Quality Improvement Health Equity Committee

4/19/2024

Committee Member Name and Title	Specialty	Present
Donna Carey MD, Interim Chief Medical Officer, Alameda Alliance for Health		X
Lao Paul Vang, Chief Health Equity Officer, Alameda Alliance for Health		X
Sanjay Bhatt, Senior Medical Director, Quality & Behavioral Health, Alameda Alliance for Health, Emergency Medicine		X
Aaron Chapman, MD, Medical Director, Alameda County Behavioral Health Care Services	Psychiatry	X
Tri Do, MD, Interim Chief Medical Officer, Community Health Center Network	Internal Medicine	
Felicia Tornabene, MD, Chief Medical Officer, Alameda Health Systems	Internal Medicine	X
James Florey, MD, Chief Medical Officer, Children First Medical Group	Pediatrician	X
Rosalia Mendoza, MD Medical Director, Utilization Management, Alameda Alliance for Health, Family Practice		X
Peter Currie, Ph.D. Senior Director, Behavioral Health, Alameda Alliance for Health		
Michelle Stott, Senior Director, Quality, Alameda Alliance for Health		X

Staff Member Name and Title	Present
Ashley Asejo, Clinical Quality Programs Coordinator	X
Kalkidan Asrat, Quality Improvement Project Specialist II	X
Linda Ayala, Director of Population Health and Equity	X
James Burke, Lead Quality Improvement Project Specialist	X
Rosa Carrodus, Disease Management Health Educator	X
Tiffany Cheang, Chief Analytics Officer	X
Andrea DeRochi, Behavioral Health Manager	X
Gil Duran, Manager, Population, Health and Equity	
Kathy Ebido, Senior Quality Improvement Nurse Specialist	X
Michelle Findlater, Director, Utilization Management	X
Kisha Gerena, Accreditation Manager	

Kimberly Glasby, Director, Long Term Services and Supports	X
Richard Golfin III, Chief Compliance Officer & Chief Privacy Officer	X
Sanya Grewal, Healthcare Services Specialist	
Bob Hendrix, Quality Improvement Project Specialist I	
Megan Hils, Quality Improvement Project Specialist I	
Lily Hunter, Director, Social Determinants of Health	X
Jessica Jew, Population Health and Equity Specialist	X
Shatae Jones, Director Housing & Community Services Program	X
Beverly Juan, Medical Director Community Health	X
Jennifer Karmelich, Director, Quality Assurance	X
Allison Lam, Senior Director, Health Care Services	X
Helen Lee, Senior Director Pharmacy Services	
Homaira Momen, Quality Review Nurse	X
Angela Moses, Quality Review Nurse	
Fiona Quan, Quality Improvement Project Specialist I	X
Christine Rattray, Quality Improvement Supervisor	X
Sangeeta Singh, Quality Improvement Project Specialist I	X
Grace St. Clair, Director, Compliance & Special Investigations	
Yemaya Teague, Senior Analyst of Health Equity	X
Loc Tran, Manager, Access to Care	X
Matthew Woodruff, Chief Executive Officer	X
Farashta Zainal, Quality Improvement Manager	X
Hellai Momen, Quality Review Nurse	X
Mao Moua	X
Ami Ambu	X
Sarbjit Larb	X
Sean Pepper	X
Community Members in Attendance	

Agenda Item		Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
I.	**Call to Order**	D. Carey	The meeting was called to order at 9:05am		
II.	**Alameda Alliance Updates**	D. Carey	- Dr. Steve O'Brien officially resigned from Alameda Alliance. - Dr. Carey will remain Interim CMO until a permanent CMO is announced. - DHCS Audit is scheduled for Mid-June. Dr. Carey will remain interim CMO during the audit period. - With the transfer of Anthem members, adult expansion and duals the Alliance memberships will continue to increase		
III.	**Chief of Health Equity Updates**	L. Vang	- The Health Equity team is currently in the process of developing a roadmap and developing a strategic committee. - First meetings are scheduled for May and June to begin the initial discussion on how to build the roadmap. - DEI Training Curriculum design in progress. A Committee has been chosen for this process. - First draft completed by summer to be submitted to DHCS for approval by September. - Go-Live for training will begin tentatively January 2025. - We will be holding 2 sessions for senior leadership in preparation for the upcoming initiatives. (May/June)		
IV.	**Committee Member Presentation: Alameda County Behavioral Health**	A. Chapman	**LPS (Lanterman Petris Short) Expansion (5150/5585)** • Expansion over the last 4 years. To expand the number of clinicians that can place individuals in a 5150/5585 hold. • 5585 is a 5150 hold but for individuals under the age of 18. • In the Welfare Institutions Codes, the county Behavioral Health Director may develop procedures for the county's designation and training of professionals who will be designated to perform functions under Section 5150. • In Alameda County, the Board of Supervisors has chosen to hold that authority in terms of making the determination of who in the community other than Peace Officers are able to grant the authority to place 5150/5585 holds. • Alameda County has had one of the highest rates of 5150 holds written per capita historically.		

