Health (SDOH) Mitigation Measures

Health Equity Engagement Strategy:

Co-Design



- Community members:
  ✓ Equal partner, Co-designer
- Users are experts in their own experience.
- Participatory approach
- Active collaboration
- Gain trust from our members; particularly those historically marginalized communities, so they will trust the healthcare system that serve them.
- Engage, Validate, Adjust.
- Three CO-DESIGN-Partners:

  1. CBOs
  2. Safety Network
  3. Members

Milestone # 5: Community Engagement

Co-DESGN model

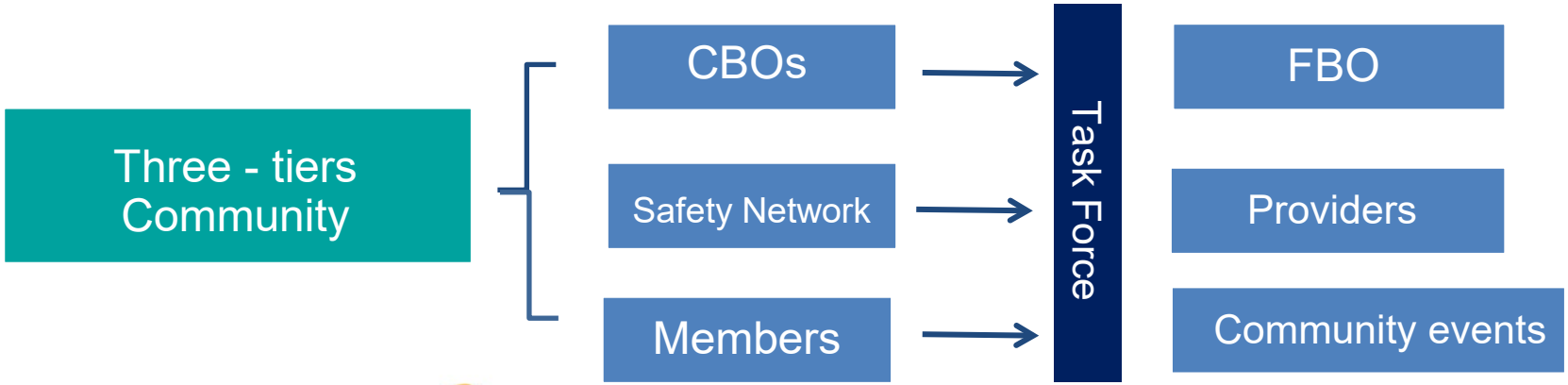
Co-Create Solutions

Three - tiers Community

- **CBOs**
  - Community-Based Organizations (CBO):
  - Trusted bodies in the community who serve directly or indirectly our members
- **Safety Network**
  - Medi-Cal, under-insured, or non-insured populations.
- **Members**
  - Members voices via community events, focus groups, town halls or surveys

Removing SDOHs → intersectoral collaboration → a network of resources.
Co-DESIGN approach → collective solutions
→ complex needs of our disenfranchised communities.

Milestone #5 Community Engagement



Why FBO?

- Trusted body and support system
- Safe space
- Sensitive topic or taboo

Stakeholders include:
HCS, PHM, QI, C&L, CS, ECM, PR, C&O, Housing

Priority Engagement with Faith-Based Organization: Three Critical Rules

❶

High Risk:
Preventive services?
High medical cost?

❷

What's my relationship with the FBO?

❸

Funding or Resources?


Health Equity : our shared destiny

Member Satisfaction Survey

Loc Tran
Manager, Access to Care

ALAMEDA Alliance FOR HEALTH

Q1 2024 – Q4 2024 CG-CAHPS

CAC 06/12/2025

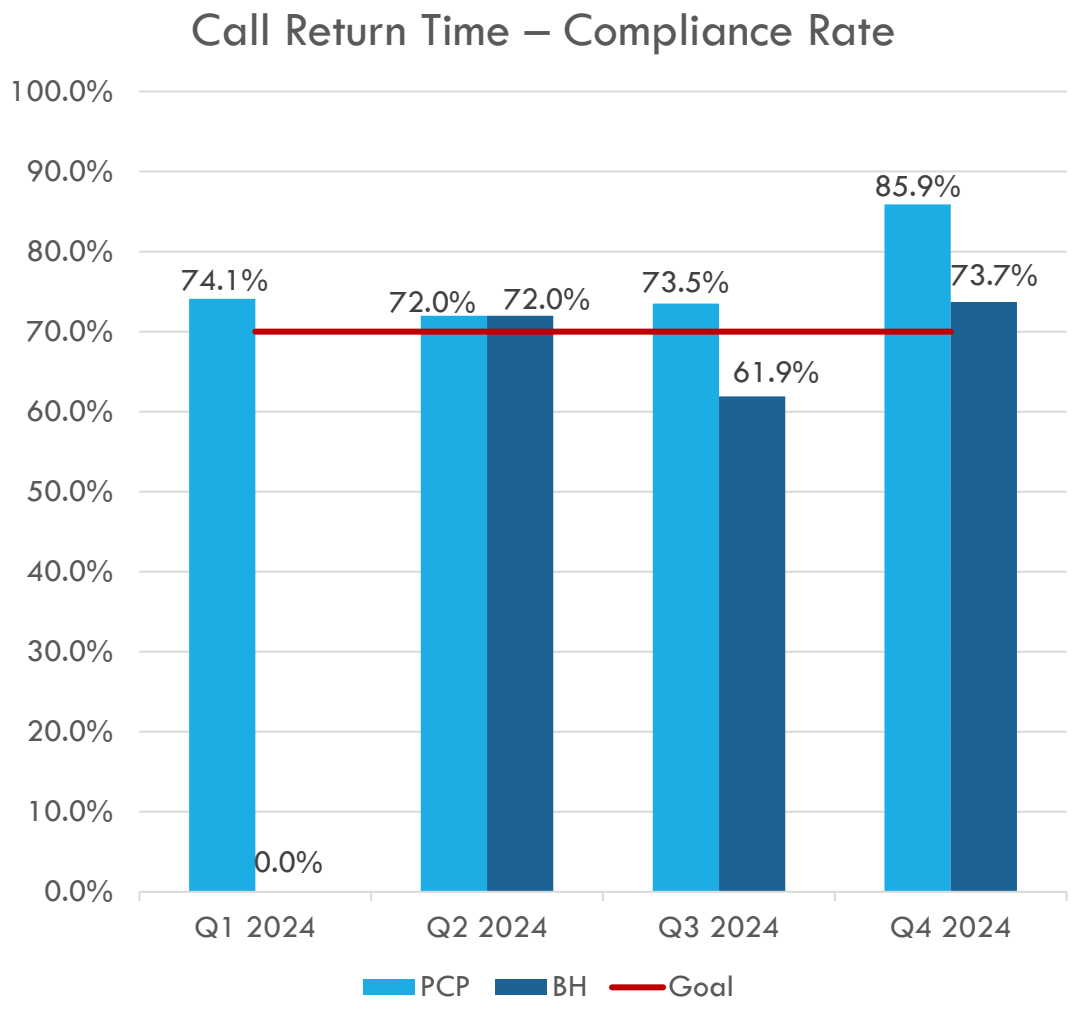
ALAMEDA Alliance FOR HEALTH

Overview of TIMELY ACCESS Standards

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

- Survey measures member's experience with their health care providers in the past 6 months in the 3 following metrics: In-Office Wait Time, Call Return Time, and Time to Answer Call

Call Return Time MY2024



Question: When you called this provider's office during regular office hours, when did you get a call back?

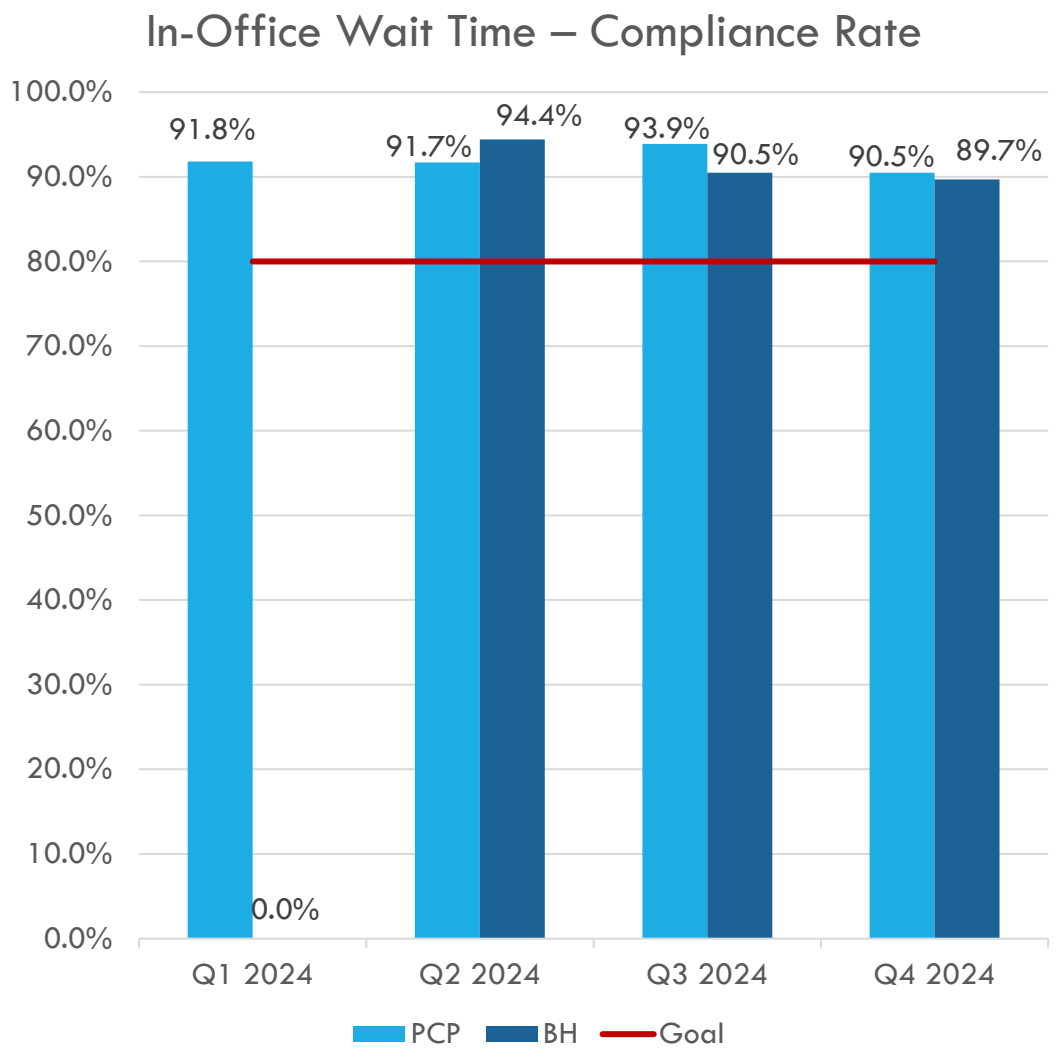
Compliant Response: Within 1 Business Day

