ALAMEDA ALLIANCE FOR HEALTH

QUALITY IMPROVEMENT HEALTH EQUITY PROGRAM DESCRIPTION 2023

ALAMEDA Alliance FOR HEALTH

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

2023 Quality Improvement Health Equity Program Description Signature Page

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OVERVIEW

Alameda Alliance for Health is a public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to lower-income people of Alameda County. Established in January 1996, the Alliance was created by and for Alameda County residents. The Alliance currently provides health care coverage to approximately 358,725 children and adults through its programs.

Alameda Alliance for Health is licensed by the State of California and product lines include Medi-Cal managed care and Group Care commercial insurance. Medi-Cal managed care beneficiaries, eligible thorough one of several Medi-Cal programs, e.g., TANF, SPD, Medi-Cal Expansion and Dually Eligible Medi-Cal members do not participate in California's Coordinated Care Initiative (CCI). For dually eligible Medi-Cal and Medicare beneficiaries, Medicare remains the primary insurance and Medi-Cal benefits are coordinated with the Medicare provider.

Alliance Group Care is an employer-sponsored plan offered by the Alliance. The Group Care product line provides comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County.

Alameda Alliance for Health's (Alliance) Quality Improvement Health Equity (QIHE) Program strives to ensure that members have access to quality and safe health care services. The QIHE Program Description is a comprehensive document with a set of interconnected documents that describes our quality program governance, structure and responsibilities, operations, scope, goals, and measurable objectives.

The Alliance QIHE Program is applicable to all product lines and is designed to assess, measure, evaluate and improve the quality and safety of care that members receive. Participation of all Alliance departments and staff in quality improvement activities is essential to the organization achieving our QI goals and objectives.

The Alliance complies with applicable State and Federal civil rights laws and does not discriminate based on race, color, religion, ancestry, national origin, ethnic group, age, mental or physically disability, sex, gender, gender identity, or sexual orientation, medical condition, genetic condition, or marital status. The Alliance QIHE Program is committed to serving the healthcare needs of our culturally and linguistically diverse membership. The Alliance staff and provider network reflect the county's cultural and linguistic diversity.

MISSION AND VISION

Mission

Improving the health and wellbeing of our members by collaborating with our provider and community partners to deliver high quality and accessible services.

Vision

All residents of Alameda County will achieve optimal health and well-being at every stage of their life.

QIHE PROGRAM SCOPE AND GOALS

The purpose of the Alliance QIHE Program is to objectively monitor and evaluate the quality, safety, appropriateness, and outcome of care and services delivered to members of the Alliance. The overall goal of the QIHE Program is to ensure that members have access to quality medical and behavioral health care services that are safe, effective, and meet their needs. The QIHE Program is structured to continuously pursue opportunities for improvement and problem resolution. The QIHE Program is organized to meet overall program objectives as described below and as directed each year by the QI and UM Work Plans. Improvement priorities are selected based on volume, opportunities for improvement, risk, and evidence of disparities.

Although not limited to, the goals of the QIHE Program are to:

1. Maintain the delivery of high quality, safe, and appropriate medical and behavioral health care that meets professionally recognized standards of practice that is delivered to all enrollees.
2. Utilize objective and systematic measurement, monitoring, and evaluation through qualitative and quantitative analysis of health care services and to implement QIHE activities based on the findings.
3. Conduct performance improvement activities that are designed implemented, evaluated, and reassessed using industry recognized quality improvement models such as Plan-Do-Study-Act (PDSA).
4. Ensure physicians and other appropriate licensed professionals, including behavioral health, are an integral and consistent part of the QIHE Program.
5. Ensure medical and behavioral health care delivery is consistent with professionally recognized standards of practice.
6. Track and trend the delivery of healthcare service to ensure care and services are not withheld or delayed for any reason, such as potential financial gain or incentive to plan providers.
7. Design and maintain an ongoing organizational culture of quality to ensure continual HEDIS improvement and accreditation readiness.

The scope of the QIHE Program is comprehensive and encompasses the following:

1. Timely access and availability to quality and safe medical and behavioral care and services.
2. Care and Disease management services.
3. Cultural and linguistic services Patient safety.
4. Member and provider experience Continuity and coordination of care.
5. Tracking of service utilization trends, including over-and under-utilization Clinical practice guideline development, adoption, distribution, and monitoring.
6. Targeted focus on acute, chronic, and preventive care services for children and adults Member and provider education.
7. Prenatal, primary, specialty, emergency, inpatient, and ancillary care.
8. Case review, investigation, and corrective actions of potential quality issues Credentialing and re-credentialing activities.

9. Delegation oversight and monitoring.
10. Delegate performance improvement project collaborations.
11. Targeted support of special needs populations including Seniors and Persons with Disabilities and persons with chronic conditions.
12. Population Health Management Integration.
13. Health care diversity and equity.

ORGANIZATIONAL STRUCTURE AND SUPPORT COMMITTEES' RESPONSIBILITY

Overview

The Alliance Board of Governors (BOG) appoints and oversees the Quality Improvement Health Equity Committee (QIHEC), Pharmacy & Therapeutics (P&T) Committee, Peer Review/Credentialing Committee (PRCC), Member Advisory Committee, and Compliance Committee which in turn, provide the authority, direction, guidance, and resources to enable Alliance staff to carry out the QIHE Program.

The organizational chart in **Appendix A** displays the reporting relationships for key staff responsible for QIHE activities at the Alliance. **Appendix B** displays the committee reporting relationship and organizational bodies.

Board of Governors

The Alliance BOG is appointed by the Alameda County Board of Supervisors and consists of up to 15 members who represent members, provider, and community partner stakeholders. The BOG is the final decision-making authority for the Alliance QIHE Program. Its duties include:

- Reviewing annually, updating, and approving the QIHE Program description, defining the scope, objectives, activities, and structure of the program.
- Reviewing and approval of the annual QI report and evaluation of QI studies, activities, and data on utilization and quality of services.
- Assessing QIHE Program's effectiveness and direct modification of operations as indicated.
- Defining the roles and responsibilities of QIHEC.
- Designating a physician member of senior management with the authority and responsibility for the overall operation of the quality management program, who serves on QIHEC.
- Appointing and approving the roles of the Chief Medical Officer (CMO) and other management staff in the QIHE Program.
- Receiving a report from the CMO on the agenda and actions of QIHEC.

Quality Improvement Health Equity Committee (QIHEC)

The QIHEC is a standing committee of the BOG and meets a minimum of four times per year, and as often as needed, to follow-up on findings and required actions. The QIHEC is responsible for the implementation, oversight, and monitoring of the QIHE Program and Utilization Management (UM) Program. As it relates to the QIHE Program, the QIHEC recommends policy decisions, analyzes, and evaluates the QI work plan activities, and assesses the overall effectiveness of the QIHE Program. The QIHEC reviews results and outcomes for all QIHE activities to ensure performance meets standards and makes recommendations to resolve barriers to quality improvement activities. Any quality issues related to the health plan that are identified through the CAHPS and Provider Satisfaction surveys and health plan service reports are also discussed and addressed at QIHEC meetings. The QIHEC oversees and reviews all QI delegation summary reports and evaluates delegate quality program descriptions, program evaluations, and work plan activities. The QIHEC presents to the Board the annual QIHE Program description, work plan and prior year evaluation. Signed and dated minutes that summarize committee activities and decisions are maintained. The Annual QIHE Program, Work Plan, Evaluation, and minutes from the QIHEC are submitted to the California Department of Health Care Services (DHCS).

Responsibilities include but are not limited to:

- Approve, select, design, and schedule studies and improvement activities.
- Review results of performance measures, improvement activities and other studies.
- Review CAHPS and other survey results and related improvement initiatives.
- On-going reporting to the BOG.
- Meeting at least quarterly and maintaining approved minutes of all committee meetings.
- Approve definitions of outliers and develop corrective action plans.
- Recommend and approve of Medical Necessity Criteria, Clinical Practice Guidelines, as well as pediatric and adult Preventive Care Guidelines and review compliance monitoring.
- Review member grievance and appeals data.
- Oversee the Plan's process for monitoring delegated providers.
- Oversee the Plan's UM Program.
- Review advances in health care technology and recommend incorporation of new technology into delivery of services as appropriate.
- Provide guidance to staff on quality improvement activities.
- Monitor progress in meeting QIHE goals.
- Evaluate annually the effectiveness of the QIHE and Population Health Management program.
- Oversee the Plan's complex case management and disease management programs.
- Review and approve annual QIHE and UM Program Descriptions, Work Plans, and Evaluations.
- Recommends and approves resource allocation for the QI Department Program. The QIHEC is chaired by the CMO and vice-chaired by the Sr. QI Medical Director. The members are representatives of the Alliance contracted provider network including those who provide health care services to Seniors and Persons with Disabilities (SPD) and chronic conditions. The QIHEC

Members are appointed for two-year terms. The voting membership includes:

- Alliance CMO (Chair)
- Medical Director of Quality (Vice-Chair)
- Chief Executive Officer (ex officio)
- Chief Health Equity Officer
- Medical Director or designee from each delegated medical group (i.e., Community Health Center Network, Children First Medical Group, Kaiser)
- Physician representative of Alameda County Medical Center
- Physician representative of Alameda County Ambulatory Clinics
- Alliance contracted physicians (3 positions)
- Representative of County Public Health Department
- A Behavioral Health practitioner
- Alliance Medical Directors
- Alliance Senior QI Director

A quorum is established when the majority of the voting membership is present at the meeting. The Chief Executive Officer does not count in the determination of a quorum.

Pharmacy and Therapeutics Committee (P&T)

The P&T Committee assists the QIHEC in oversight and assurance of ensuring the promotion of clinically appropriate, safe, and cost-effective drug therapy by managing and approving the Alliance's drug formulary, monitoring drug utilization, and developing provider education programs on drug appropriateness. P&T Committee meeting minutes and pharmacy updates are shared at the QIHEC meetings.

The voting membership consists of:

- Alliance Chief Medical Officer (Chair) or designee
- Alliance Director of Pharmacy Services (Co-Chair)
- Practicing physician(s) representing Internal Medicine
- Practicing physician(s) representing Family Practice
- Practicing physician(s) representing Pediatrics
- Practicing physician(s) representing common medical specialties
- Practicing community pharmacists contracted with Alliance (not to exceed 1/3 of the voting membership of the committee or three pharmacists, whichever is greater).

Peer Review and Credentialing Committee (PRC)

The PRC is a standing committee of the BOG that meets a minimum of ten times per year. The chair of the Peer Review Committee is the Medical Director of QI. The chair of the Credentialing Committee is the CMO.

Responsibilities include:

- Recommending provider credentialing and re-credentialing actions.
- Performing provider-specific clinical quality peer review.
- Reviewing and approving PRC Program Description.
- Monitoring delegated entity credentialing and re-credentialing.

The voting membership consists of:

- Alliance Chief Medical Officer (Chair) or Designee
- Alliance Case Management and Quality Improvement Medical Directors
- Medical Director/physician designee from Children First Medical Group
- Medical Director/physician designee from Community Health Center Network
- Physician representative for Alameda County Medical Center
- Two physicians from the South County area contracted with the Alliance.
- Physician representative from the Alliance BOG

Internal Quality Improvement Committee (IQIC)

The IQIC assists the QIHEC in oversight and assurance of the quality of clinical care, patient safety, and customer service provided throughout the AAH organization. Its primary roles are to maintain and improve clinical operational quality, review organization-wide performance against the Alliance quality targets, and report results to the QIHEC. All members shall complete a confidentiality and conflict-of-interest form, as required. A quorum, defined as a simple majority of voting members, must be present to conduct a meeting. The IQIC shall meet quarterly, at least four times per year. If urgent matters (as determined by the Alliance CMO) arise between meetings, additional meetings will be scheduled. Meetings may be conducted via conference call or webinar. All relevant matters discussed in between meetings will be presented formally at the next meeting. An agenda and supplementary materials, including minutes of the previous meeting, shall be prepared, and submitted to the IQIC members prior to the meeting to ensure proper review of the material. IQIC members may request additions, deletions, and modifications to the standard agenda. Minutes of the IQIC proceedings shall be prepared and maintained in the permanent records of the Alliance. Minutes, relevant documents, and reports will be forwarded to QIHEC for review.