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		• Up until 2020, Alameda County continued to have one of the highest rates. Majority placed by law enforcement. • Too often what is a medical emergency was being treated as a law enforcement issue. Leading to Emergency Departments and outpatient clinic staff were frustrated with the need to call the police for the placement of the 5150. • With the 2020-2023 LPS Pilot, all community Emergency Departments became designated facilities with trained professional providers. • In 2021, started a Pilot with 5 different partners to train clinicians and designate them to place 5150 holds. Successful Pilot. • 2022, Pilot expanded to any interested clinical treatment program. • 82 non-ACBH staff have been designated from 2021-2023. • Organizations that were designated during that time will retain that designation. • Over time, fewer involuntary holds were placed by law enforcement. "treating a mental health crisis as the medical emergency that it is". • Involuntary holds placed by clinicians were more likely to result in inpatient hospitalization. • Many individuals that may have met criteria for 5150/5585 could be engaged with and diverted to voluntary care to meet their needs. This leads to a reduction in total number of 5150s across the county, • We are working on a pursuit of permanent delegation moving forward and continue to expand designation to additional programs. **<u>Questions/Comments</u>** D. Carey: Even though the designation sunsetted with the end of the public emergency, do the 82 newly designated continue? A. Chapman: Organizations that were designated during that time will continue to have that designation. Clinicians who have done the training to		

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		become designated will retain it. We are looking at SB43 that will expand LPS and 5150s included those with substance use disorders. We are asking the question of what other programs would need to implement the same process. We do not want programs to become dependent on having to call 911 to have someone come to place 5150. It can be traumatizing to patients as well as staff. F. Tornabene: Does the department have access to data on the duration of hold whether they expire at 72 hours or dropped short of that? How did this change impact the duration of these holds? A.Chapman: We likely have some of it. We know how many 5150s turn into 5250s. If someone is discharged sometime in the first 72 hours, it may be harder to get information. F. Tornabene: With the decrease of the number of patients who have been put on an initial hold, and converted to 5250, has rate of 5250 increased?? A.Chapman: What we do know is that conversion from a psychiatric emergency room to an inpatients setting has increased. LP. Vang: In the data which states that law enforcements place a lot more involuntary holds than clinicians, are we saying that this is happening without probable cause? If so, what are we doing about that? A.Chapman: Technically, when someone in the community places someone on a 5150 hold that is a transportation order to get that person from where they are to the psychiatric facility. Technically, the hold is not official until a clinician at the facility confirms. It is likely that a number of police order may not meet the criteria. They are turned around and discharged the same day. S. Jones: Can you share how you have invited housing and supportive services to the table for this conversation?		

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		A.Chapman: In part of those pilot partners identified as interested in working with us includes a diversity in the types of providers we partnered with. (Peds, adult, mental health treatment programs). Any program with a licensed BH clinicians can approach us and be considered for designation. Who is staffing the particular programs, if there are MFT, Psych, Nurses, MDs, those are the programs that we would consider for designation. S. Bhatt: Often, police or various folks are bringing patients in to the ED on 5150s when they may be intoxicated and after time, sober up. Are there thoughts on providers dropping 5150s in these cases or expanding telehealth or in-person psych visits to evaluate the validity of the 5150? A.Chapman: Another part of this pilot was not only to designate certain staff in community Emergency Departments on the placement of 5150/5585s but to also designate the Emergency room physicians with consultation from a psychiatrist who can drop a 5150 in an emergency department without having to send the patient to another psychiatric facility.		
V. Policies & Procedures	D. Carey	Policies & Procedures packet was sent out prior to QIHEC for committee review. • QI-107: Appointment Access and Availability Standards • QI-108: Access to Behavioral Health Services • QI-114: Monitoring of Access and Availability Standards • QI-115: Access and Availability Committee • QI-116: Provider Appointment Availability Survey (PAAS) • QI-117: Member Satisfaction Survey (CAHPS) • QI-118: Provider Satisfaction Survey • QI-133: Inter-Rater Reliability Testing for Clinical Decision Making • HED-010:Doula Services • CM-XXX: Prescreening Process - ECM and CS Providers • CM-002: Complex Case Management Plan Development and Management	Move to Approve: 1st: F. Tornabene 2nd: A. Chapman	