Top 3 **Ethnicity** for the follow categories	
Within 1 Business Day	**Over 1 Business Day**
Hispanic	Hispanic
Other	Other
Chinese	Black

Top 3 **Language** for the follow categories	
Within 1 Business Day	**Over 1 Business Day**
English	English
Spanish	Spanish
Chinese	Chinese

Total Members Response in 2024: PCP: 8,690 BH: 764

In-Office Wait Time MY2024



Question: About how many minutes did you typically wait in the waiting room and exam room until you/your child saw the provider?

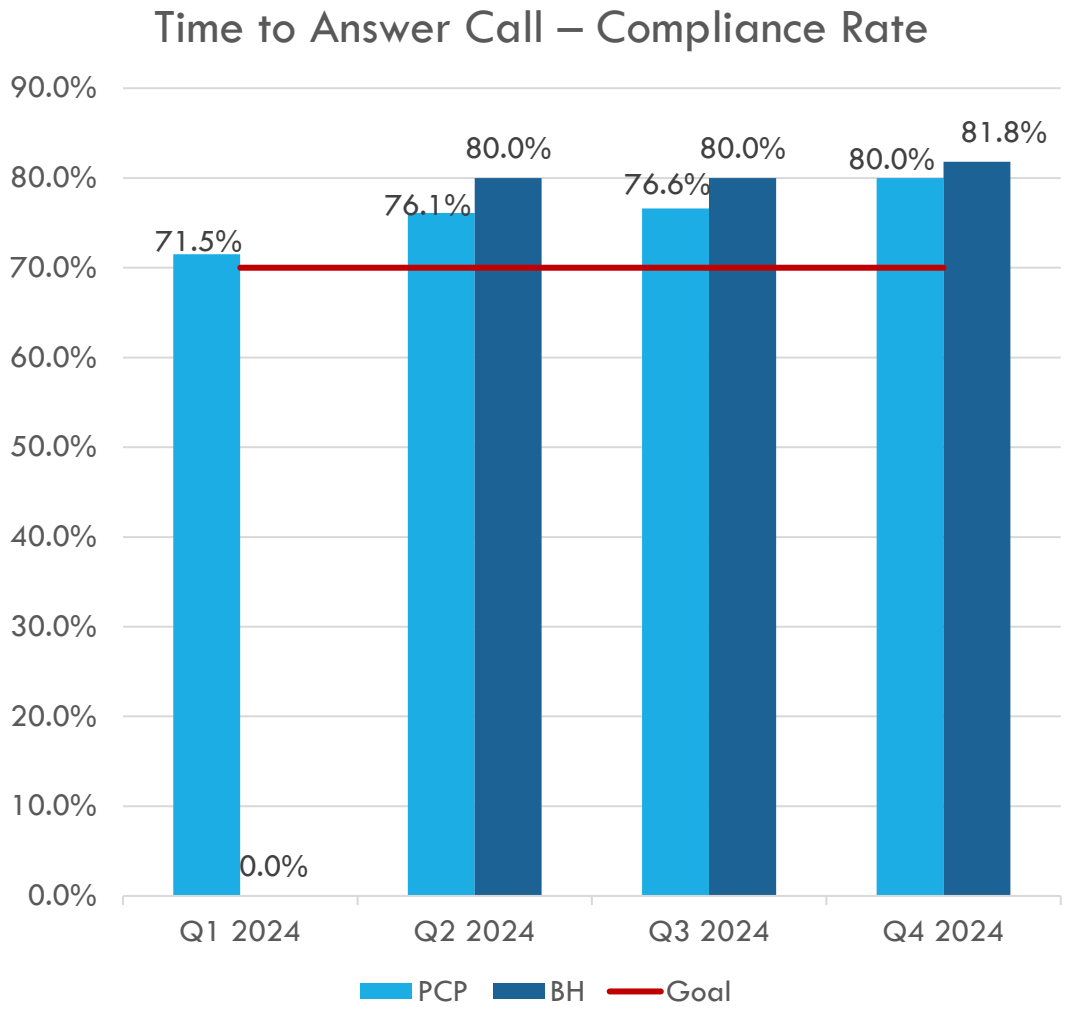
Compliant Response: Less than 60 minutes

Top 3 **Ethnicity** for the follow categories	
Less than 60 minutes	**Over 60 minutes**
Hispanic	Hispanic
Other	Other
Chinese	Black

Top 3 **Language** for the follow categories	
Less than 60 minutes	**Over 60 minutes**
English	English
Spanish	Spanish
Vietnamese	Chinese

Total Members Response in 2024: PCP: 10,660 BH: 1,100

Time to Answer Call MY2024



Question: When calling the provider's office during regular office hours, how long did you wait to speak to a staff member?

Compliant Response: within 0 – 10 minutes

Top 3 **Ethnicity** for the follow categories	
Within 0-10 Minutes	**Over 10 Minutes**
Hispanic	Hispanic
Other	Other
Black	Chinese

Top 3 **Language** for the follow categories	
Within 0-10 Minutes	**Over 10 Minutes**
English	Spanish
Spanish	English
Vietnamese	Chinese

Total Members Response in 2024: PCP: 8,411 BH: 777

CG-CAHPS SUMMARY

- Overall, we continue to meet the compliance rate for all three measures.
- Improvement on ratings for Time to Answer Call.

Next Steps:

- Share results with Delegate and Direct entities.
- Track and Trend compliant rates.
- Send out Non-Compliant CAPs to provider who are not meeting compliance rate.
- Ongoing provider education and onsite/virtual office visits to providers with trends.

Q&A

Population Health Management 2025 Strategy

Presented to the Alliance CAC
June 12, 2025

ALAMEDA Alliance FOR HEALTH

What is Population Health Management?

- Understand Alliance member needs
  - → Assessment and data
  - → Medical, behavioral and social health
  - → Identify groups of members at risk
- Provide equitable access to needed services
  - → Wellness and prevention services
  - → Care coordination
  - → Care management programs
- Collaborate with
  - → Providers
  - → Community partners
- Improve health and equity

2025 PHM Strategy Programs

Strategic Pillars	2025 Programs
Address primary care gaps and inequities	• Cancer Prevention • Under 30 Months Well-Visits – Equity
Support members managing health conditions	• BirthWise Wellbeing – Equity • Blood Pressure Monitoring • Diabetes Prevention Program (DPP) • Disease Management Health Education
Connect members in need to whole person care	• Doula Services • Multiple Chronic Case Management • Post ED Visit for Mental Illness • Transitional Care Services (TCS)

2025 PHM Strategy Highlighted Activities

ALAMEDA Alliance FOR HEALTH

Community Health Worker Programs

- *Disease Management Health Education* – The Good Life nutrition and wellness program for members with diabetes and high blood pressure.
- *BirthWise Wellbeing* – Our Roots peer mental health coaching for members who are or were pregnant in the last year.

Questions for CAC Members:

- Have you heard of or worked with a Community Health Worker (CHW) before?
- What would encourage you to join a CHW program?
- What other topics or populations should the Alliance consider for future CHW programs?

At-home blood pressure tracking and cancer screening

- *Blood Pressure Monitoring* – Assist Alameda Health System members with getting a blood pressure monitor through the Alliance.
- *Cancer Prevention* – At-home HPV swab test for cervical cancer and Cologuard stool test for colorectal cancer.

Questions for CAC Members:

- What would help members track their blood pressure or complete a cancer screening at home?
- How can providers support members with blood pressure control?
- Who can we partner with to increase cancer screening for groups with lower rates (Am. Indian/Alaska Native, Black, Other Asian*, White)?

*Note: "Other Asian" category excludes Chinese, Vietnamese, and Filipino

Questions?