Committee Responsibilities include but are not limited to:

- Develop, approve, and monitor a dashboard of key performance and QI indicators compared to organizational goals and industry benchmarks.
- Oversee and evaluate the effectiveness of AAH's Performance Improvement and Quality Plans.
- Review reports from other sub-committees and, if acceptable, forward them for review at the next scheduled QIHEC.

- Review plan and delegate corrective plans regarding negative variances and serious errors.
- Oversee compliance with NCQA accreditation standards.
- Make recommendations to the QIHEC on all matters related to:
- Quality of Care, Patient Safety, and Member/Provider Experience.
- Performance Measurement.
- Preventive services including:
    - Seniors and Persons with Disability (SPD)
    - Members with chronic conditions
    - Medi-Cal Expansion (MCE) members.

The Committee shall be comprised of the following members:

- Alliance Chief Medical Officer (CMO)
- Alliance Medical Director(s)
- Sr. Director of Quality
- Quality Improvement Manager
- Access to Care Manager
- Population Health and Equity Director
- Members from Provider Relations, Member Services, Business Analytics, Health Education, Compliance, and Grievance and Appeals.

Utilization Management Committee (UCM)

The UMC is a forum for facilitating clinical oversight and direction. Its responsibilities are to:

- Maintain the annual review and approval of the:
    - UM Program, UM Policies/Procedures, UM Criteria
    - Other pertinent UM documents such as the UM, Evaluation and UM Workplan, UM Notice of Action Templates
    - Case/Care Management (CM) and Enhanced Care Management (ECM) Programs Policies/Procedures,
    - Health Risk Assessment (HRA) and Health Information Form/Member Evaluation Tool (HIF/MET) Policies and Procedures.
- Participate in the utilization management/continuing care programs aligned with the Program's quality agenda.
- Assist in monitoring for potential areas of over and under-utilization and recommend appropriate actions when indicated.
- Review and analysis of utilization data for the identification of trends.
- Recommend actions to the Quality Oversight Committee when opportunities for improvement are identified from review of utilization data including, but not limited to Ambulatory Visits,

Emergency Visits, Hospital Utilization Rates, Hospital Admission Rates, Average Length of Stay Rates, and Discharge Rates.

- Review information about New Medical Technologies from the Pharmacy & Therapeutics Committee including new applications of existing technologies for potential addition as a new medical benefit for Members.

Access and Availability Subcommittee (AASC)

The AASC reviews the Alliance's access and availability data to evaluate whether the Alliance is meeting regulatory standards and provides corrective actions and recommendations for improvement when needed. The committee identifies opportunities for improvement and provides recommendations to maintain compliance with access and availability regulatory requirements.

Membership is comprised of Alliance staff within departments that are involved with access and availability which include the following representation:

- Chief Medical Officer
- Senior Medical Directors
- Senior Quality Director
- Access to Care Manager
- Quality Improvement Manager
- Health Education (Cultural & Linguistics) Manager
- Quality Assurance
- Grievance and Appeals Management
- Compliance
- Healthcare Analytics
- Utilization Management
- Member Services
- Provider Services

The following are the monitoring activities the subcommittee reviews to ensure compliance with access and availability and network adequacy requirements including but not limited to:

- Provider network capacity levels
- Facility Site Reviews
- Geographic accessibility
- Appointment availability surveys
- High volume and high impact specialists
- Access-related grievances and appeals. Access-related potential quality issues. Provider language capacity. Wait time and telephone practices related to access. Member and provider satisfaction survey

- After hours care

Cultural and Linguistic Services Committee

The Cultural and Linguistic Services Committee (CLSC)'s role is to ensure members receive culturally and linguistically appropriate health care services and to monitor the Alliance's Cultural and Linguistic Services Program. The CLSC reviews demographic changes in the Alliance membership, language services, grievances and potential quality issues related to language access and discrimination, alternate format and translation services, and overall execution of the Alliance's Cultural and Linguistic Services Program. The CLSC makes recommendations for program improvements and corrective actions as needed. The CLSC reports results to the QIHEC.

Responsibilities include but are not limited to:

- Monitor the cultural and linguistic needs of members.
- Review reports related to provision of cultural and linguistic services.
- Ensure that language assistance services are provided at all points of contact.
- Maintain and update cultural and linguistic services policies and procedures to be compliant with ongoing regulatory and contractual requirements.
- Annually review Cultural and Linguistic Services program description and work plan.
- Review input from the Member Advisory Committee on cultural and linguistic services and consider how it may inform Alliance's programs, policies, and procedures.
- Identify issues related to access to and provision of culturally and linguistically appropriate services and develop corrective actions to correct deficiencies found.
- Review plan and delegate corrective action plans.

The CLSC is composed of the following voting members:

- Chief Medical Officer
- Chief Health Equity Officer
- Senior Director of Quality
- 1 Representative from Compliance
- 1 Representative from Communications and Outreach
- 1 Representative from Grievance and Appeals
- 1 Representative from Population Health and Equity
- 1 Representative from Health Care Services
- 1 Representative from Member Services
- 1 Representative from Provider Services
- 1 Representative from Quality Improvement

Joint Operations Committee/Delegation

The contractual agreements between the Alliance and delegated entities specify:

- The responsibilities of both parties.
- The functions or activities that are delegated.
- The frequency of reporting on those functions and responsibilities to the Alliance and how performance is evaluated.
- Corrective action plan expectations, if applicable.

The Alliance may delegate QI, Credentialing, UM, Case Management, Disease Management, Claims, Grievance and Appeals activities to Health Plans, County entities, and/or vendors that meet the requirements as defined in a written delegation agreement, delegation policies, accreditation standards, and regulatory standards.

To ensure delegated entities meet required performance standards, the Alliance:

- Provides oversight to ensure compliance with federal and state regulatory standards, and accreditation standards.
- Reviews and approves program documents, evaluations, and policies and procedures relevant to the delegated activities.
- Conducts required pre-delegation activities.
- Conducts annual oversight audits.
- Reviews reports from delegated entities.
- Collaborates with delegated entities to continuously improve health service quality.

As part of delegation responsibilities, delegated entities must:

- Develop, enact, and monitor quality plans that meet contractual requirements and Alliance standards.
- Provide encounter information and access to medical records pertaining to Alliance members as required for HEDIS and regulatory agencies.
- Provide a representative to the Joint Operations Committee.
- Submit at least semi-annual reports or more frequently if required on delegated functions.
- Cooperate with state/federal regulatory audits as well as annual oversight audits.
- Complete any corrective action deemed necessary by the Alliance.

The Alliance collaborates with delegated entities to formulate and coordinate QIHE activities and includes these activities in the QI work plan and program evaluation. Delegated activities are a shared function. Delegate program descriptions, work plans, reports, policies and procedures, evaluations and audit results are reviewed by the Delegation Oversight Committee and Joint Operations Committee and findings are summarized at QIHEC meetings, as appropriate.

The Alliance currently delegates the following functions:

Table 1: Alameda Alliance Delegated Entities

Delegate	Quality Improvement		Utilization Management		Credentialing		Grievances & Appeals		Claims		Call Center		Case Management		Cultural & Linguistic Services		Provider Training	
	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care
Community Health Center Network (CHCN)			X	X					X	X			X	X			X	X
March Vision Care Group, Inc.					X				X									
Children's First Medical Group (CFMG)			X		X				X									
PerformRx			X	X	X	X			X	X					X	X		
Kaiser	X		X		X		X		X		X		X		X		X	
UCSF					X	X												
Physical Therapy PN					X	X												
Lucile Packard					X	X												
Teledoc					X	X												

QUALITY IMPROVEMENT PROGRAM RESOURCES

Responsibilities for QIHE Program activities are an integral part of all Alliance departments. Each department is responsible for setting and monitoring quality goals and activities.

The Alliance QI Department is part of the Health Care Services Department, and responsible for implementing QIHE activities and monitoring the QIHE Program. The QI Department participates in the accreditation process, manages the HEDIS and CAHPS data collection and improvement process, conducts facility site reviews (FSRs), and oversees the quality activities in other departments and those performed by delegated groups.

Resource allocation for the QI Department is determined by recommendations from the QIHEC, CMO, CEO and BOG. The Alliance recruits, hires, and trains staff, and provides resources to support activities required to meet the goals and objectives of the QIHE Program.

The Alliance's commitment to the QIHE Program extends throughout the organization and focuses on QIHE activities linked to service, access, continuity and coordination of care, and member and provider experience. The Senior Director of Quality, with direction from the Medical Director of Quality and CMO, coordinates the QIHE Program. Titles, education and/or training for key positions within the Quality Department include:

Chief Medical Officer

The Alliance Chief Medical Officer (CMO) is a board-certified physician who holds a current unrestricted license to practice medicine in California. The CMO has relevant experience and current knowledge in clinical program administration, including utilization and quality improvement management. The CMO is responsible for and oversees the QIHE Program. The CMO provides leadership to the QIHE Program through oversight of QI study design, development, and implementation, and chairs the QIHEC, PRCC, and P&T committees. The CMO makes periodic reports of committee activities, QI study and activity results, and the annual program evaluation to the BOG. The CMO reports to the Alliance CEO.

Chief Health Equity Officer

The Chief Health Equity Officer (CHEO) reports directly to the Chief Executive Officer (CEO) and is matrixed to the Chief of Human Resources (CHR). The position partners with leaders across the organization to develop and drive forward the key strategies of the organization as they relate to Diversity, Equity, and Inclusion (DEI) for members, providers, and employees. The executive position implements policies that ensure health equity is prioritized and addressed and is responsible for setting and implementing an overarching vision of DEI for the organization, including programmatic and administrative outcomes. The position is responsible for the promotion of internal and external DEI for members, providers, and employees. With supervision by the Chief Medical Officer (or designee) of the QIHE program, the CHEO participates in QIHEC and collaborates on QIHE program activities.

Senior Medical Director

The Senior Medical Director is a board-certified physician trained in Emergency Medicine who holds a current unrestricted license to practice medicine in California. The Senior Medical Director has relevant experience and current knowledge in clinical program administration, including utilization and quality improvement management and holds a Medical Doctorate, Master of Medical Management, and Master of Science in Biomedical Investigations, over 16 years of clinical experience, and 12 years of QI experience. The Senior Medical Director is part of the medical team and is responsible for strategic

direction of the Quality and Program Improvement programs. The Medical Director also forms a dyad partner with the Sr. Director of Quality and will serve as an internal expert, consultant, and resource in QI. They are responsible for clinical appropriateness, quality of care, pay for performance, access and availability, provider experience, member experience and cost-effective utilization of services delivered to Alliance members. The Senior Medical Director has executive oversight over the Behavioral Health Program responsibilities include participating in the grievance and external medical review procedure process, resolving medically related and potential quality related grievances, and issuing authorizations, appeals, decisions, and denials. The Senior Medical Director reports to the CMO.