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		• CM-003: Complex Case Management Plan Evaluation and Closure • CM-005: Disease Management Programs • CM-006: Internal Audit and Monitoring • CM-007: SPD High Risk Stratification and Care Planning • CM-019: Private Duty Nursing Case Management For Members under the age of 21 • CM-028: Disease Management - Home Placed Developmentally Disabled HPDD Members • CM-030: Early Start • CM-031: School Linked CHDP Services • CM-032: Care Coordination - Local Education Agency Services • LTC-004: LTC Bed Hold and Leave of Absence • UM-057: Authorization Service Request • UM-058: Continuity of Care for New Enrollees Transitioned to Managed Care After Receiving a Medical ExemptionBH-001: Behavioral Health Services		
VI. Meeting Minutes	D. Carey	Meeting Minutes packet was sent out prior to QIHEC for committee review. • QIHEC- 2/16/2024 • UMC- 3/22/2024 • IQIC-3/20/2024 • CLSS-1/24/2024 • A&A-3/6/2024 • MAC-12/14/2023 • CAC - 12/28/2023	Move to Approve: 1st: F. Tornabene 2nd: J. Florey	
VII. QIHE Program Description, Evaluation & Workplan	M. Stott F. Zainal L. Tran C. Rattray G. Duran M. Moua L. Ayala	• The Quality Improvement Health Equity Program is designed to monitor, evaluate and take effective action on any needed improvement of the quality of care for our members. • Trilogy Documents are a way for us to communicate all activities. • There are 5 areas of focus in the evaluation workplan (Quality of Care, Quality of Service, Safety, Member Experience & Access, Population Health)	Move to Approve: 1st: J. Florey 2nd: A. Chapman	

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		QI Activities Update • F. Zainal went over the 2023 Preliminary HEDIS Rates. • Final rates will be submitted and presented in the next QIHEC. • Behavioral Health: Currently below MPL on both measures. However, we are still pending data from the county. Rates have improved significantly. We will be above MPL for the FUA measure. • Disease Management: Below MPL for Controlling High Blood Pressure. This is a hybrid Measure. • HEDIS team is currently doing chart review for Hybrid Measures. • Children's Domain: Below MPL on Lead screening and topical fluoride. • We are above MPL on all Women's Health measures. • We had 2 State Mandated QI Projects. One being the 2023-2026 Equity Performance Improvement Project (PIP) for well child visits in the first 15 months of life for African American Children. Another is the 2023-2023 Non-Clinical Performance Improvement Project(PIP) to improve the percentage of Provider Notification for Members with SUD/SMH Diagnosis following or within 7 days of an emergency department visit. • A number of activities were done in 2023 to help improve our HEDIS rates. The QI team has done many outreach, education and incentive projects. Many of which were member focused. • Established QI Meetings and webinars for providers. • Provider incentive programs (P4P) • Worked with providers on actionable care gap reports. • Big focus on receiving supplemental data from our providers. • Removed members who had other health insurance to help improve our numbers. • We were able to match mom and newborn medical records to well visits. • In 2024 QIHE Plan Focus consists of the P4P Program, the newly launched Health Equity Incentive Pilot to improve some of our		