Contact Linda Ayala, Director of Population Health and Equity, at layala@alamedaalliance.org

ALAMEDA Alliance FOR HEALTH

Annual Review: Cultural and Linguistic Services (CLS)

ALAMEDA Alliance FOR HEALTH

CULTURAL AND LINGUISTIC SERVICES (CLS) PROGRAM: GOAL

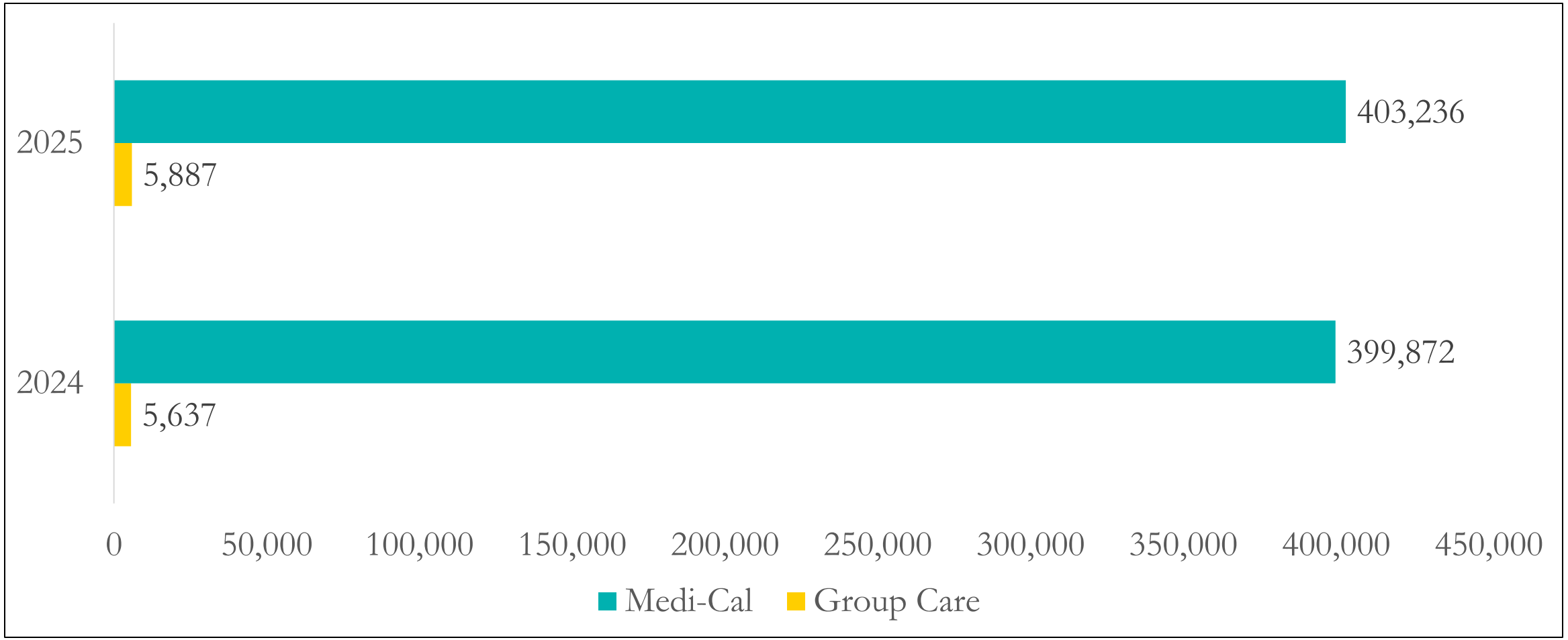
Ensure that all Alliance members receive equitable health care services, including behavioral health services, that are culturally and linguistically appropriate.

CLS PROGRAM: OBJECTIVES

- Follow state and federal guidelines to provide culturally and linguistically appropriate services.
- Offer language assistance at no cost for all covered benefits.
- Ensure that all staff, providers, and partners are compliant complete cultural competency training.
- Support limited English proficient (LEP) members in accessing quality interpreter services.
- Ensure Alliance health care providers follow the CLS Program.
- Use community input and population assessments to shape accessibility standards.
- Keep improving efforts to better meet members' cultural and linguistic needs and reduce health gaps.

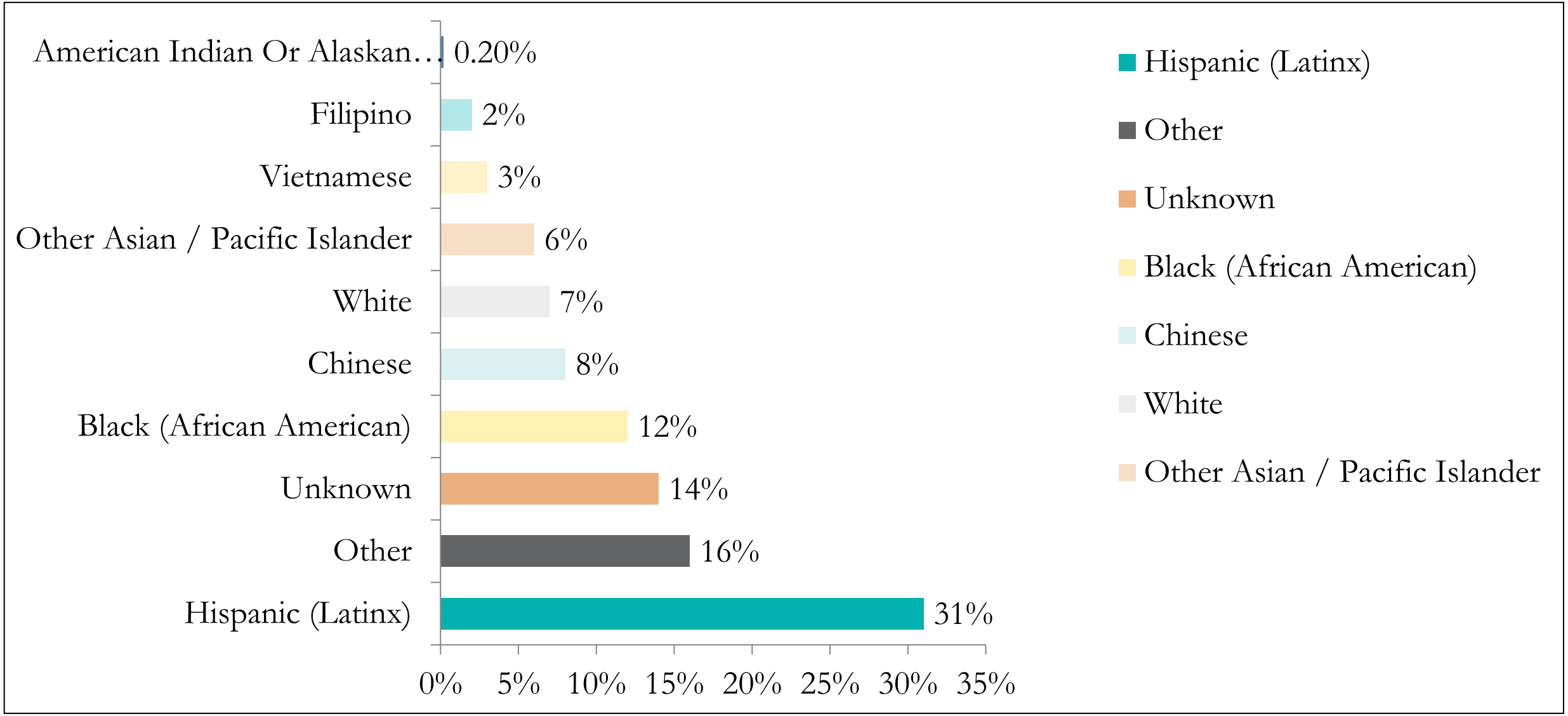
Alameda Alliance for Health Membership

TOTAL MEMBERSHIP IN 2024 AND 2025



Data as of May 2024 and May 2025

MEMBERSHIP BY ETHNICITY



Data as of May 2025

ALAMEDA COUNTY & AAH COMPARISON

Alameda County and AAH Comparison		
Race/Ethnicity	Alameda County	2025 AAH
White alone	47%	7%
Asian alone [c]	35%	14%
Hispanic or Latino [a]	22%	31%
Black or African American alone	11%	12%
American Indian and Alaska Native alone	1%	.2%
Native Hawaiian and Other Pacific Islander alone [b]	1%	2%

(a) Hispanics may be of any race, so also are included in applicable race categories

(b) Includes persons reporting only one race

(c) Includes Chinese, Vietnamese, Filipino

Source: Census Alameda County estimates, 7/1/2024, U.S. Census Bureau QuickFacts: Alameda County, California; viewed 05/30/2025.