Senior Director of Quality

The Sr. Director of Quality is responsible for the strategic direction of the Quality Improvement Program. The Sr. Director of Quality holds a master's in nursing, with 20 years of QI management and experience. The Sr. Director of Quality is a Registered Nurse who holds an active license to practice in California. This position has direct responsibility for the development, implementation, and evaluation of HEDIS and CAHPS. This position is responsible for all performance improvement activities, including improving access and availability of network services; developing and managing quality programs as identified by DHCS, DMHC, and NCQA (PIPs, Improvement Programs i.e., EAS/MCAS measures, QI Standards) as well as managing, tracking, analyzing, and reporting member experience/satisfaction as requested. The Sr. Director is also responsible for the oversight of FSR and potential quality issues (PQIs) and will direct performance improvement, FSR, access and availability. The Sr. Director is also the senior nurse to the organization to augment clinical oversight. This position, along with the Director of Population Health, assists with setting the priorities of the Population Health Management program, and ensures Health Education and Cultural and Linguistic Services are incorporated into the QIHE program. The Sr. Director of Quality is a dyad partner with the QI Medical Director and reports to the CMO.

Senior Director of Behavioral Health

The Senior Director of Behavioral Health is a licensed psychologist with an active license to practice in California. The Senior Director of Behavioral Health has relevant experience and current knowledge in clinical program administration, including behavioral health and autism spectrum disorder management. Alongside the Sr. Medical Director, the Sr. BH Director is responsible for and oversees the BH program. Responsibilities include participating in the QI, UM, and CM processes as they pertain to behavioral health and autism spectrum disorder programs. The Senior Director of BH reports to the Senior Medical Director.

Quality Improvement Manager

The Quality Improvement Manager is a non-clinical/licensed staff member who holds a master's in business administration degree and has 7 years of Medicaid Health Plan experience and holds certification as a Project Management Professional. The QI Manger is responsible for the day-to-day management of the QI department, including but not limited to HEDIS project improvement development and submission oversight, Physician Profiling (practice profiling) activities, and Quality and Performance Improvement Project oversight. The Manager also acts as liaison between the Alliance's physician leadership and community practitioners/providers of care across all specialties and delegates. The Manager is also responsible for creating report cards and assessing gaps in care. The QI manager works collaboratively throughout the organization to lead and establish appropriate performance management/quality improvement systems including PDSA. The Quality Improvement Manager reports to the Sr. Director of Quality.

Access to Care Manager

The Access to Care Manager is a non-clinical/licensed staff member who holds a bachelor's degree in media and technology and has 11 years of community health and provider network experience. The Access to Care Manager is responsible for day-to-day management of access to care activities throughout the organization and leading and establish appropriate access to care systems. The Access to Care Manager ensures the access program complies with timely access standards as regulated by the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA). The Access to Care Manager ensures planning and oversight of access to care surveys, ensures appropriate follow up when compliance monitoring identifies deficiencies The Access to Care Manager reports to the Sr. Director of Quality.

Quality Improvement Nurse Supervisor

The QI Nurse Supervisor is a Registered Nurse who holds an active license to practice in California and has 10 years of managed care experience.

The Quality Improvement Nurse Supervisor works collaboratively throughout the organization to ensure appropriate oversight of performance management and clinical quality improvement assignments. The Quality Improvement Supervisor is responsible for day-to-day supervision of the work assigned to the clinical staff in the Quality Department. The Supervisor also acts as liaison between the health plan's physician leadership and community practitioners/providers of care across all specialties and delegates. The Quality Improvement Supervisor is responsible for oversight of timely and accurate investigation and completion of Potential Quality Issues (PQI), Provider Preventable Conditions (PPC), and quality of care corrective action plans, and participation in HEDIS activities. The QI Nurse Supervisor reports to the Sr. Director of Quality.

Quality Improvement Review Nurse (3)

The QI Review Nurse is a Registered Nurse who holds an active license to practice in California and has at least 3 years of managed healthcare experience. Under the direct supervision of the Quality Improvement Nurse Supervisor, the Quality Review Nurse is responsible for timely and accurate investigation and completion of Potential Quality of Care Issues (PQIs), collecting quality related data and reviewing medical records for HEDIS abstraction and over reads, regulatory compliance, Facility Site Review (FSR) evaluations, quality improvement (QI) activities development, data tracking and trending, and outcomes reporting. The Quality Review Nurse keeps accurate records, manages, and analyzes data, as well as responds appropriately and timely, both verbally and in writing to internal and external clinical issues of staff and regulatory agencies.

Senior Quality Improvement Nurse Specialist (1)

The QI Review Nurse is a Registered Nurse who holds an active license to practice in California and has at least 20 years of managed healthcare experience. Under the direct supervision of the Sr. Quality Improvement Director, the Sr. Quality Improvement (QI) Nurse Specialist is responsible for the training, certification and recertification of all Alliance Network Management and Delegated Provider Oversight staff in conducting FSR audits. The Sr. QI Nurse Specialist is also responsible for the oversight and monitoring of the qualitative and quantitative content of the medical record process and maintaining compliance with state and regulatory quality of care standards. The QI Nurse Specialist develops provider training and education materials to assist providers with meeting quality standards.

The Senior QI Nurse Specialist identifies, investigates, and reports on Potential Quality Issues (PQIs) and Provider Preventable Conditions (PPCs) as appropriate from FSR findings. The QI Nurse

Specialist prepares cases and presents quality of care issues to the Medical for review and determination with support from the Sr. Director of Quality Improvement.

Quality Improvement Project Specialist (5)

QI Project Specialist (QIPS) are bachelor or extensive health care experience prepared non-clinical support staff responsible for providing support for quality assessment and performance improvement activities including quality monitoring, accreditation, access, and availability monitoring, evaluation, and facilitation of performance improvement projects. The QI Project Specialist reports directly to either the Quality Improvement Manager or Access to Care Manager. The QIPS acts as a liaison between the Alliance and the survey vendors, assist with accreditation needs, collaborate on HEDIS interventions, and perform regular assessments of access surveys, provider surveys, CAHPS and grievances. The QIPS ensures accuracy of DHCS performance improvement projects, internal subcommittees and QIHEC and subcommittee meeting facilitation. QIPS have experience in managed care as well as other highly regulated organizations.

Facility Site Review QI Coordinator (1)

The Facility Site Review Coordinator (FSRC) has 8 years of training and experience within the managed healthcare industry. The FSRC reports to the Access to Care Manager and is responsible for performing facility site review audits and quality improvement activities in conjunction with the Sr. QI Nurse Specialists. The position assists with access and availability reports, provider training, HEDIS data collection, disease specific outreach, and preparation for accreditation and compliance surveys by external agencies such as DHCS, DMHC and NCQA.

Quality Program Coordinator (2)

The Quality Program Coordinator (QPC) is a bachelor's prepared non-clinical support staff. Under the general direction of the Quality Improvement Manager, the QPC is responsible for helping to plan, organize, and implement Alliance quality programs. Responsibilities include coordination of quality projects including PQI case tracking, conducting reminder calls/mailings to targeted members or providers participating in quality improvement initiatives or activities, represents the Alliance at community meetings/events, create/runs periodic departmental reports, and maintains departmental worksheets.

ANCILLARY SUPPORT SERVICES FOR THE QIHE PROGRAM

Population Health and Equity

The Population Health and Equity team consists of a Population Health and Equity Director, a Population and Health Equity Manager, a Cultural and Linguistics Services Manager and supporting staff. The Population Health and Equity team is a component of the QI Department. The Population Health and Equity staff ensure integration of the QI initiative into the Alliance Population Health Strategy and support the QI team in the development and implementation of member and provider educational interventions and community collaborations to address health care quality, health equity and access to care. The Population Health and Equity team also manages and monitors the Population Health Management, Health Education and Cultural and Linguistic programs for the Alliance. The Health Education and Cultural and Linguistic Programs and the Population Health Management Strategy are outlined in separate documents.

Healthcare Analytics Services

The Healthcare Analytics Department performs data analyses involving clinical, claims, provider, and member data in support of the Quality department with improvement activities and initiatives. The Healthcare Analysts are available to the QI department and produce analytics and reporting for various QI activities and projects including HEDIS. Additionally, some analytics and reporting for QI are produced by outside vendors under contract with the Alliance.

Quality Assurance

The Director, Quality Assurance is responsible for the operations management of the Grievance and Appeals Department, NCQA Standard Accreditation, and internal monitoring of regulatory requirements for Health Care Services. under the direction of the Chief Medical Officer. The Director is responsible for ensuring the Health Care Service's overall regulatory compliance with Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) contractual responsibilities for Health Care Service Departments. The role is also responsible for overseeing ongoing audit readiness activities for DHCS, DMHC and NCQA. The Director is also responsible in coordinating processes, activities, and regulatory compliance involving grievances and appeals for all lines of business. The position identifies, analyzes, and coordinates resolution of grievances and appeals.

Utilization Management (UM) Services

The UM and QI Departments are part of the Alliance Health Care Services Department. These departments work collaboratively to ensure that appropriate quality and safe health care is delivered to members in a timely and organized manner. QI ensures that QIHEC can identify improvement opportunities regarding concurrent reviews, tracking key utilization data, and the annual evaluation of UM activities.

The Alliance's Utilization Management (UM) activities are outlined in the UM Program Description which includes persons with complex health conditions. The UM Program Description defines how UM decisions are made in a fair and consistent manner. There is also a Case Management (CM) and Complex Case Management Program Description. These programs address serving members with complex health needs, such as, seniors and people with physical or developmental disabilities (SPDs) and/or multiple chronic conditions in addition to case management for high-risk members identified through the disease management program. Responsibilities include conducting outreach and care coordination activities for members in the programs to ensure the improvement of member outcomes and overall member satisfaction. The staff will also assist the QI department in QIHE activities through conducting member outreach calls and mailings.

There are identified staff persons dedicated to working with "linked and carved out services" such as East Bay Regional Center, California Children Services (children with complex health care needs), and the Alameda County Behavioral Health Care Department. The UM Program Description is approved by the UMC and QIHEC. For additional information, refer to the UM and CM/Complex CM Program Descriptions.

Pharmacy Services

The Pharmacy Department and QI Department work collaboratively on various QI projects. The Pharmacy Department supports patient safety initiatives including working with the Pharmacy Benefit Manager (PerformRx) to inform members, providers, and network pharmacies of medication safety alerts. Responsibilities also include review and update of the formulary through P&T, oversight of the Pharmacy Benefit Manager, and collaboration with QIHEC.

Network Management/Provider Relations

The Network Management/Provider Relations Department is the primary point of contact for network providers. They assist the QI Department on various QIHE activities with network providers as appropriate as well as disseminating QI information to practitioners. The Department monitors provider capacity and collaborates with Access and Availability in assessing provider satisfaction with Alliance processes and educates providers on monitoring availability and accessibility standards at physician offices, including after-hours coverage. Provider Services staff also assist the QI Department with practitioners who do not comply with requests from QI including scheduling HEDIS abstraction visits.

Credentialing Services

The Credentialing staff support the credentialing and re-credentialing processes for practitioners and network providers. The Credentialing staff conducts ongoing monitoring and evaluation of network practitioners to ensure the safety and quality of services to members. The QI Department provides the Credentialing Department with Facility Site Review and Medical Record audit scores. The Credentialing staff is responsible for coordinating the PRCC meetings.

Member Services and Member Outreach

The Member Services staff fields all member inquiries regarding eligibility, benefits, claims, programs, and access to care. The Communication and Outreach conducts New Member orientations to educate new members about the health plan benefits. Member Services staff also work with the QI Department on member complaints via the PQI referral process and appeals in accordance with established policies and procedures. To assist in improving HEDIS scores, the QI Department may conduct member outreach activities to get HEDIS services completed. Hold messages are used to remind members of plan benefits and services offered while waiting to speak to an agent.