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		measures for particular ethnicities. Also, continue the multidisciplinary workgroups. We started utilizing practice facilitation to work alongside our frontline staff to improve rates as well as work with providers to improve coding. • Access is also at the forefront of our work. • R. Mendosa: In terms of residual gaps that we are trying to close with the Pediatric measures, is this still an access issue to render these services? Or a documentation issue that we are still trying to optimize with data/claims? What options are we exploring? • F. Zainal: In general, we are seeing that there is enough access for pediatric members. I have heard in terms of dental, there is just not enough dental providers to see children. The State only pays up to age 5 for PCPs to provide fluoride but the measure is up to age 20. We are also looking at coding to see if we are receiving accurate data from the state. Lead screening is requiring member to go get the labs done. We are working to with provider to get point of care testing to avoid second visits. • R. Mendoza: We know with dental, we do not have enough dental visits alone to meet the criteria. It will require finding interested clinics to provide fluoride varnish in the primary care setting to meet the measure. We may want to look at the clinics that are not currently submitting claims to both medi and denta -cal to see if we are capturing the claims data. • M. Stott: For the question on access, there are a few incentives that we have modified for P4P to ensure that we emphasize PCP visits. Most of the points are allocated to PCP visit utilization . Extended hours are continuing as well, and a new incentive for Initial Health Appointments. • J. Florey: Are we working on a mechanism that the Denti Cal provider and the PCP will know that each are delivering the fluoride? PCPs do not know if services are already scheduled. • R. Mendoza: for those FQHC Dental Clinics that are using Epic, they do have complete visibility to know when those fluoride varnishes		

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		are being applied. It is safe to apply up to 3 times a year. Some children withing the 0-3 window receive fluoride at WIC or Head Start. • M. Woodruff: DHCS may take topical fluoride off as a quality measure. We are hoping that they move quickly due to discrepancy in payments. <u>Potential Quality Issues (PQI)</u> • Total of 9,077 cases that were referred to Quality for review. Of those there were 4 classifications (Quality of Service, Quality of Access, Quality of Care, Quality of Language) • Dr. Bhatt reviews the final leveling for Quality of Care cases at our weekly reviews. • Quality of Service issues are handled by our RNs and G&A along with standard grievances. • Quality of Service issues made up the most number of issues, followed by access issues. Quality of Care represents the most intensive work we do in terms of investigation and resolution. • Increase in PQIs coming in as of January due to the increase in the membership. • Total of 18 PQI Corrective Action Plans for 2023. The highest being Highland Hospital followed by Modivcare. • Our focus for 2024 will be to continue to monitor clinical safety of PQIs, Substance use disorder, facility site review and Integrated reliability. • We will implement quality monitoring processes for Skilled Nursing Facilities and Long Term Care Facilities.		

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		Member Experience & Access **MY 2022 Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.1H Survey** • Measures how well plans meet member's expectations and goals. • Medi Cal Child Trended Survey Results:		

Summary Rate Scores: Medi-Cal Child

	2022 QC %	MY2022	Previous Year Comparison	MY2021	MY2020
Getting Needed Care (% Always or Usually)	84.2%	79.2%	↑	78.4%	82.2%
Getting Care Quickly (% Always or Usually)	86.7%	73.0%	↓	77.8%	78.8%

- Medi Cal Adult Trended Survey Results:

Summary Rate Scores: Medi-Cal Adult

	2022 QC %	MY2022	Previous Year Comparison	MY2021	MY2020
Getting Needed Care (% Always or Usually)	81.9%	75.2%	↓	75.9%	79.0%
Getting Care Quickly (% Aways or Usually)	80.2%	72.9%	↓	75.9%	72.4%

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		• Commercial Adult Trended Survey Results **Summary Rate Scores: Commercial Adult** **2022 QC %** / **MY2022** / **Previous Year Comparison** / **MY2021** / **MY2020** **Getting Needed Care (% Always or Usually)**: 83.8% / 72.0% / ↑ / 65.8% / 75.2% **Getting Care Quickly (% Always or Usually)**: 82.6% / 56.0% / ↓ / 62.0% / 71.1% **Provider Appointment Availability Survey (PAAS) MY2022** • Ancilary non-urgent appointment score: 83.3% • PCP Urgent: 51.7% Non-Urgent: 70.0% • Non-Physician Mental Health Urgent: 75.3% Non-Urgent: 87.6% • Psychiatrists Urgent: 57.8% Non-Urgent: 85.2% • Specialists Urgent: 46.3% Non-Urgent: 57.1% **First Prenatal visit Survey MY 2023** • 75.9%. Significant increase from 202 • 2024 Workplan focus is to discuss and develop improvement strategies with internal stakeholders. • Encourage providers in approaches toward open access scheduling. Allow a portion of each day for urgent care and/or follow up visits. • Continue provider education and on-site office visits to providers not meeting Timely Access year over year. • Include Access related measures in 2024 P4P.		