THRESHOLD LANGUAGES

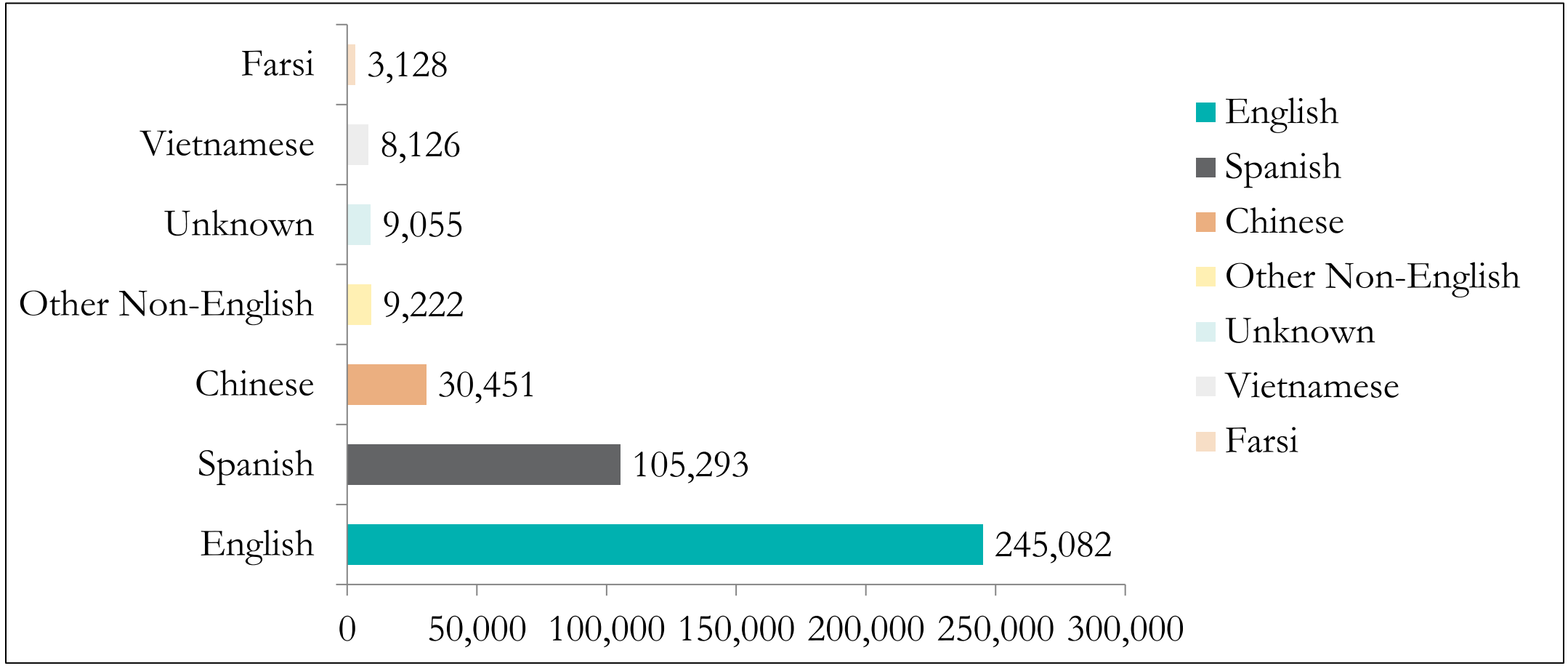
Medi-Cal and Group Care

- English
- Spanish
- Chinese
- Vietnamese
- Farsi*

**New Alliance threshold language as of February 2025*

- What is a threshold language?
  - A language spoken by 5% or over 3,000 of the Medi-Cal members in Alameda County.
  - Alliance must translate key documents and letters into these languages.

MEMBERSHIP BY THRESHOLD LANGUAGE

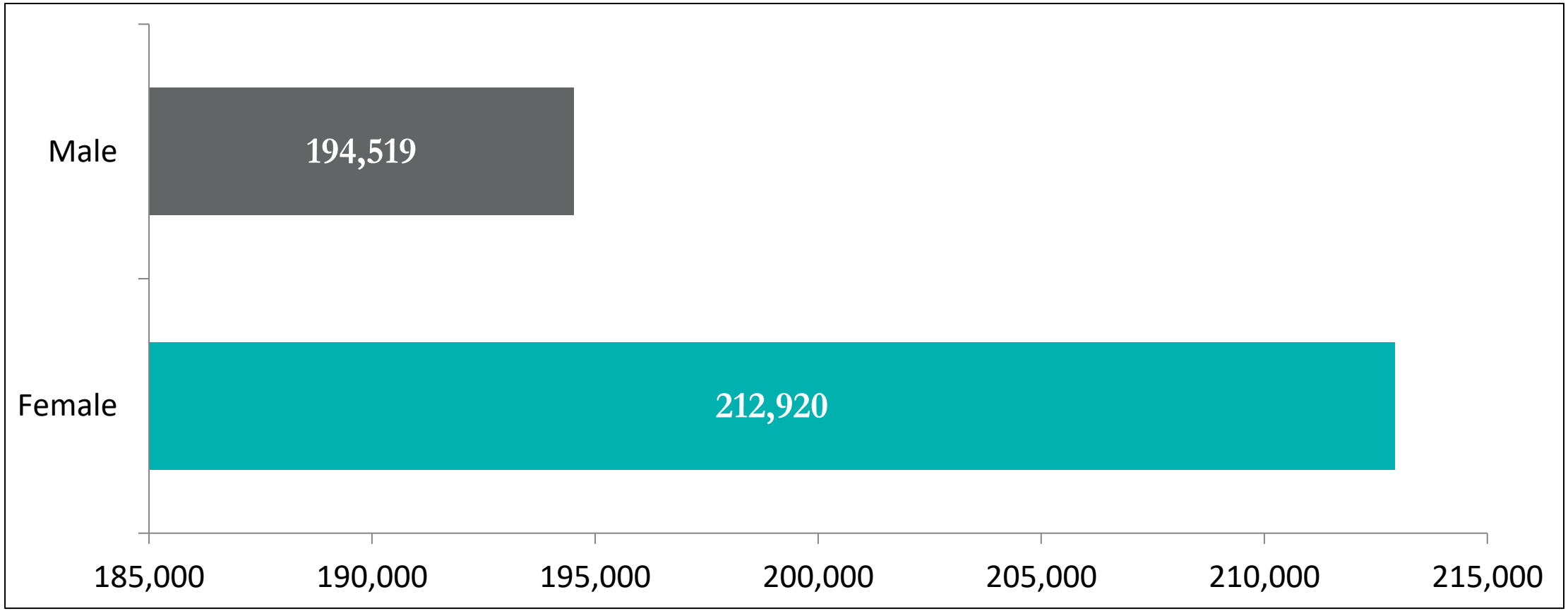


Data as of May 2025

LANGUAGES WITH 500+ MEMBERS

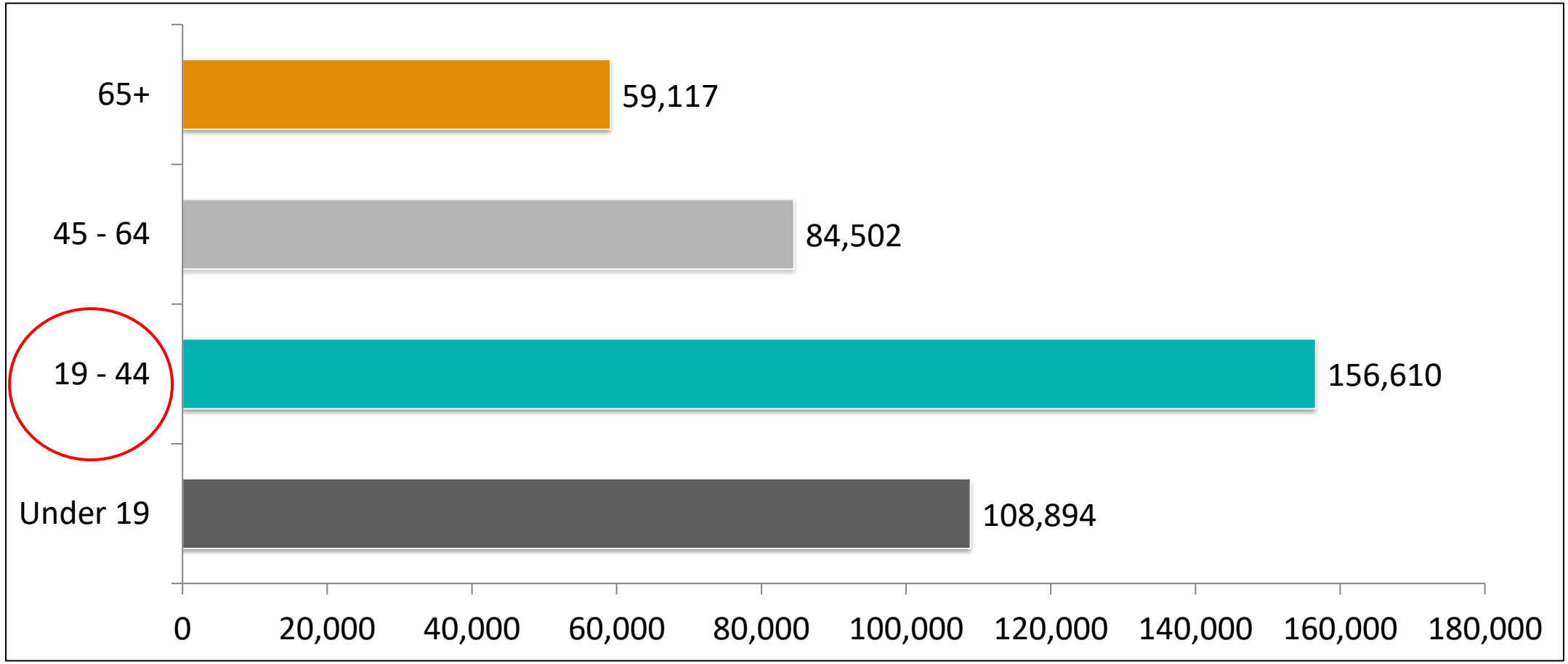
Language	May 2025
ENGLISH	60%
SPANISH	26%
CANTONESE	5%
VIETNAMESE	2%
UNKNOWN	2%
MANDARIN CHINESE	2%
FARSI	0.7%
ARABIC	0.6%
TAGALOG	0.%
KOREAN	0.2%
RUSSIAN	0.2%
CENTRAL KHMER	0.2%