Grievance and Appeals

Alameda Alliance for Health reviews and investigates all grievance and appeal information submitted to the plan to identify quality issues that affect member experience. The grievance and appeals intake process are broken down into two processes, complaints, and appeals. In both instances, the details of the member's complaints are collected, processed, and reviewed and actions are taken to resolve the issue and Potential Quality Issues are forwarded to QI for review and investigation as needed. QI will continue to collaborate with G&A for assurance of accurate reporting exempt grievance data in 2022.

Methods and Processes for Quality Improvement

The QIHE Program employs a systematic method for identifying opportunities for improvement and evaluating the results of interventions. All program activities are documented in writing and all quality studies are performed on any product line for which it seems relevant. The Alliance QIHE Program follows the recommended performance improvement framework used by the Department of Health Care Services (DHCS). The Alliance Quality department has adopted the DHCS framework based on a modification of the Institute for Health Care Improvement (IHI) Quality Improvement (QI) as a Model of Quality Improvement. Key concepts for DHCS performance improvement projects (PIP) utilize the following framework:

- PIP Initiation
- SMART Aim Data Collection

- Intervention Determination
- Plan-Do-Study-Act
- PIP Conclusion

Identification of Important Aspects of Care

The Alliance uses several methods to identify aspects of care that are the focus of QIHE activities. Some studies are initiated based on performance measured as part of contractual requirements (e.g., HEDIS). Other studies are initiated based on analyses of the demographic and epidemiologic characteristics of Alliance members and others are identified through surveys and dialogue with our member and provider communities (e.g., CAHPS, provider satisfaction survey). Particular attention is paid to those areas in which members are high risk, high volume, high cost, or problem prone.

Data Collection and Data Sources

The Alliance uses internal resources and capabilities to design sound studies of clinical and service quality that produce meaningful and actionable information.

Much of the data relevant to QIHE activities is sourced from our NCQA-certified HEDIS software (Cotiviti). Data integrity is validated annually through the HEDIS reporting audit process.

Data sources to support the QIHE Program include, but are not limited to the following:

- ODS (Operational Data Store) and Datawarehouse: These are the main databases and the primary sources for all data including member, eligibility, encounter, provider, pharmacy data, lab data, vision, encounters, etc. and claims. The databases are used for abstracting data required for quality reporting.
- HealthSuite: Claims processing system CareAnalyzer (DST): used to inform Population Health Management and Population Needs Assessment initiatives and provide QI/UM/CM access to risk-stratified, segmented data that can be effectively applied to target high-risk members for early intervention and improve the overall coordination of care.
- TruCare: in-house medical record software.
- HEDIS: Preventive, chronic care, utilization, access, and other measures run through NCQA-certified HEDIS software (Cotiviti).
- CAHPS 5.1H and CG-CAHPS: Member experience survey via SPH vendor support
- California Immunization Registry (CAIR): Immunization registry information.
- Laboratory results supplemental data sources from: Quest, Foundation, and AHS Credentialing via Cactus, a credentialing database.
- Provider satisfaction and coordination of care surveys via SHP vendor support
- Pre-service, concurrent, post-service and utilization review data (TruCare).
- Member and provider grievance and appeal data.
- Potential Quality of Care Issue Application database used for tracking/trending data.
- Internally developed reports (e.g., asthma and diabetes).
- Provider Appointment Availability Survey (PAAS), as well as after-hours access and emergency instructions.
- Other clinical or administrative data.

Evaluation

Health care analysts collect and summarize quality data. Quality performance staff analyzes the data to determine variances from established criteria, performance goals, and for clinical issues. Data is analyzed to determine priorities or achievement of a desired outcome. Data is also analyzed to identify disparities based on ethnicity and language. Subsets of our membership may also be examined when they are deemed to be particularly vulnerable or at risk.

HEDIS related analyses include investigating trends in provider and member profiling, data preparation (developing business rules for file creation, file creation for HEDIS vendors, mapping proprietary data to vendor and NCQA specifications, data quality review and data clean-up). These activities involve data sets maintained by the Alliance and supplemental files submitted by various trading partners, such as delegated provider organizations and various external health registries and programs (e.g., Kaiser Permanente, Quest Diagnostics, and the California Immunization Registry).

Aggregated reports are forwarded to the QIHEC. Status and final reports are submitted to regulatory agencies as contractually required. Evaluation is documented in committee minutes and attachments.

ACTIONS TAKEN AS A RESULT OF QIHE ACTIVITIES

Action plans are developed and implemented when opportunities for improvement are identified. Each performance improvement plan specifies who or what is expected to change, the person responsible for implementing the change, the appropriate action, and when the action is to take place. Actions will be prioritized according to possible impact on the member or provider in terms of urgency and severity.

Actions taken are documented in reports, minutes, attachments to minutes, and other similar documents.

An evaluation of the effectiveness of each QIHE activity is performed. A re-evaluation will take place after an appropriate interval between implementation of an intervention and remeasurement. The evaluation of effectiveness is described qualitatively and quantitatively, in most cases, compared to previous measurements, with an analysis of statistical significance when indicated.

Based on the HEDIS data presented, areas of focus for 2023 include but are not limited to the following:

- Childhood Immunizations: Combo 10
- Immunizations for Adolescents: Combo 2
- Well-Child Visits in the First 15 months of Life
- Well-Child Visits in members 3-15 months of Life
- Well Child Visit 3-21 Years of Age
- Breast Cancer Screening
- Cervical Cancer Screening
- HbA1c Testing for Diabetics
- Controlling Blood Pressure

Other Non-HEDIS related measures of focus will include but not be limited to:

- Initial Health Assessment
- Emergency Department Visits per 1,000 Members
- PCP Visits per 1,000 Members
- Readmission Rate
- Member Satisfaction Survey: Non-Urgent Appointment Availability
- Screening for Depression
- EPSDT Service Utilization
- Under and Over Service Utilization
- Behavioral Health Care Coordination

TYPES OF QI MEASURES AND ACTIVITIES

Healthcare Effectiveness Data Information Set (HEDIS)

The Managed Care Accountability Set (MCAS) Performance Measures, a subset of HEDIS (Health Effectiveness Data Information Set) are calculated, audited, and reported annually as required by DHCS. Additional measures from HEDIS are also reviewed. A root cause analysis may be performed, and improvement activities initiated for measures not meeting benchmarks.

Consumer Assessment of Health Plan Survey (CAHPS 5.1H and CG-CAHPS)

The Alliance evaluates member experience periodically. Third party vendors conduct the Consumer Assessment of Health Plan Survey (CAHPS). The Alliance assists in the administration of these surveys, receives, and analyzes the results, and follows up with prioritized improvement initiatives. Survey results are distributed to the QIHEC and made available to members and providers upon request. The CAHPS survey is conducted annually for the entire Medi-Cal population and the results from the CAHPS are reported in the annual QIHE evaluation and used to identify opportunities to improve health care and service for our members.

State of California Measures

DHCS has developed several non-HEDIS measures that the Alliance evaluates. These measures, specified in the Alliance contract with DHCS, involve reporting rates for Developmental Screening in the First Three Years of Life, Topical Fluoride and Under/Over-Utilization Monitoring Measure Set.

State Quality improvement Activities

DHCS requires Medi-Cal Managed Care plans to conduct at least four QI projects each year. Forms provided by DHCS are used for QI project milestones.

Annually, the Alliance submits its QIHE Program Description, an evaluation of the prior year's QIHE Work Plan and a QIHE Work Plan for the next year. The QIHE Work Plan is updated throughout the year as QIHE activities are designed, implemented, and reassessed.

The Alliance complies with the requirements described in the regulatory All Plan Letters.

Monitoring Satisfaction

The QIHE Program measures member and provider satisfaction using several sources of satisfaction, including the results of the CAHPS survey, the Population Needs Assessment (PNA), the annual DMHC Timely Access survey, plan member and provider satisfaction surveys, complaint and grievance data, disenrollment and retention data, and other data as available. These data sets are presented to the QIHEC and BOG at quarterly and annual intervals. The plan may administer topic specific satisfaction surveys depending on findings of other QIHE studies and activities.

Health Education Activities

The Health Education Program at the Alliance operates as part of the Health Care Services Department. The primary goal of Health Education is to improve members' health and well-being through the lifespan through promotion of appropriate use of health care services, preventive health care guidelines: Bright Futures/American Academy of Pediatrics and U.S. Preventive Services Task Force, healthy lifestyles and condition self-care and management. The primary goal of Health Education is to provide the means and opportunities for Alameda Alliance members to maintain and support their health.

Health education programs include individual, provider, and community-focused health education and disease management activities which address health concerns such as nutrition, injury prevention, maternal health, diabetes, pre-diabetes, asthma, hypertension, and mental health. The Alliance also collaborates on community projects to develop and distribute important health education messages for at risk populations.

Cultural and Linguistic Activities

The Alliance Cultural and Linguistic Services Program operates under the Health Care Services Department. It reflects the Alliance's adherence and commitment to the U.S. Department of Health & Human Services "National Standards for Culturally and Linguistically Appropriate Services". The program offers services and conducts activities designed to ensure that all members have access to quality health care services that are culturally and linguistically appropriate. These activities encompass efforts within the organization, as well as with Alliance members, providers, and our community partners.

Objectives include:

- Comply with state and federal guidelines related to assessment of enrollees to offer our members culturally and linguistically appropriate services.
- Provide no-cost language assistance services at all points of contact for covered benefits.
- Identify, inform, and assist Limited English Proficiency (LEP) members in accessing quality interpretation services and written information materials in threshold languages.
- Ensure that all staff, providers, and subcontractors are compliant with the cultural and linguistic services program through cultural competency training.
- Integrate community and Alliance member input into the development and implementation of Alliance cultural and linguistic accessibility standards and procedures.
- Monitor and continuously improve Alliance activities and services aimed at achieving cultural competence and reducing health care disparities.

The objectives for cultural and linguistic activities are addressed and monitored in the Cultural and

Linguistic Services work plan which is updated annually.

Diseases Surveillance

The Alliance has executed a Memoranda of Understanding with DMHC and maintains procedures to ensure accurate, timely, and complete reporting of any disease or condition to public health authorities as required by State law. The Provider Manual describes requirements and lists the Public Health Department contact phone and fax numbers.

Patient Safety and Quality of Care

The Alliance QI process incorporates several mechanisms to review incidents that pose potential risk or safety concerns for members. The following activities are performed to demonstrate the Alliance's commitment to improve quality of care and safety of its members via monitoring, investigation, track, and trending of:

- Complaints and grievances and determining quality of care impact.
- Iatrogenic events such as hospital-acquired infections reported on claims and reviewing encounter submissions.
- Inpatient admissions to evaluate and monitor the medical necessity and appropriateness of ongoing care and services. Safety issues may be identified during this review.
- Identified potential quality of care issues.
- Auditing Alliance internal processes/systems and delegated providers.
- Credentialing and re-credentialing of malpractice, license suspension registries, loss of hospital privileges for providers.
- Site review of provider offices for compliance with safety, infection control, emergency, and access standards.
- Operations compliance with local regulatory practices.
- Medication usage (e.g., monitoring the number of rescue medications used by asthmatics).
- Pharmacy benefit management to notify members and providers of medication recalls and warnings.
- Reviewing hospital readmission reports.
- Improve continuity and coordination of care between practitioners.
- In addition to providing educational outreach to members (e.g., member newsletter, telephonic outreach) on patient safety topics including questions asked prior to surgery and questions asked about drug-drug interaction.