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		• D Carey: On the trending survey results, we see a discrepancy in terms of race and ethnicity. What type of follow up do we do in getting to the root reasoning to that discrepancy? • L. Tran: This is the first year that we are looking at how our members rate us based off ethnicity. We are looking to create a member-facing document on timely access standards to promote and educate members to increase in access rate. We are in the process of analyzing the data. • J. Florey: Do you have data about the members who felt that they didn't have adequate access to care? Asian ethnicities seem to pop up a lot. My concern is this a lack of capacity at Asian Health that's driving our metrics or whether practices that are predominantly Asian also have an access problem? • L. Tran: Based off of our appointment availability survey and when we meet with our providers, most of the time, the providers indicate shortage of staff/providers and high turnover. We are asking providers to promote telehealth and communicate with us if they are having capacity issues so that way we can assign members appropriately. <u>Population Health Management</u> • A lot of the focus was to bolster our strategy and incorporate revisions from DHCS within our PHM strategy work but also evaluating and monitoring our PHM process. • There was a big focus on Diabetes Prevention and Maternal Mental Health within our Health Education Program. • Health Education Programs include Asthma, Diabetes, Depression and Hypertension programs from Disease Management in collaboration with our Case management team. • Submitted the complete Population Health Management Strategy for 2023 and submitted it to DHCS which was approved.		

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<tr><th>Agenda Item</th><th>Responsible Person</th><th>Discussion</th><th>Vote</th><th>Action Items (High, Medium, Low)</th></tr>
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State is requesting AAH to work with Alameda County and the City of Berkeley to develop shared goals and meaningful participation in their Community Health Assessment and Community Health Improvement Plans.
Developing monitoring and key performance indicators and submitting those to the State.

2023 PHM Strategy Programs
<table>
<tr><th>Strategic Pillars</th><th>2023 Programs</th></tr>
<tr><td>Address primary care gaps and inequities</td><td>• Non-utilizer outreach campaigns
• Breast cancer screening - Equity
• Under 30 months well visits – Equity</td></tr>
<tr><td>Support members managing health conditions</td><td>• Hypertension & diabetes disease management
• Maternal mental health
• Follow-up after ED visit for mental illness and substance use</td></tr>
<tr><td>Connect members in need to whole person care</td><td>• Transitional Care Services
• Catastrophic case management
• California Children’s Services (CCS) referrals</td></tr>
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In Health Education, we launched Diabetes Prevention Programs with Yumlish and HabitNu. The Maternal Mental Health workgroup met to define guidelines for providers, workflows and a program outreach strategy.
In Disease Management, we launched campaigns for diabetes and asthma as well as offered health coaching for members with diabetes.
For 2024, our workplan focus will be working on our 2024 Strategy, continuing our work with Alameda County and The City of Berkeley

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		as well as expanding and monitoring our population health programs. • For Health Education we will continue to launch doula efforts, maternal and child health equity programs and continue to support Disease Management populations with closing care gaps. <u>Cultural and Linguistics Services</u> • Services focused on interpreter services, member satisfaction, community engagement and input, provider language capacity and Cultural Sensitivity Training. • In 2023, Interpreter utilization increased for all modalities (telephonic, in-person, video). Vendors provided over 57,000 interpreter services in 112 languages. • Increase in favorable responses on the member satisfaction survey. • Began work on the 2024 requirements for the new Community Advisory Committee (CAC). • 100% Attendance for our Cultural Sensitivity Training. • Some 2023 focus areas were carried on into 2024 such as monitoring our fulfillment rates, continue to review provider language capacity, and continuing to monitor member satisfaction for interpreter service rates. • Continue implementation of the 2024 newly added requirements for CAC. • Added new focus areas such as tracking interpreter services for utilization around Behavioral Health services, analyzing results for the Timely Access Requirements Survey. The following is a summary of the 2024 QIHE Workplan based on the 2023 QIHE Program Evaluation and recommended activities. In 2024, there are regulatory activities, including DSNP, NCQA Accreditation, and audit preparation for DMHC and DHCS.		