MEMBERSHIP BY GENDER



Data as of May 2025

MEMBERSHIP BY AGE



Data as of May 2025

Language Assistance Services

Utilization of Interpreter Services

ALAMEDA Alliance FOR HEALTH

INTERPRETER SERVICES PROVIDED IN 2024

ALAMEDA Alliance FOR HEALTH

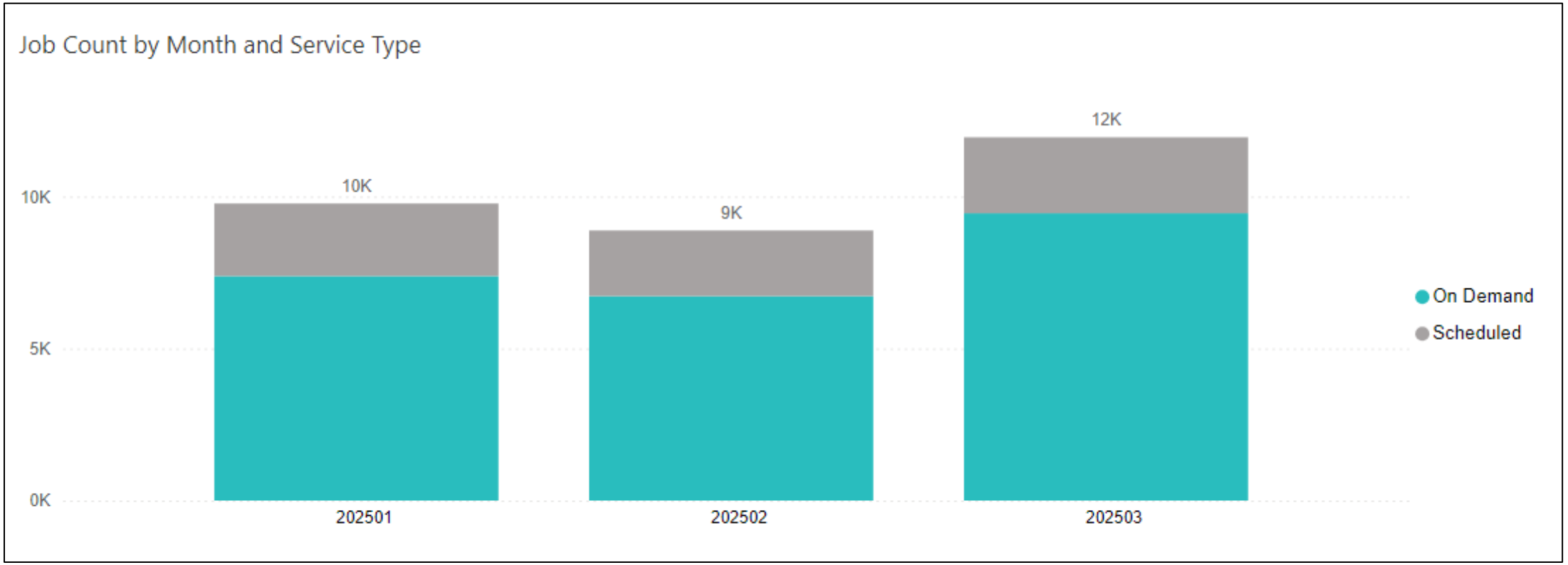
- Provided over **97,000** services in **135** languages.
- Top 10 Languages Requested:

2024 Top 10 Languages		
In-Person	**Telephonic**	**Video**
Spanish	Spanish	Spanish
Cantonese	Cantonese	Cantonese
Vietnamese	Vietnamese	Vietnamese
Mandarin	Mandarin	American Sign Language
Mam	Mam	Arabic
Arabic	Arabic	Mandarin
American Sign Language	Dari	Hindi
Russian	Khmer	Russian
Dari	Farsi	Farsi
Farsi	Mien	Mam

- Compared to 2023:
  - **70% increase** across all types of interpreter services used.
  - Telephonic: Highest increase in Spanish, Mandarin, and Mam languages
  - In-person: Highest increase in Spanish, Mandarin, Cantonese languages
  - Video: Highest increase in Spanish

INTERPRETER SERVICES UTILIZATION 2025 Q1

- The Alliance met our goal with a **fulfillment rate** of **99%** in Q1.

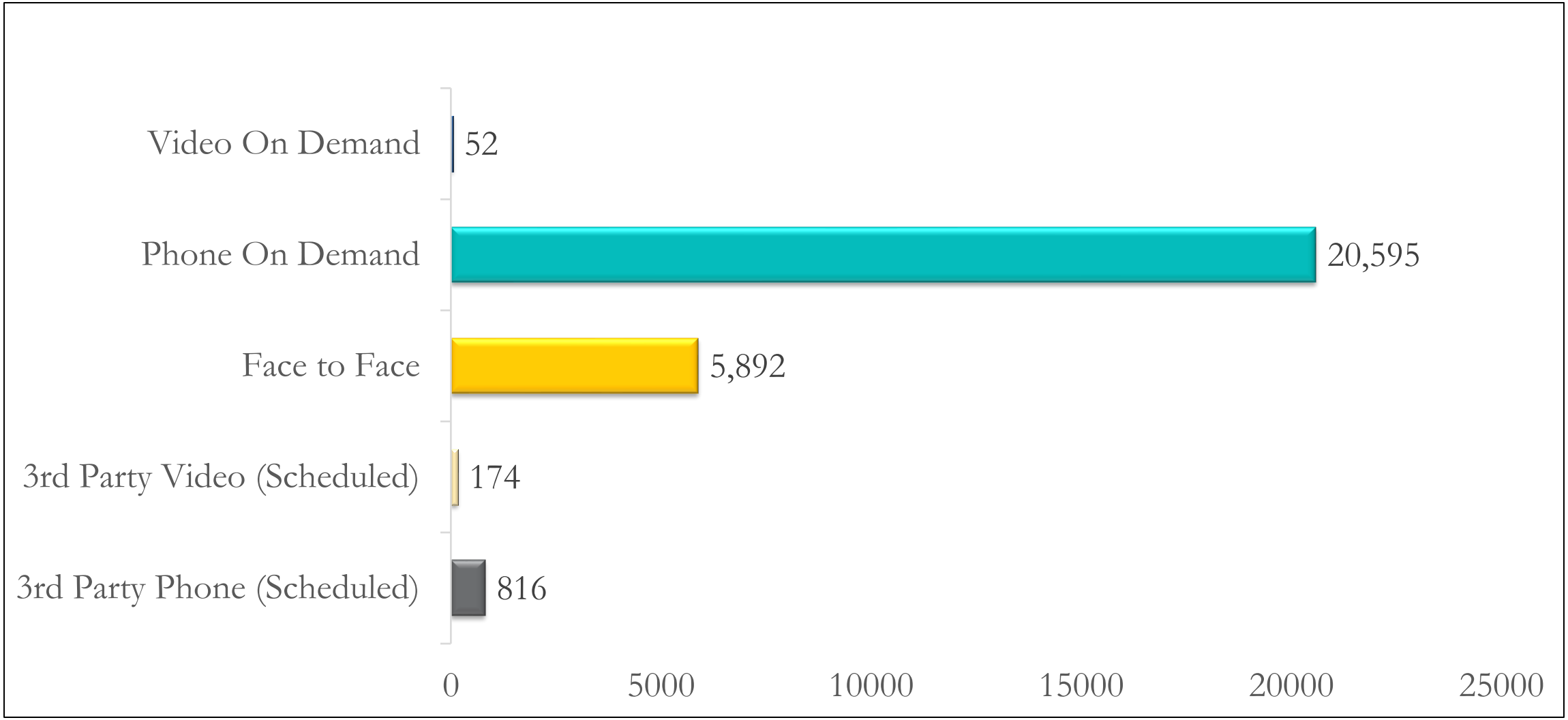


K= thousand

- Top 5 Languages Requested: Spanish followed by Cantonese, Vietnamese, Mandarin, and Mam.

INTERPRETER SERVICES UTILIZATION 2025 Q1

- Most interpreter services used were on-demand (75%), followed by scheduled interpreter services (25%).



2024 Availability of Practitioners to Meet the Cultural Needs and Preferences of Members (Net 1A Report)

ALAMEDA Alliance FOR HEALTH

MEMBER-PROVIDER RACE/ETHNICITY

- Provider by Race/Ethnicity Comparison-Medi-Cal and Group Care Members
  - Based on 55% self-reporting
  - Underrepresentation:
    - → Latinx PCPs, Specialists and Behavioral Health
    - → Black Specialists
    - → Pacific Islander PCPs, Specialists and Behavioral Health.

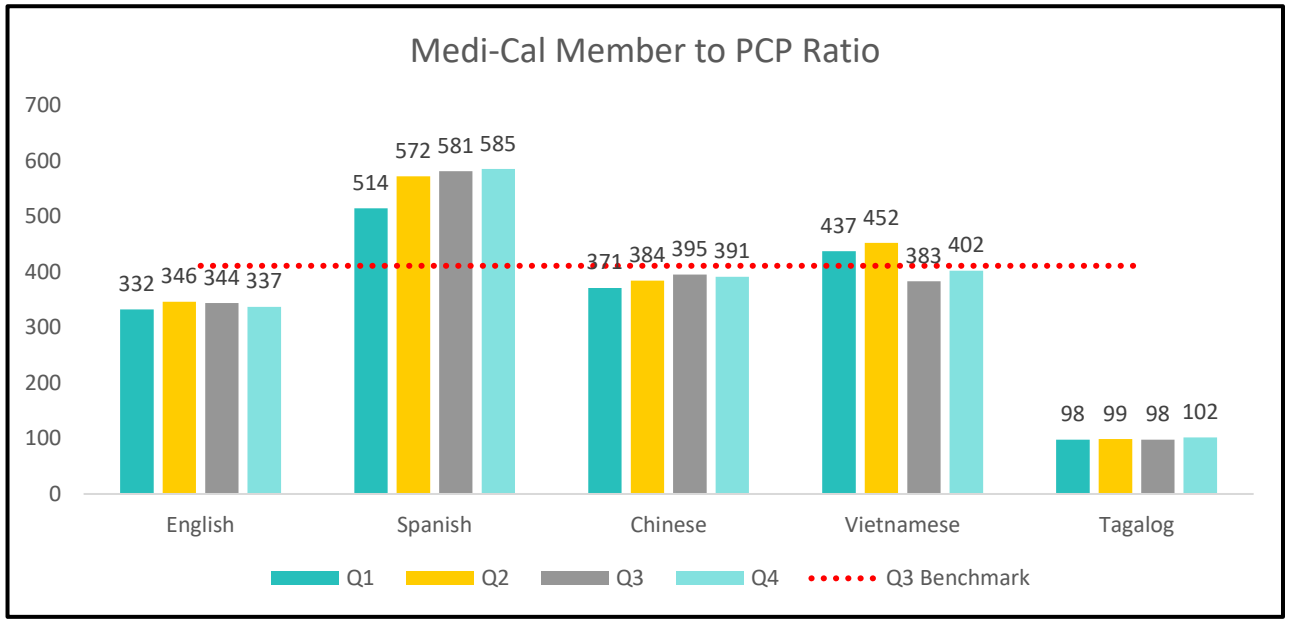
Race/Ethnicity	% Members	% PCP	% Specialists	% Behavioral Health
Hispanic (Latinx)	33%	6%	3%	20%
Asian *	13%	43%	46%	19%
Black (African American)	12%	13%	4%	11%
White	7%	34%	41%	48%
Asian Indian	<1%	2%	3%	<1%
Pacific Islander **	7%	1%	1%	<1%
American Indian or Alaskan Native	<1%	1%	<1%	1%
Other ***	17%	1%	1%	<1%
Unknown	10%	<1%	<1%	<1%
Total	**100%**	**100%**	**100%**	**100%**