Quality issues are referred to the QI Department to evaluate the issue, develop an intervention and involve the CMO when necessary.

ACCESS AND AVAILABILITY

The Alliance implements mechanisms to maintain an adequate network of primary care providers (PCP) and high volume and high impact specialty care providers. Alliance policy defines the types of practitioners who may serve as PCPs. Policies and procedures establish standards for the number and geographic distribution of PCPs and high-volume specialists. The Alliance monitors and assesses the cultural, ethnic, racial, and linguistic needs and preferences of members, and adjusts availability of

network providers, if necessary.

The following services are also monitored for access and availability:

- Children's preventive periodic health assessments/EPSDT
- Adult preventative health screenings
- Initial health appointments

The QIHE Program collaborates with the Provider Relations Department to monitor access and availability of care including member wait times and access to practitioners for routine, urgent, emergent, and preventive, specialty, and after-hours care. Access to medical care is ensured by monitoring compliance with timely access standards for practitioner office appointments, telephone practices, and appointment availability. The QIHEC also oversees appropriate access standards for appointment wait times. Alliance appointment access standards are no longer than DMHC and DHCS established standards. The Provider Manual and periodic fax blasts inform practitioners of these standards.

The QIHEC reviews the following data and makes recommendations for intervention and quality activities when network availability and access improvement is indicated:

- Member complaints about access.
- CAHPS 5.1H and CG-CAHPS results for wait times and telephone practices.
- HEDIS measures for well child and adolescent primary care visits.
- Immunizations.
- Emergency room utilization.
- Facility site review findings.
- The review of specialty care authorization denials and appeals.
- Additional studies and surveys may be designed to measure and monitor access.

BEHAVIORAL HEALTH QUALITY

The Alliance maintains procedures for monitoring the coordination and quality of behavioral healthcare provided to all members including, but not limited to, all medically necessary services across the health care network. The Alliance involves a senior behavioral healthcare in quarterly QIHEC meetings to monitor, support, and improve behavioral healthcare aspects of QI.

Prior to 4/1/23, Behavioral Health Services were delegated to Beacon Health Strategies, an NCQA Accredited MBHO, except for Specialty Behavioral Health for Medi-Cal members, excluded from the Alliance contract with DHCS. The Specialty Behavioral Health Services are coordinated under a Memorandum of Understanding between the Alliance and Alameda County Behavioral Health (ACBH).

Some primary care physicians may choose to treat mild mental health conditions. As of 4/1/2023, Behavioral Health Services were insourced and became the responsibility of the health plan.

The Alliance includes the involvement of a Senior Director of Behavioral Health in program oversight and implementation. In 2023, the Alliance will review Beacon's QIHE Program Description, Work Plan, and Annual Evaluation in addition to creating trilogy documents that include the plans responsibility of the QI / CM / UM Functions of Behavioral Health. The Alliance will review behavioral health quality,

utilization, and member satisfaction quarterly reports in its standing sub-committee meetings to ensure members obtain necessary and appropriate behavioral health services.

Please see the UM / CM Program Description for additional information.

COORDINATION, CONTINUITY OF CARE AND TRANSITIONS

Member care transitions present the greatest opportunity to improve quality of care and decrease safety risks by ensuring coordination and continuity of health care as members transfer between different locations or different levels of care within the same location and/or across the healthcare continuum.

The Alliance Health Care Services focuses on interventions that support planned and unplanned transitions and promote chronic disease self-management. Primary goals of the department are to reduce unplanned transitions, prevent avoidable transitions and maintain members in the least restrictive setting possible.

Comprehensive case management services are available to each member. It is the PCP's responsibility to act as the primary case manager to all assigned members. Members have access to these services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability. All services are provided in a culturally and linguistically appropriate manner.

Members who may need or are receiving services from out-of-network providers are identified. Procedures ensure these members receive medically necessary coordinated services and joint case management, if indicated. Written policies and procedures direct the coordination of care for the following:

- Services for Children with Special Health Care Needs (CSHCN).
- California Children's Service (CCS) eligible children are identified and referred to the local CCS program.
- Overall coordination and case management for members who obtain Child Health and Disability Prevention Program (CHDP) services through local school districts or sites.
- Early Start eligible children are identified and referred to the local program.
- Members with developmental difficulties are referred to the Regional Center of the East Bay for evaluation and access to developmental services.

All new Medi-Cal members are expected to receive an Initial Health Appointment (IHA) within 120 days of their enrollment with the plan. Members are informed of the importance of scheduling and receiving an IHA from their PCP. The Provider Manual informs the PCP about the IHA, the HRA (for SPDs), and recommended forms. All new Medi-Cal members also receive a Health Information Form\Member Information Tool (HIF\MET) in the New Member Packet upon enrollment. The Alliance ensures coordination of care with primary care for all members who return the form with a condition that requires follow up.

The Alliance coordinates with PCPs to encourage members to schedule their IHA appointment. The medical record audit of the site review process is used to monitor whether baseline assessments and evaluations are sufficient to identify CCS eligible conditions, and if medically necessary follow-up services and referrals are documented in the member's medical record.

COMPLEX CASE MANAGEMENT PROCESS

All Alliance members are potentially eligible for participation in the complex case management program. The purpose of the complex case management program is to provide the case management process and structure to a member who has complex health issues and medical conditions. The components of the Alliance complex case management program encompass member identification and selection; member assessment; care plan development, implementation, and management; evaluation of the member care plan; and closure of the case. Program structure is designed to promote quality case management, client satisfaction and cost efficiency using collaborative communication, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

The objectives of the complex case management program are concrete measures that assess effectiveness and progress toward the overall program goal of making high quality health care services accessible and affordable to Alliance membership. The Chief Medical Officer, Senior Director of Health Care Services, Director of Social Determinants of Health, and Manager of Case and Disease Management develop and monitor the objectives. The QIHEC reviews and assesses program performance against objectives during the annual program evaluation, and if appropriate, provides recommendations for improvement activities or changes to objectives. The objectives of the program include:

- Preventing and reducing hospital and facility readmissions as measured by admission and readmission rates.
- Preventing and reducing emergency room visits as measured by emergency room visit rates.
- Achieving and maintaining member's high levels of satisfaction with case management services as measured by member satisfaction rates.
- Improving functional health status of complex case management members as measured by member self-reports of health condition.

The complex case management program is a supportive and dynamic resource that the Alliance uses to achieve these objectives as well as respond to the needs and standards of consumers, the healthcare provider community, regulatory and accrediting organizations.

The Alliance annually measures the effectiveness of its complex case management program based on the following measures (detailed information can be found in the Comprehensive Case Management Program Description):

1. Satisfaction with case management services - members are mailed a survey after case closure and are asked to rate experiences and various aspects of the program's service.
2. All-cause readmission rates - the Alliance measures admission rates for all causes within six months of being enrolled in complex case management.
3. Emergency room visit rate - the Alliance measures emergency room visit rates among members enrolled in complex case management.
4. Health status rate - the Alliance measures the percentage of members who received complex case management services and responded that their health status improved because of complex case management services.
5. Use of appropriate health care services - The Alliance measures enrolled members' office visit activity, to ensure members seek ongoing clinical care within the Alliance network.

The Chief Medical Officer and the Senior Director of Health Care Services collaboratively conduct an annual evaluation of the Alliance complex case management program. This includes an analysis of performance measures, an evaluation of member satisfaction, a review of policies and program description, analysis of population characteristics and an evaluation of the resources to meet the needs of the population. The results of the annual program evaluation are reported to the QIHEC for review and feedback. The QIHEC makes recommendations for improvement and interventions to improve program performance, as appropriate.

DISEASE MANAGEMENT PROGRAM

The Alliance makes available to its members a disease management program. The purpose of the disease management program is to provide coordinated health care interventions and communications to both pediatric and adult members with chronic asthma and adults with diabetes to support disease self-management and promote healthy outcomes. This is accomplished through the provision of interventions based on member acuity level. The intervention activities range from case management for those members at high risk, to those members at high risk to making educational materials and care coordination available for those members who may have gaps in care. The components of the Alliance disease management program include member identification and risk stratification; provision of case management services, chronic condition monitoring; identification of gaps in care, and education.

Program structure is designed to promote quality condition management, client satisfaction and cost efficiency using collaborative communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

The objectives of the disease management program are concrete measures that assess effectiveness and progress toward the overall program goals of meeting the health care needs of members and actively supporting members and practitioners to manage chronic asthma and diabetes. The QIHEC reviews and assesses program performance against objectives during the annual program evaluation, and if appropriate, provides recommendations for improvement activities or changes to objectives. The objectives of the disease management program include:

- Preventing and reducing hospital and facility readmissions as measured by admission and readmission rates.
- Preventing and reducing emergency room visits as measured by emergency room visit rates.
- Achieving and maintaining member's high levels of satisfaction with disease management services as measured by member satisfaction rates.
- Reducing gaps in care as measured by HEDIS clinical effectiveness measures specific to the management of asthma and diabetes.

POPULATION HEATLH MANAGEMENT (PHM) PROGRAM

Alameda Alliance for Health has a Population Health Management (PHM) Program that identifies member needs across the continuum of care and ensures access to a comprehensive set of services with the aim of improving health outcomes and supporting enhanced quality of life. This continuum includes intensive case management and support for members with the highest levels of needs, programs and interventions for those with emerging risks, and basic population health management for all members. The Alliance PHM Program follows the NCQA 2023 Population Health Program Standards and Guidelines and aligns with the California Department of Health Care Services

Population Health Management Policy Guide.

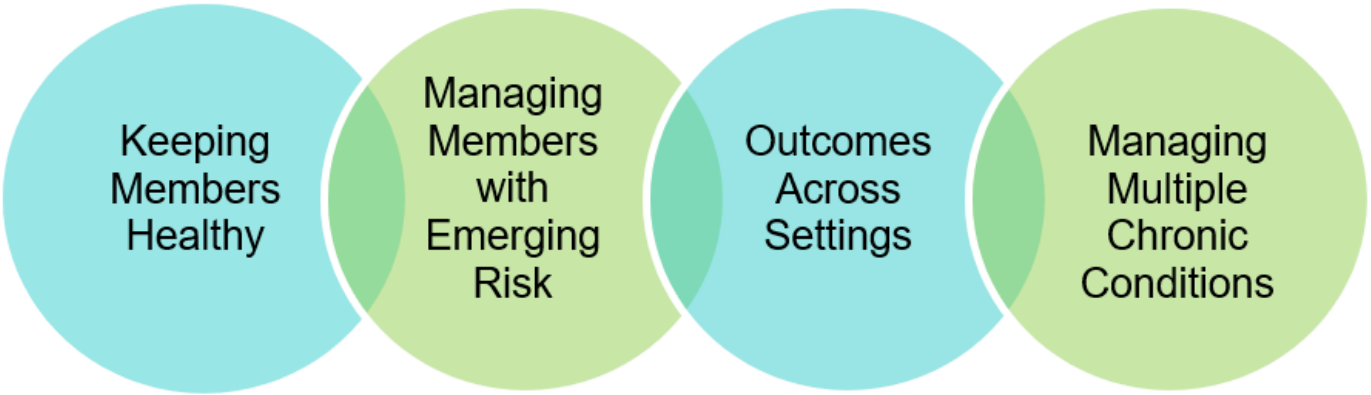
The PHM Program strives to target and close gaps in care and address upstream drivers of health disparities by addressing the social drivers of health (SDOH) that cause those disparities. The PHM Program is monitored via the Population Health Workgroup, which is comprised of representatives from Quality Improvement, Utilization Management, Case Management, Pharmacy and Quality Assurance. In addition, overall outcomes, and findings from the Alliance population health assessments, population health strategy and evaluations are presented, reviewed, and approved by the Quality Improvement Health Equity Committee (QIHEC).