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		Quality Improvement Health Equity Workplan **Quality of Care & Service** ▸ Annual QIHE Program Evaluation ▸ Increase HEDIS Rates MY 2024 to meet/exceed minimum performance level (MPLs) ▸ Pay for Performance: webinars and joint meetings with delegates/directs ▸ Health Equity Incentive Pilot (New) ▸ QI PDSA Cycle Training ▸ Performance Improvement Projects: → Priority PIP: Follow Up After Emergency Department Visit for Mental Illness/substance use (FUA/FUM) → Equity PIP: Improve Well Child (W15) for African Americans ▸ Workgroups & Projects: Meet/Exceed MPLs for Women's Health, Well-Child, Chronic Disease Management, Behavioral Health (New: initiatives for quality monitoring). ▸ Engagement outreach program (New) ▸ Provider trainings on HEDIS measures ▸ Non/Under Utilization Outreach ▸ Increase Initial Health Appointment rates **Safety** ▸ Potential Quality Issue turn around time (≥95%) within 120 days, annual training, and inter-rater reliability audits ▸ Exempt Grievances Auditing ▸ 100% Corrective Action Plan closure within 30 days for Facility Site Reviews ▸ Skilled Nursing Facility/Long Term Care Quality Monitoring (i.e. attestation, site visit audit tool, quality measures) (New) **Member Experience** ▸ Provider and member education for Opioid/SUD ▸ Access to Care (meet/exceed timely access standard goals) ▸ Provider Satisfaction Survey ▸ Member Satisfaction Survey ▸ Provider visits and Training (New) **Population Health/Health Ed/Cultural & Linguistic** ▸ Population Health Management: DHCS Readiness, Health Equity NCQA Readiness, KPIs, PHM Strategy/Evaluation, Population Assessment, DEI Strategic Framework ▸ Health Education Programs: Maternal Mental Health, Health Education Program Description, Asthma, Diabetes, Heart Disease (New) ▸ Cultural & Linguistics (CLS) Assessment, Language Assistance Services, (BH: New), Provider Language Capacity, CLS training, Community Advisory Committee, Timely Access Survey – interpreter (New), PQI-QOLs (New)		
VIII. CM Program Description, Evaluation & Work Plan	L. Hunter A. DeRochi	<u>Case Management Program Evaluation</u> • 2023 Alliance Delegated Network: Kaiser is fully delegated for Care Coordination and Complex Case Management. CHCN is delegated for Care Coordination only. • Case Management offers basic population and health management (formerly basic case management). This includes care coordination management and disease management programs. • We also offer complex case management (Kaiser fully delegated) • Specialty programs such as Transitional Caser Management, Enhanced Care Management (ECM) and Community Supports Services.	Move to Approve: 1st: J. Florey 2nd: A. Chapman	

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		• Majority of referrals come from the Case/Disease Management internally. Majority of individuals were able to complete the program. • Transitional Care service was a new regulatory requirements as of January 2023 which contained High-risk members only and brought in 3586 new cases. • For ECM, we went from 1,509 members in 2022 to 2,501 in 2023 with 36 ECM sites from 24 in 2022. • The preliminary trends show that there is a possible improvement in hospital utilization. Further data validation is in progress. • A lot of growth in Community Supports Services. In 2023 we added Personal Care & Homemaker Services, Caregiver Respite Services and Home Modifications. • In 2023 we only had DHCS with no adverse findings from any of the 2023 audits. • Health Risk Assessments (HRA): Outreach to seniors and persons with disabilities. It goes out to anyone who is newly enrolled or had a gap in coverage for 6 months or more and will receive this questionnaire annually. • Interdisciplinary rounds (IDT): every complex case that is open for more than 90 days need to be reviewed at the bi-weekly IDT Rounds. A daily aging report notifies us of cases that have been open for 60 days or more. All 18 cases presented timely. • Transportation: 2023 was the start for a full year of the CM team acquiring this. We ended 2023 with an 88% compliance rate. • 2023 Delegated Annual Audit Results: In 2023, Kaiser was full delegated for CM and Complex CM. CHCN had 1 finding and re-training was addressed.		