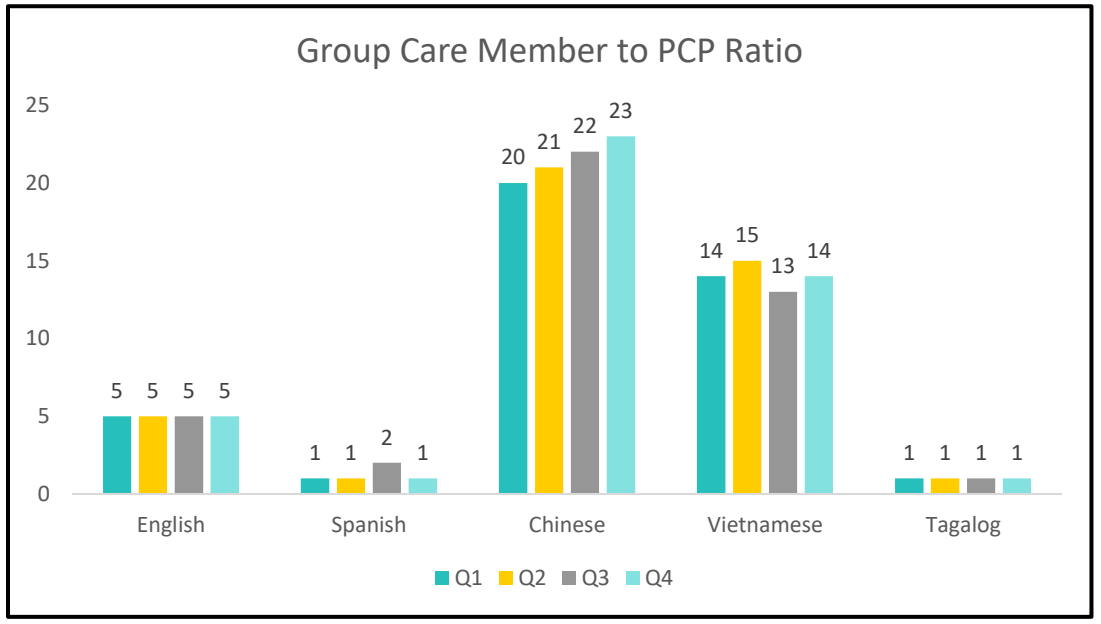
** Includes Chinese, Vietnamese, Korean, Cambodian, Japanese, Filipino and Laotian*
*** Includes Hawaiian*
**** Includes Samoan, Guamanian, Amerasian, and Other self-reported ethnicities*

Source: Provider Race/Ethnicity and Language Report, 2024 and Alliance Monthly Health Education Report, December 2024

PROVIDER LANGUAGE CAPACITY – PCP

- Third Quartile (Q3) Benchmark
  - 75% of data falls below this point value
  - X Members to one Provider ratios above the Q3 benchmark = top 25% (potential language access gaps)
- Member to PCP by Threshold Language
  - Medi-Cal - Spanish > Q3 benchmark in all quarters.
  - Group Care – Lower numbers indicate greater access, no concerns noted.

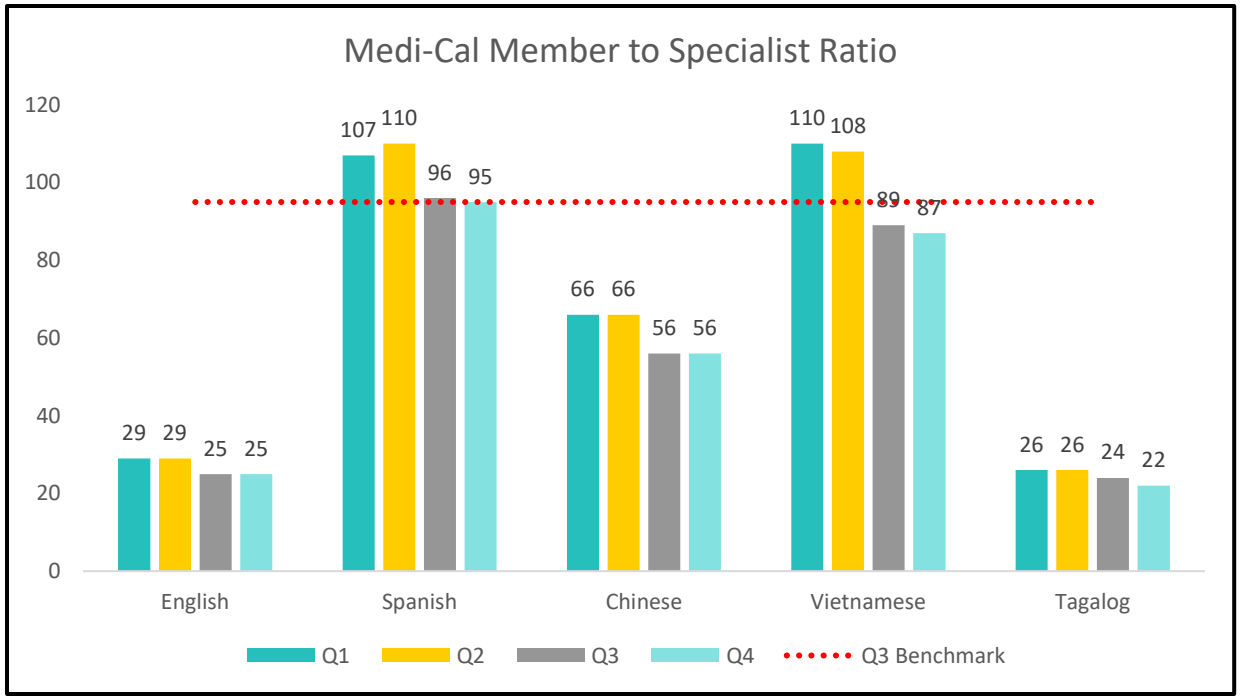


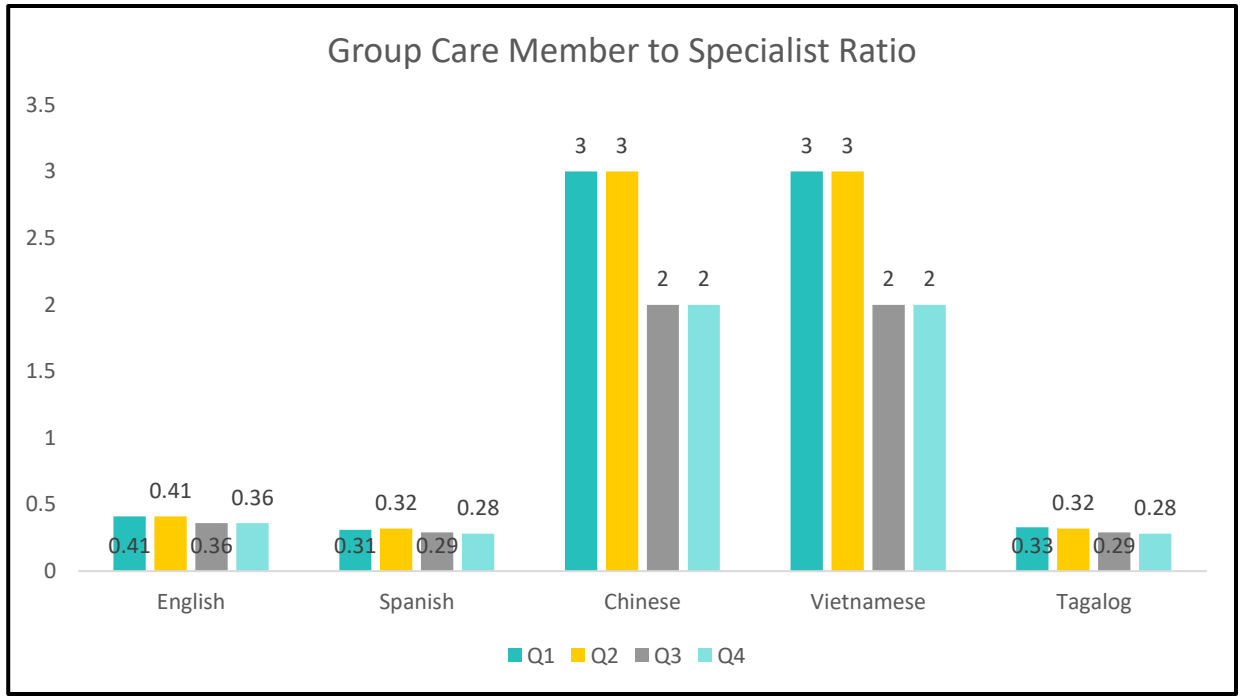


Source: Alliance Provider Language Access Report, 2024

PROVIDER LANGUAGE CAPACITY - SPECIALIST

- Member to Specialists by Threshold Language
  - Medi-Cal - Spanish and Vietnamese > Q3 benchmark in Quarters 1 and 2
    - → Improved by Quarter 3 and 4
  - Group Care – Lower numbers indicate greater access, no concerns notes.