The PHM Strategy is used to:

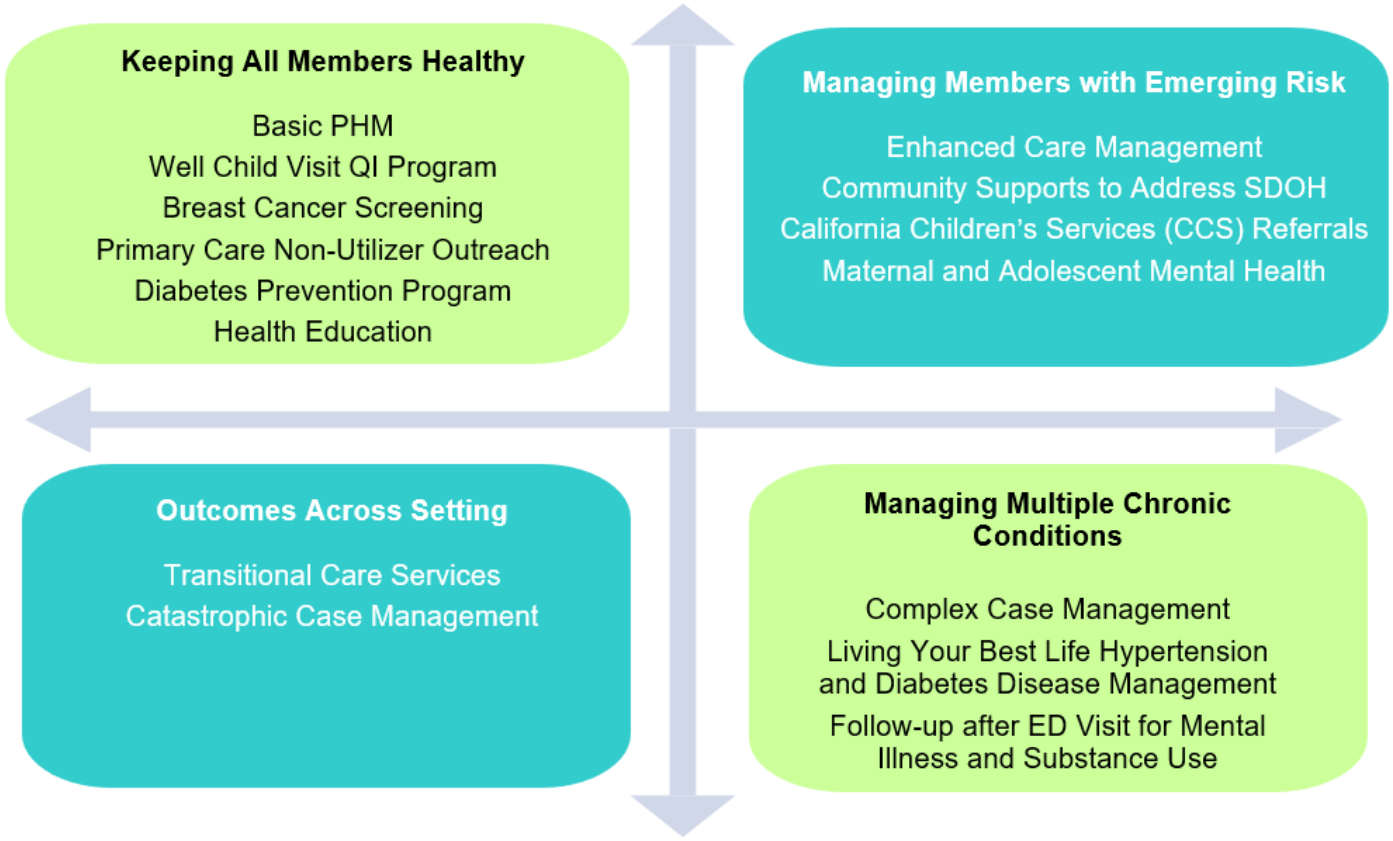
- Improve case management programs including Complex Case Management (CCM), Enhanced Care Management (ECM), Community Supports (CS), and Transitional Care Services (TCS).
- Support development of basic population health activities to promote self-management of conditions and preventative care.
- Inform quality improvement projects.
- Guide development of health education materials and programs.
- Influence interventions that target member safety and outcomes across settings.
- Better understand utilization and identify high-risk members.

The framework of this strategy is designed to address the four focus areas of population health that promote a whole-person approach to identify members at risk, and to provide strategies, programs, and services to mitigate or reduce that risk. The strategy has 4 areas of focus:

Four Areas of Focus



The Alliance also aims to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through best practice and culturally affirming member's needs:



<u>The Population Health Strategy includes:</u>

- Population health assessment
- Population risk stratification and segmentation
- PHM Strategy goals and programs
- Integration of Community Resources
- Delivery systems provider support structures:
- Sharing data – provider measures and gaps in care
- Quality Dashboards – HEDIS measure-specific data
- Comparable Data – Peer performance, local averages, and national benchmarks
- Value-Based Payment Programs
- Ongoing Education/Support – Provider Newsletters & Education

The Alliance Population Health Management Assessment and Strategy can be found in separate documents. The Alliance Population Health Evaluation is included in the QI Evaluation.

SENIORS AND PERSONS WITH DISABILITY (SPD)

The Alliance categories all new SPD members as high risk. High risk members are contacted for an HRA within 45 calendar days and low risk members are contacted within 105 calendar days from their date of enrollment. Existing SPD members receive an annual HRA on their anniversary date. The objectives of an HRA are to assess the health status, estimate health risk, and address members' needs relating to medical, specialty, pharmacy, and community resources. Alliance staff uses the responses to the HRAs, along with any relevant clinical information, to generate care plans with interventions to decrease health risks and improve care management.

DHCS has established performance measures to evaluate the quality of care delivered to the SPD population using HEDIS measures and a hospital readmissions measure.

PROVIDER COMMUNICATION

The Alliance contracts with its providers to foster open communication and cooperation with QIHE activities:

- Provider cooperation with QIHE activities.
- Plan access to provider medical records to the extent permitted by state and federal law.
- Provider maintenance of medical record confidentiality.
- Open provider-patient communication about treatment alternatives for medically necessary and appropriate care.
- Provider regulatory requirements

Provider involvement in the QIHE Program occurs through membership in standing and ad-hoc committees, and attendance at BOG and QIHEC meetings. Providers and members may request copies of the QIHE Program description, work plan, and annual evaluation. Provider participation is essential to the success of QI studies including HEDIS and those that focus on improving aspects of member care. Additionally, providing feedback on surveys and questionnaires is encouraged as a means of continuously improving the QIHE Program.

Providers have an opportunity to review the findings of the QIHE Program through a variety of mechanisms. The QIHEC reports findings from QIHE activities to the BOG, at least quarterly. Findings include aggregate results, comparisons to benchmarks, deviation from threshold, drill-down results for provider group or type, race/ethnicity, and language, and other demographic or clinical factors. Findings are distributed directly to the provider when data is provider specific. Findings are included in an annual evaluation of the QIHE Program and made available to providers and members upon request. The Provider Bulletin contains a calendar of future BOG and standing committee dates and times.

EVALUATION OF QIHE PROGRAM (SEPARATE DOCUMENT)

The QIHEC reviews, makes recommendations, and approves a written evaluation of the overall effectiveness of the QIHE Program on an annual basis. The evaluation includes, at a minimum:

- Changes in staffing, reorganization, structure, or scope of the program during the year.
- Allocation of resources to support the program.
- Comparison of results with goals and targets.

- Tracking and trending of key indicators.
- Description of completed and ongoing QIHE activities.
- Analysis of the overall effectiveness of the program, including assessment of barriers or opportunities.
- Recommendations for goals, targets, activities, or priorities in subsequent QIHE Work Plan.

The review and revision of the program may be conducted more frequently as deemed appropriate by the QIHEC, CMO, CEO, or BOG. The QIHEC's recommendations for revision are incorporated into the QIHE Program Description, as appropriate, which is reviewed by the BOG and submitted to DHCS on an annual basis.

ANNUAL QIHE WORK PLAN (SEPARATE DOCUMENT)

A QIHE Work Plan is received and approved annually by the QIHEC. The work plan describes the QI goals and objectives, planned projects, and activities for the year, including continued follow-up on previously identified quality issues, and a mechanism for adding new activities to the plan as needed. The work plan delineates the responsible party and the time frame in which planned activities will be implemented.

The work plan is included as a separate document and addresses the following:

- Quality of clinical care
- Quality of service
- Safety of clinical care
- Members’ experience
- Yearly planned activities and objectives
- Time frame within which each activity is to be achieved.
- The staff member responsible for each activity
- Monitoring previously identified issues.
- Evaluation of the QIHE Program

Progress on completion of activities in the QI work plan is reported to the QIHEC quarterly. A summary of this progress will be reported by the CMO to the BOG.

QI DOCUMENT

In addition to this program description, the annual evaluation and work plan, the other additional documents important in communicating QI policies and procedures include:

- "Provider Manual" provides an overview of operational aspects of the relationship between the Alliance, providers, and members. Information about the Alliance's QIHE Program is included in the provider manual. It is distributed to all contracted provider sites.
- "Provider Bulletin" is a newsletter distributed to all contracted provider sites on topics of relevance to the provider community, and can include QI policies, procedures, and activities.

- "Alliance Alert" is the member newsletter that also serves as a vehicle to inform members of QI policies and activities.

These documents, or summaries of the documents, are available upon request to providers, members, and community partners. In addition, the QIHE Program information is available on the Alliance website.

CONFIDENTIALITY AND CONFLICT OF INTEREST

All employees, contracted providers, delegated medical groups and sub-contractors of the Alliance maintain the confidentiality of personally identifiable health information, medical records, peer review, internal and external, and internal electronic transmissions, and quality improvement records. They will ensure that these records and information are not improperly disclosed, lost, altered, tampered with, destroyed, or misused in any manner. All information used in QIHE activities is maintained as confidential in compliance with applicable federal and state laws and regulations.

Access to member or provider-specific peer review and other QI information is restricted to individuals and/or committees responsible for these activities. Outside parties asking for information about QIHE activities must submit a written request to the CMO. Release of all information will be in accordance with state and federal laws.