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		Behavioral Health • In-source began in April 2023. • The State requires that we complete a mental health screening tool which determines which system of care the member is expected to receive care. • Care coordination referrals continue to rise. We usually see a seasonal variation when school starts. 2024 Case Management Program Description • In 2023, the CM program continued programs from 2022 and is expanding into 2024. This includes: – Insourcing Behavioral Health – Transitional Care Services changed to cover every one transitioning from one level of care to another. – Brought in more populations of focus in 2024 with plans to further expand. – Additional community support services. – Continue management of transportation services benefit. • Redesigning the CM program to focus on key CM activities and monitoring through UMC and QIHEC. • Expand ECM and CS network of providers. • Enhancing transportation benefit oversight.		
IX. UM Program Description, Evaluation & Work Plan	M. Findlater	UM Program Evaluation 2023 • UM Combined Inpatient & Outpatient Authorization TAT benchmark is 95%. We exceeded that benchmark in 2022 and 2023 with a consistent year-over-year trend above 95%. • Denial Rates: Inpatient denial rate – 1.9% outpatient – 3.1% • Combined all denial rates for all networks was 2.5% • ER Visits for 2023 averaging 525 visits fer 1000 across all networks. CFMG had the lowest ER utilization and AHS is the highest. • Average length of stay: decrease -0.05% compared to 2022.	Move to Approve: 1st: A. Chapman 2nd: J. Florey	

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		• Readmission's goal is 18%. We are above the goal (20.1%) and will re-think what an appropriate benchmark would be moving forward. • Overall readmission rates were 20.1% in 2023 (higher than the 18% benchmark) AHS, Alliance and CHCN rates are similar. • Barriers identified were issues due to primary care providers and establishing follow ups after visit which led to readmissions (AHS). • R. Mendoza: One of our main drivers are heart failure, cardio myopathy and sepsis. We have seen higher readmission rates with certain populations such as long-term care members and seniors/persons with disabilities and dual members. We will be closely monitoring these trends of readmissions in 2024. <u>Long Term Care</u> • New benefit for the Alliance in 2023. Turnaround times did not meet the 95% goal in 2023 with an overall compliance of 68% for the year. This is due to an increased volume of long-term care. All issues have been addressed. We have reached the goal in QI 2024. • 2023 there was a monthly average of 90 ER visits per month with peaks in July, September and October. Top 3 reasons being surgical complications, contusions, and other conditions and injuries due to external causes. • In 2024, LTC will be collaborating with QI to develop quality performance measures for LTC facilities. The goal is to prevent unnecessary/avoidable ER visits. • For 2023 the number of acute admissions were consistent. Average 85 per month. Average length of stay was 6.25 days. • UM Provider Satisfaction: All scores were well above the benchmark of 35%. All scores were lower in comparison to 2022. <u>Behavioral Health</u> • Increase in authorizations from 94 in April to 355 in December.		

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		• Turnaround times need improvement, TAT will continue to be tracked and trended. Denial rates are low as AAH seeks to engage members in appropriate care. <u>UM Program Description 2024</u> • Notable changes include the carve in of Sub Acute and Intermittent Care Facilities for the Developmentally Disabled, insourcing Behavioral Health. Transitional Care Services for ALL Members. • We want to continue to collaborate with our delegates to enhance oversight for all regulatory processes.		
X. Initial Health Appointment	F. Zainal	Deferred to May QIHEC Meeting		
XI. NCQA Update	J. Karmelich	Deferred to May QIHEC Meeting		
XII. Community Advisory Committee Update	L. Ayala	• Community Advisory Committee (CAC) was previously named the Member Advisory Committee (MAC). • Overall efforts is to take into account the valued input of our members and community advisors. • Once a year we will be reporting out some of the major inputs from members. • Selection Committee: Requirement by DHCS. “The committee that will create the committee”; Intent is to make sure community leaders have input and to help find informative members.		
XIII. Public Comment	D. Carey	None		
XIV. Meeting Adjournment	D. Carey			

X_____ <click to insert a date>
Dr. Donna Carey
Interim Chief Medical Officer
Chair

Minutes prepared by: Ashley Asejo - Clinical Quality Programs Coordinator