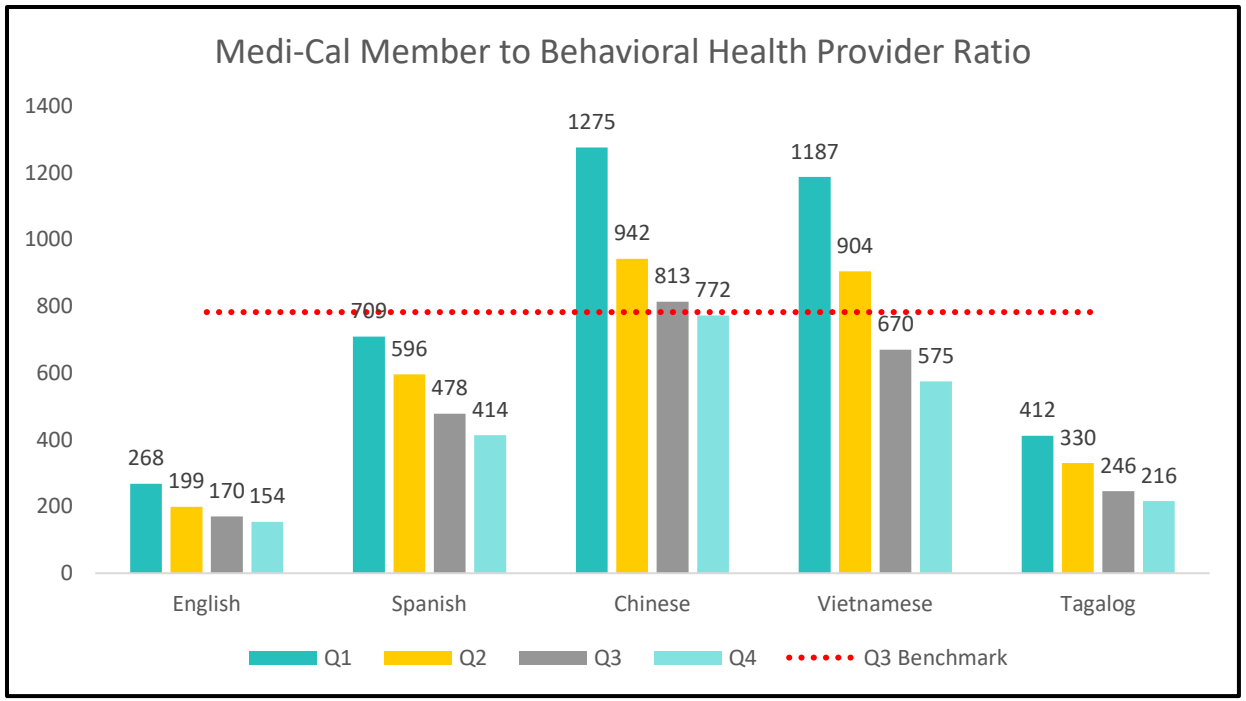


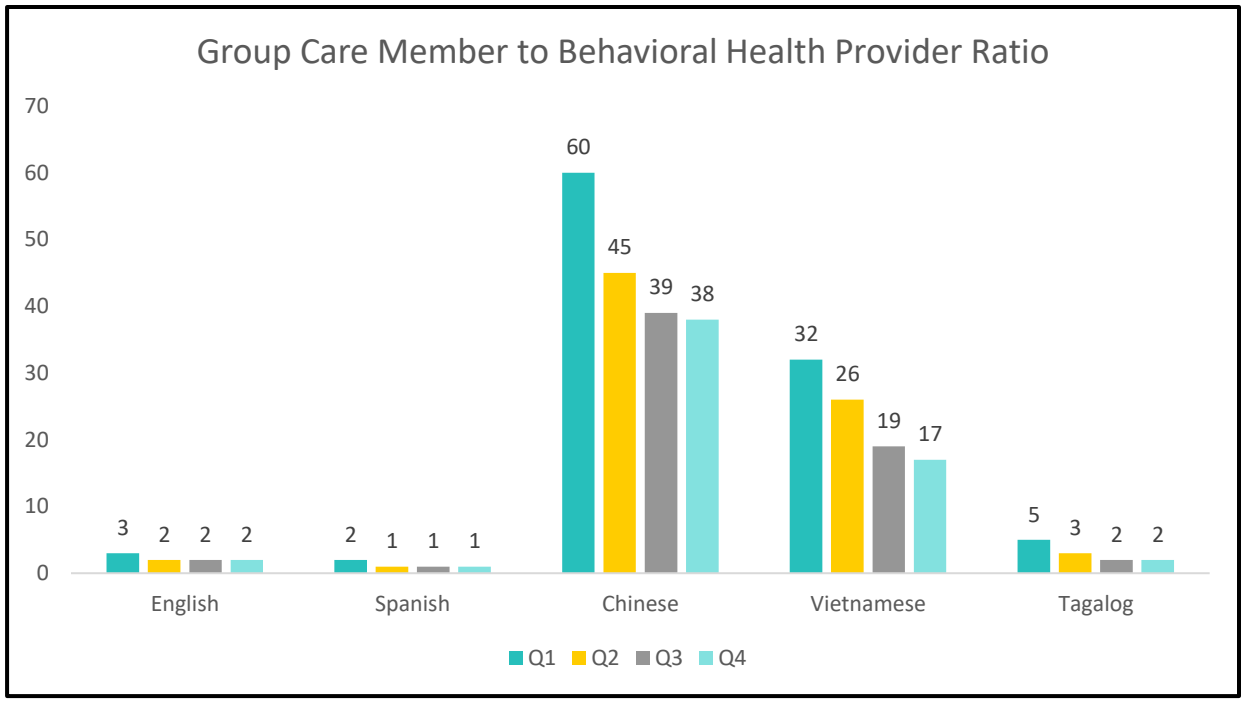


Source: Alliance Provider Language Access Report, 2024

PROVIDER LANGUAGE CAPACITY – BH

- Member to Behavioral Health (BH) Providers by Threshold Language
  - Medi-Cal - Chinese and Vietnamese > Q3 benchmark for Quarter 1 and 2
    - → All languages improved in Quarter 3 and 4
  - Group Care – Lower numbers indicate greater access, no concerns noted.





Source: Alliance Provider Language Access Report, 2024

CLS Work Plan
2024 Evaluation

2024 CLS WORKPLAN EVALUATION

Activity/ Initiative	Goal Met
Member Cultural and Linguistic Assessment	Yes
Language Assistance Services (Fulfillment rate of 95%)	Yes
Language Assistance Servies (Tracking of behavioral health services)	In-progress
Language Assistance Services (Member Satisfaction)	Yes
Provider Language Capacity (Member Satisfaction)	Q1: Unmet for Child; Q2-Q3: Met; Q4: Planned implementation for Q1 2025
Provider Language Capacity and Race and/or Ethnicity (Provider Network-Net 1A Report)	Yes
Community Engagement: Community Advisory Committee (CAC)	Ongoing
Potential Quality Issues-Quality of Language (PQI-QOL)	Q1: Met; Q2: Unmet; Q3: Met; Q4: Unmet

2024 CLS WORKPLAN EVALUATION

Activity/ Initiative	Goal	Outcome(s)	Goal Met
Member Cultural and Linguistic Assessment	Assess the cultural and linguistic needs of plan enrollees.	• Completed assessments at CLS meetings on 01/24/2024, 04/24/2024, 08/28/2024, 12/03/2024. • Increase in overall membership. • Significant increase in Spanish-speaking and Latinx members.	Yes
Language Assistance Services	Reach or exceed an average fulfillment rate of ninety-five percent (95%) or more for in-person, video, and telephonic interpreter services.	• Q1 2024: 97% • Q2 2024: 98% • Q3 2024: 98% • Q4 2024: 98%	Yes
Language Assistance Services	Ensure tracking of interpreter services utilization for behavioral health services.	• Vendor can't identify behavioral health (BH) calls without caller's initial prompt. • Continue to work with the vendor to resolve flagging BH calls anytime during a call.	In-progress

2024 CLS WORKPLAN EVALUATION

Activity/ Initiative	Goal	Outcome(s)	Goal Met
Language Assistance Services (Member Satisfaction)	Based on the Timely Access Requirement (TAR) Survey results, develop and implement action steps, as needed, to address member's satisfaction with a)scheduling appointments with an interpreter; b)availability of interpreters who speak member's preferred spoken language; c)knowledge, skill, and quality of interpreters.	• 2024 results reviewed by SMEs at CLSS and QIHEC meetings—no concerns identified. • No additional actions needed based on 2024 results. The Alliance will continue sharing quality concerns with interpreter services vendors at Joint Operations Meetings.	Yes

2024 CLS WORKPLAN EVALUATION

Activity/ Initiative	Goal	Outcome(s)	Goal Met
Provider Language Capacity (Member Satisfaction)	Based on the Member CG-CAHPS Survey 81% of adult members and 92% of child members who need interpreter services will report receiving a non-family qualified interpreter through their doctor's office or health plan.	• Q1 2024-Adult: 84%; Child: 91.4% • Q2 2024-Adult: 86.6%; Child: 94% • Q3 2024-Adult: 90%; Child: 93%. • Q4 2024-Data not available. • For Adult and Child surveys, satisfaction results improved in both Q2 and Q3. We will continue to monitor satisfaction results.	• Q1: Unmet for Child • Q2: Met • Q3: Met • Q4: Planned implementation for Q1 2025
Provider Language Capacity and Race and/or Ethnicity (Provider Network)	Complete NCQA NET 1A Analysis of Capacity of Alliance Provider Network to meet Cultural and Linguistic needs of members.	• Received and reviewed consultant feedback. • Net 1A Report met all standards. • Presented updates at the Quality Improvement & Health Equity Committee (QIHEC) on 11/15/2024 and Cultural and Linguistic Services Subcommittee on 12/03/2024. • Met with Compliance to review the discrimination case report for inclusion of substantial vs. non-substantial cases.	Yes