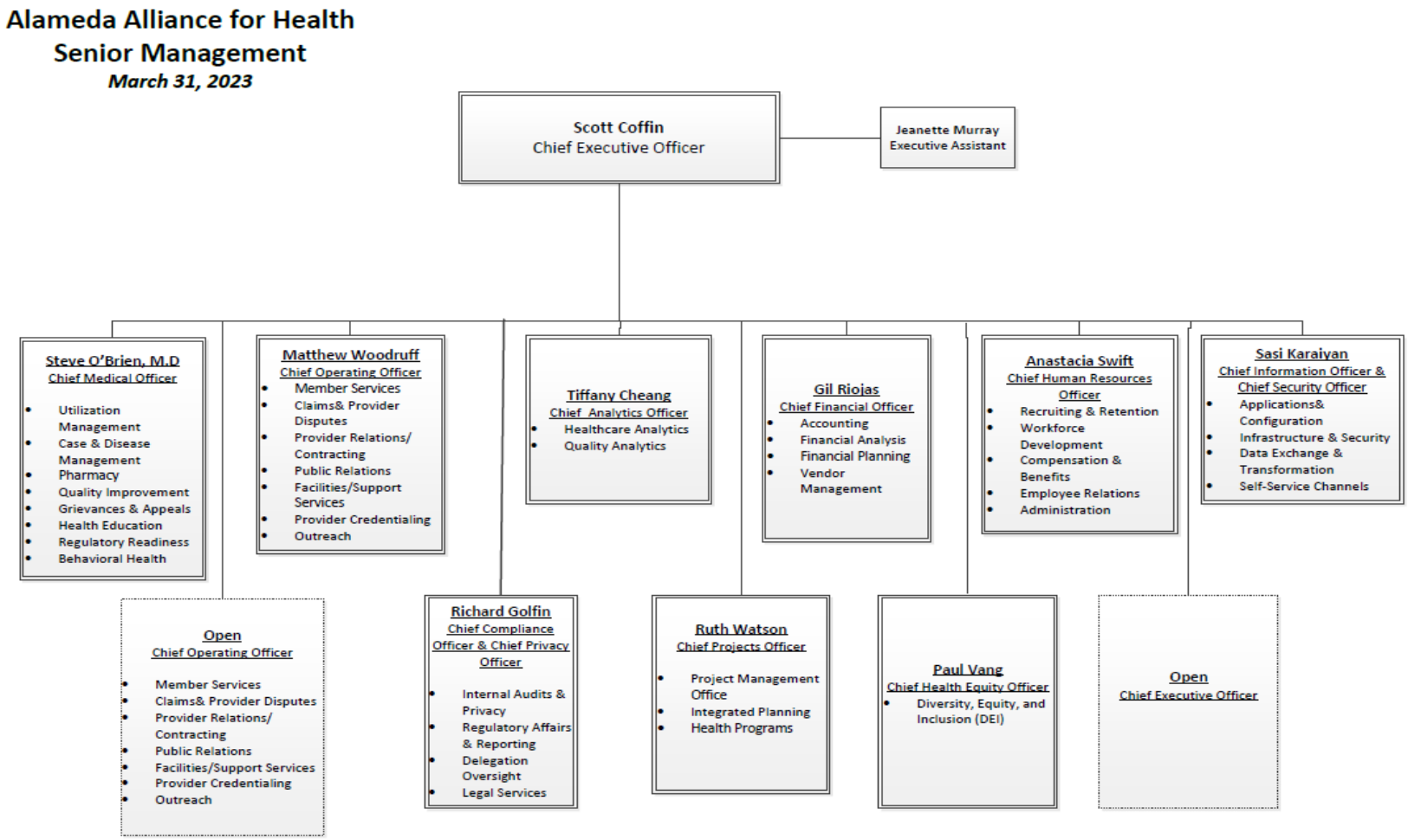
All providers participating in the QIHEC or any of its subcommittees, or other QIHE Program activities involving review of member or provider records, will be required to sign and annually renew confidentiality and conflict of interest agreements. Guests or additional Alliance staff attending QIHEC meetings will sign a confidentiality agreement.

Committee members may not participate in the review of any case in which they have a direct professional, financial, or personal interest. It is each committee member's obligation to declare actual or potential conflicts of interest.

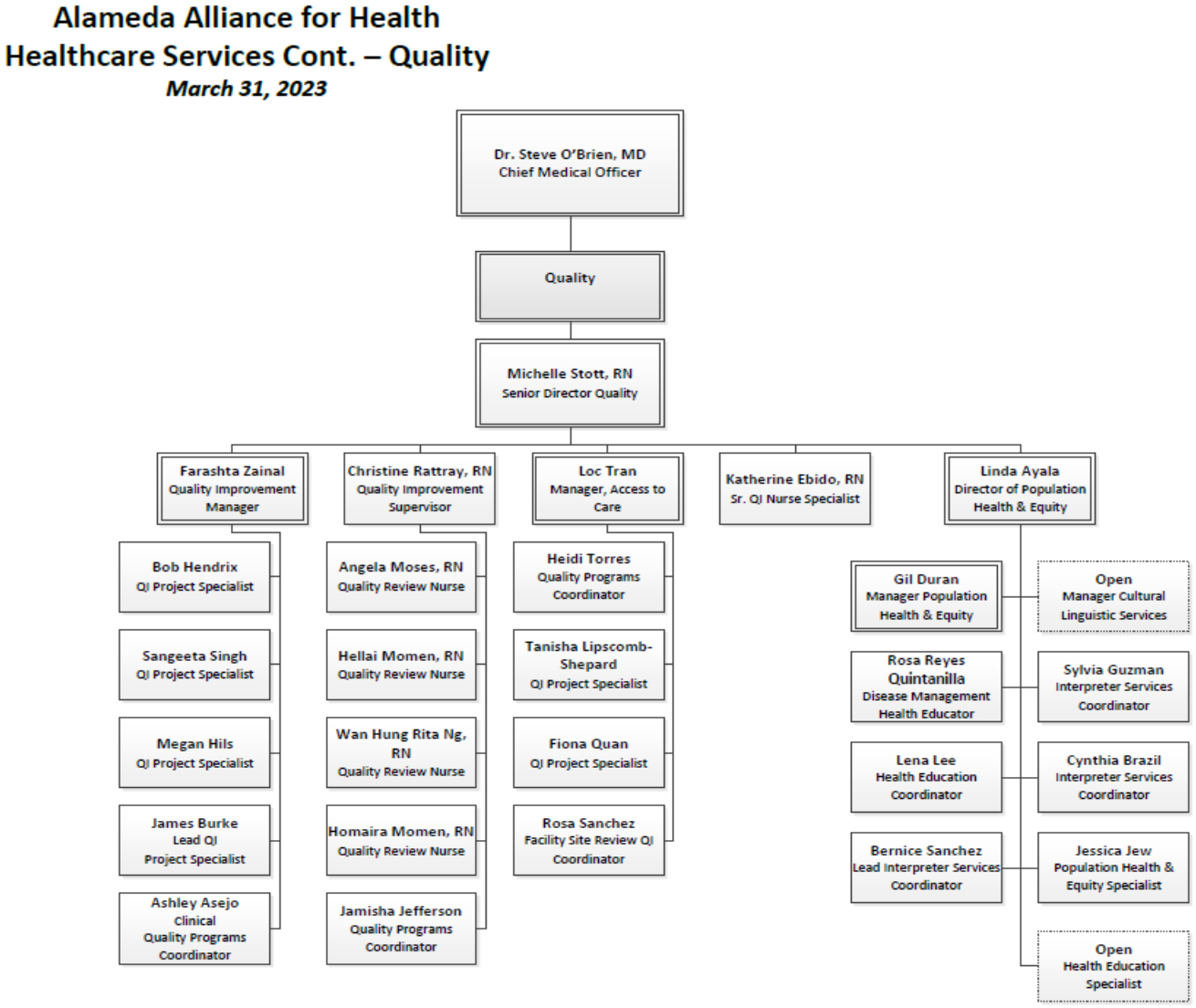
All QI meeting materials and minutes are marked with the statement "Confidential". Copies of QI meeting documents and other QI data are maintained separately and secured to ensure strict confidentiality.

APPENDIX A: Organizational Charts

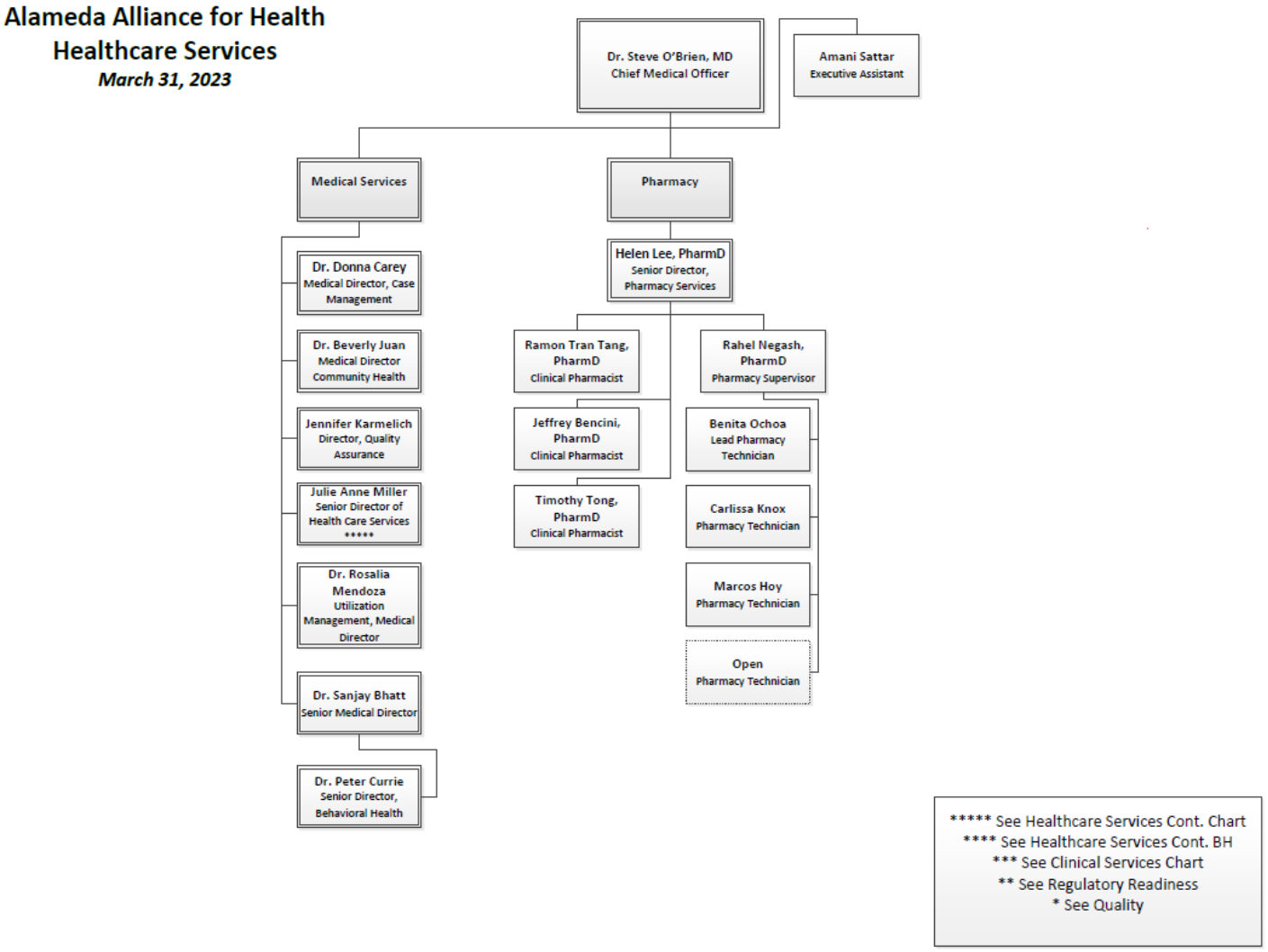
Senior Management



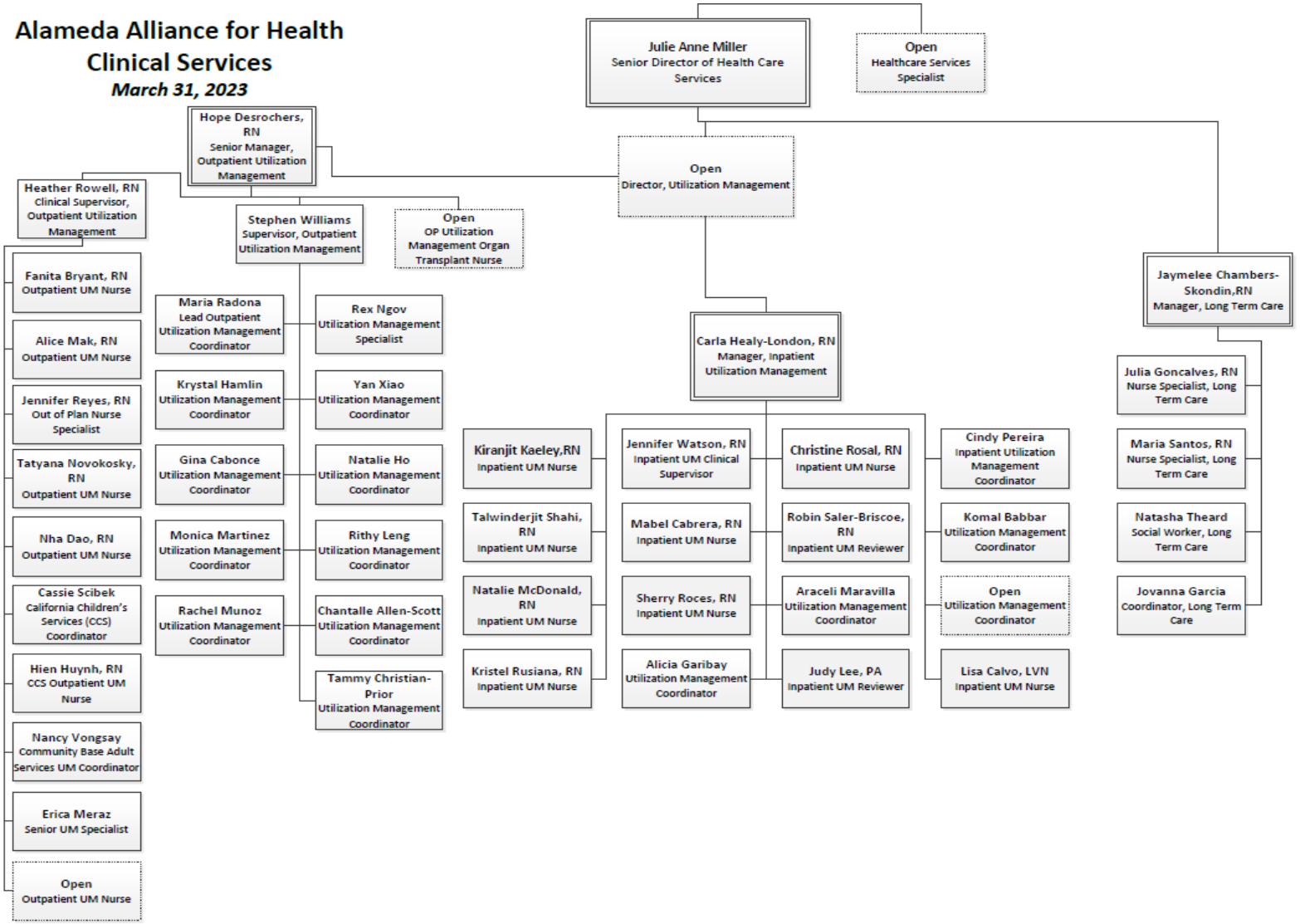
Health Care Services



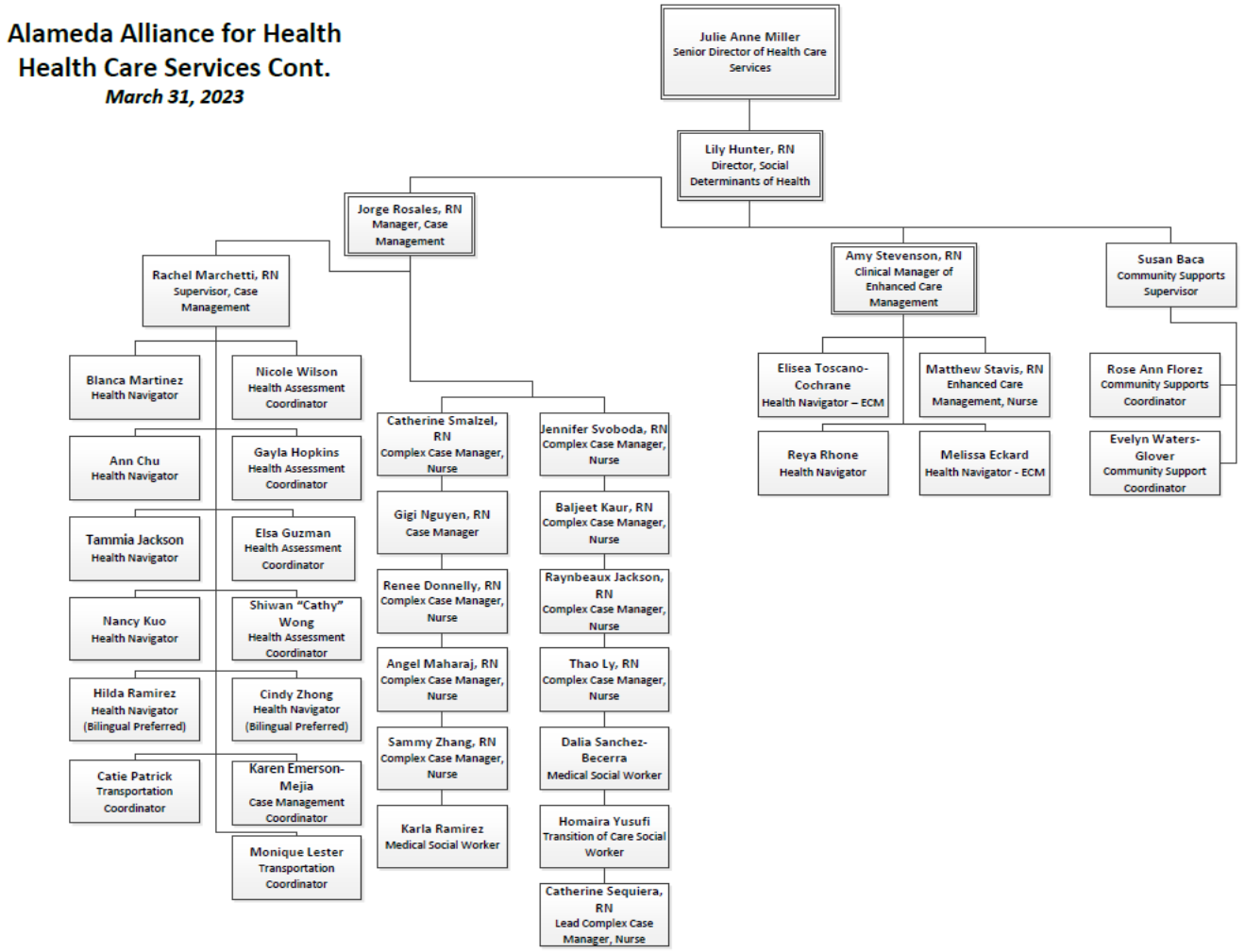
Medical Services and Pharmacy



Utilization Management

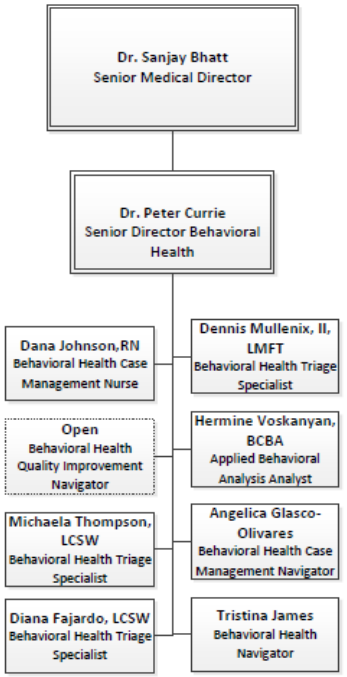


Case Management

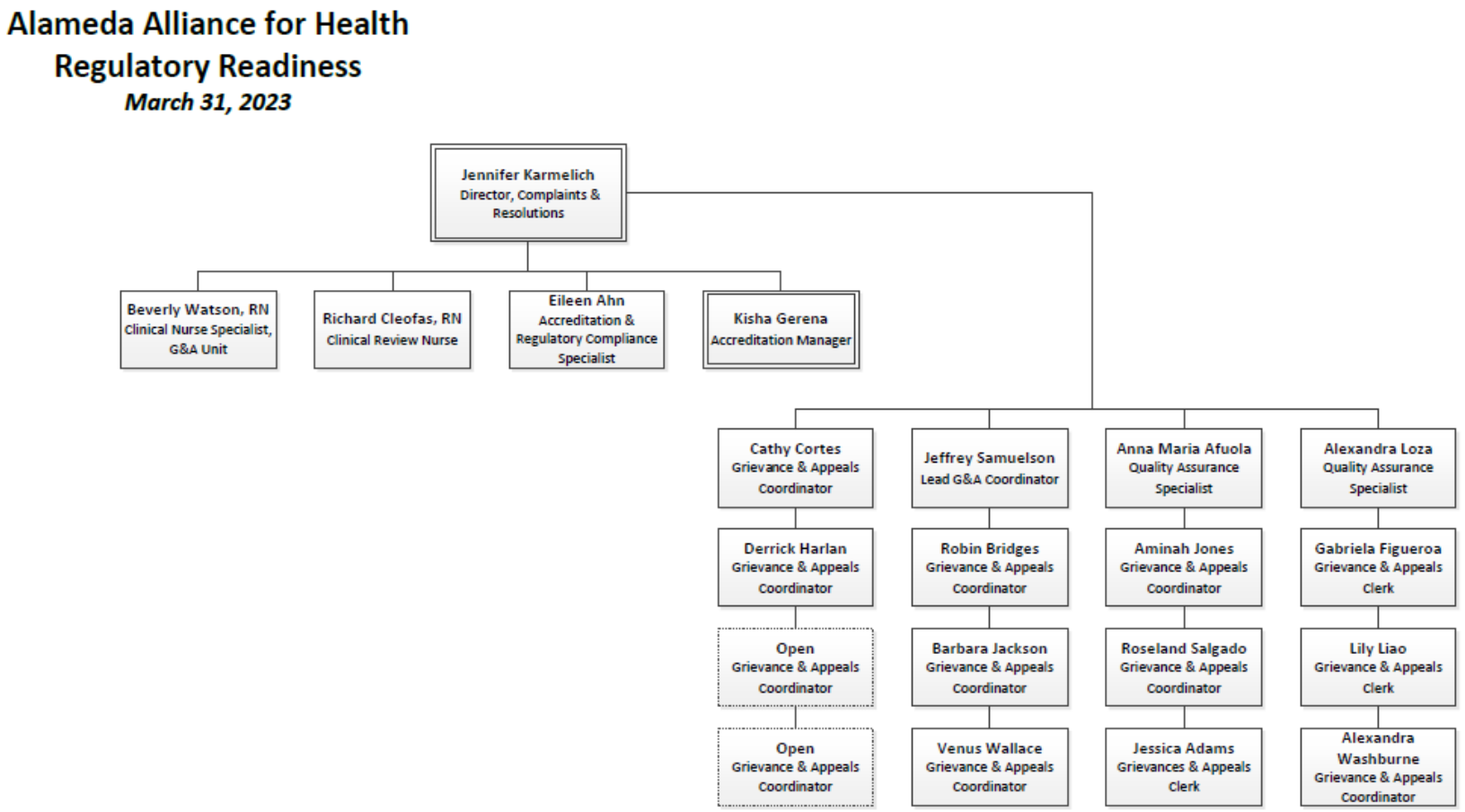


Behavioral Health

Alameda Alliance for Health
Behavioral Health
March 31, 2023



Regulatory Readiness



APPENDIX B: Alameda Alliance Committees