2024 CLS WORKPLAN EVALUATION

Activity/ Initiative	Goal	Outcome(s)	Goal Met
Community Engagement: Community Advisory Committee (CAC)	Ensure implementation of DHCS 2024 Contract updates to CAC and community engagement.	• Connected and presented information about the CAC as part of membership recruitment efforts: a. Father-Friendly Provider Network Members (FFPN): 11/15/2024. b. Healthy Relationships Learning Community (HRLC): 11/21/2024. c. Health and Human Resource Education Center (HHREC). d. Alameda County Public Health Fatherhood Initiative. • Held a CAC Selection Committee meeting on 12/17/2024. • Next steps: Ongoing CAC recruitment with guidance from the CAC Selection Committee.	Ongoing

2024 CLS WORKPLAN EVALUATION

Activity/ Initiative	Goal	Outcome(s)	Goal Met
Potential Quality Issues-Quality of Language (PQI-QOL)	Monitor, evaluate, and conduct appropriate interventions for PQI-QOLs with a closure rate of 95% or more within 60 business days.	• Q1 2024: 96% closure rate. • Q2 2024: 86% closure rate. • Q3 2024: 95% closure rate. • Q4 2024: 93% closure rate. • Challenges: -Increased volume of scheduling. -Difficulty reaching provider offices due to no answer. • Action Steps: -Hiring additional staff. -Workflow enhancements to address when unable to reach provider office.	• Q1: Met • Q2: Unmet • Q3: Met • Q4: Unmet

OVERVIEW: CLS SUCCESSES AND CHALLENGES

- What We Did Well:
  - Met or exceeded our interpreter service fulfillment goals.
  - Received favorable responses related to accessing interpreter services through member satisfaction surveys.
  - Met all standards for Net 1A report and identified enhancement opportunity to improve reporting regarding discrimination cases.
  - Met contractual requirements for CAC regarding CAC Selection Committee, member recruitment, and the annual CAC Demographic Survey.
- What Was Hard:
  - Interpreter scheduling requests and Potential Quality Issues (PQIs) increased.
  - Some provider offices were hard to reach for follow-up for PQIs.
  - Our vendor had trouble tracking certain behavioral health (BH) interpreter calls.
- What We're Doing Next:
  - Implement a batch scheduling system with the vendor to handle increased scheduling volumes.
  - Hire additional staff.
  - Review and streamline workflows for QOL-PQIs.
  - Continue to explore solutions for BH interpreter services tracking.
  - Include more detail about discrimination cases in our reports.

2025 CLS WORKPLAN PLANNING AND DISCUSSION

ALAMEDA Alliance FOR HEALTH

What We're Focusing on in 2025

- **Data:** Assessing the cultural and linguistic needs of members.
- **Member Feedback:** Making sure members are satisfied with language services for members and provide input into services
  - Member survey
  - Community Advisory Committee
- **Diverse Providers**: Making sure our provider network reflect our membership.
- **Grievances**: Reviewing complaints and follow-up issues (QOL-PQI).

Thank you!

Please contact us if you have ideas to help improve our Cultural and Linguistic Services.

Mao Moua, Cultural and Linguistic Services Manager

mmoua@alamedaalliance.org,

Linda Ayala, Director, Population Health and Equity

layala@alamedaalliance.org

ALAMEDA Alliance FOR HEALTH

Alliance Reports

ALAMEDA Alliance FOR HEALTH

COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2024 - 2025 | **3RD QUARTER (Q3) OUTREACH REPORT**

ALLIANCE IN THE COMMUNITY

FY 2024 - 2025 | 3RD QUARTER (Q3) OUTREACH REPORT

Between January 2025 and March 2025, the Alliance completed **2,430** member orientation outreach calls among net new members and non-utilizers and conducted **312** member orientations (**12.8%** member participation rate). In addition, the Outreach team completed **153** Alliance website inquiries, **14** service requests, **7** community events, **12** member education events and **2** Community Meeting/Presentation events in Q3.

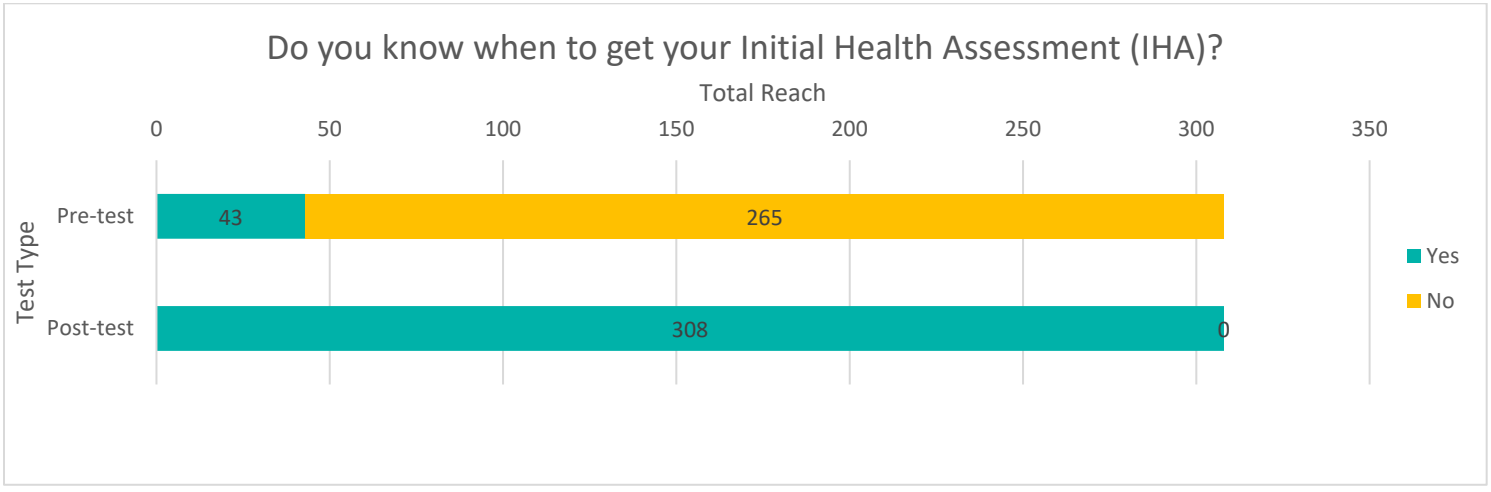
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **38,033** self-identified Alliance members have been reached during outreach activities.

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 **Monday, March 31, 2025**, the Outreach Team completed **47,497** member orientation outreach calls and conducted **9,591** orientations, achieving a **20.2%** 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, 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, 2025 – **9,591** members completed our MO and Non-utilizer program by phone.

After completing a MO **100%** of members who completed the post-test survey in Q3 FY 24-25 reported knowing when to get their IHA, compared to only **16.2%** 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 24-25\Q3\3. March 2025**

ALLIANCE IN THE COMMUNITY

FY 2024 - 2025 | 3RD QUARTER (Q3) OUTREACH REPORT

Q3 FY 2024-2025 TOTALS

7 COMMUNITY EVENTS	1875 TOTAL REACHED AT VIRTUAL COMMUNITY EVENTS
12 MEMBER EDUCATION EVENTS	1194 TOTAL REACHED AT MEMBER EDUCATION EVENTS
312 MEMBER ORIENTATIONS	312 TOTAL REACHED AT MEMBER ORIENTATIONS
2 MEETINGS/ PRESENTATIONS	247 TOTAL REACHED AT MEETINGS/PRESENTATIONS
23 TOTAL INITIATED/INVITED EVENTS	2210 TOTAL MEMBERS REACHED AT EVENTS
333 TOTAL EVENTS	3628 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 20 CITIES

Cities represent the mailing addresses for members who completed a Member Orientation by phone. The italicized cities are outside of Alameda County. The following cities had <1% reach during Q3 2025: Albany, Brentwood, Cherryland, Emeryville, Fairfield, and Los Angeles. The C&O Department started including these cities in the Q3 FY21 Outreach Report.

$750.00

TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

** Includes refundable deposit.*

CAC Business

ALAMEDA Alliance FOR HEALTH

CAC Chair Nominations and Voting

ALAMEDA Alliance FOR HEALTH

CHAIR SELECTION PROCESS

1. Inform member 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.

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 member 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.

CAC Membership Recruitment

ALAMEDA Alliance FOR HEALTH

CAC MEMBERSHIP RECRUITMENT UPDATES

- Priority Areas for Recruitment
  - Foster parents of Alliance members, advocates, and/or youth
  - Long-Term Support Services (LTSS) advocates, or Alliance members participating in LTSS
  - Members:
    - → Men
    - → Younger Adults
    - → Preferred language is non-English
  - Providers

CAC MEMBERSHIP RECRUITMENT UPDATES

- Connected and presented information about the CAC to the following groups and organizations:
  - New Greater Beginnings: 01/17/2025
  - Oakland Catholic Worker (Immigrant Services): 4/28/2025
  - Children's First Medical Group (CFMG): 04/29/2025
  - City of Berkeley (Local Health Department): 05/20/2025
  - Community Health Center Network (CHCN): 05/21/2025
  - Native American Health Center (NAHC): 05/29/2025

CAC MEMBERSHIP RECRUITMENT UPDATES

- Next Steps
  - Follow up with the groups/organizations we presented to.
  - CAC Recruitment Workgroup.
  - Present CAC candidates at the next CAC Selection for review and voting.

Questions?
Thank you!

ALAMEDA Alliance FOR HEALTH