ALAMEDA Alliance FOR HEALTH

Health care you can count on.
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Quality Improvement Program
Program Evaluation

2018

2018 Quality Improvement Program Evaluation
Signature Page

Date 5/7/19

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INTRODUCTION

Alameda Alliance for Health (Alliance) is a public, not-for-profit managed care health plan committed to making high-quality health care services accessible and affordable to citizens most in need in Alameda County. Established in January 1996, the Alliance was created by the Alameda County Board of Supervisors for Alameda County residents and reflects the cultural and linguistic diversity of the community.

Under the leadership and strategic direction established by Alameda Alliance for Health (The Alliance) Board of Directors, senior management and the Health Care Quality Committee (HCQC), the Health Services 2018 Quality Improvement Program was successfully implemented. This report serves as the annual evaluation of the effectiveness of the program activities.

The processes and data reported covers activities conducted from January 1, 2018 through December 31, 2018.

Membership and Provider Network

The Alliance products include Medi-Cal Manage Care beneficiaries eligible thorough one of several Medi-Cal programs, e.g. TANF, SPD, Medi-Cal Expansion and Dually Eligible Medi-Cal members who do not participate in California's Coordinated Care Initiative (CCI). For dually eligible beneficiaries, Medicare remains the primary insurance and Medi-Cal benefits are coordinated with the Medicare provider.

Alliance Group Care is an employer-sponsored plan services by The Alliance that provides low cost comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County. The Alliance provides services to IHSS workers through the commercial product, Group Care.

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Current Membership by Network By Category of Aid

Category of Aid	Dec 2018	% Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN	KAISER
ADULTS	35,559	14%	9,163	6,892	351	13,447	5,706
CHILD	95,322	37%	9,459	8,355	29,880	31,404	16,224
SPD	26,006	10%	8,918	3,576	1,350	10,309	1,853
MCE	85,345	33%	15,620	27,478	929	32,656	8,662
DUALS	16,072	6%	6,297	1,812	10	6,167	1,786
Medi-Cal	258,304		48,457	48,113	32,520	93,983	34,231
Group Care	5,886		2,695	760	0	2,431	0
Total	264,190	100%	52,152	48,873	32,520	96,414	34,231
Medi-Cal %	97.8%		94.8%	95.4%	100.0%	97.5%	100.0%
Group Care %	2.2%		5.2%	1.6%	0.0%	2.5%	0.0%
	Network Distribution		*19.7%*	*18.5%*	*12.3%*	*36.5%*	*13.0%*
			% Direct:	38%		% Delegated:	62%

Age Category Trend

	Members			
Age Category	Dec 2016	Dec 2017	Nov 2018	Dec 2018
Under 19	101,385	103,264	98,950	98,122
19 - 44	86,207	87,080	84,900	84,868
45 - 64	59,141	58,915	57,493	57,340
65+	20,317	22,538	23,789	23,862
Total	267,050	271,797	265,132	264,190

In 2018, the Alliance membership remained relatively steady, as seen in Figure 1. Compared to 2017, the Alliance lost a small number of members in 2018, (271,797 to 264,190) from the Adult and Child members.

Medical services are provided to beneficiaries through one of the contracted provider network. Currently, The Alliance provider network includes:

Provider Network	Provider Type	Members (Enrollment)	% of Enrollment to Network
Independent (Direct)	Independent	52,152	19.7%
Alliance Health Systems	Managed Care Organization	48,873	18.5%
Children First Medical Group (CFMG)	Medical Group	32,520	12.3%
Community Health Clinic Network (CHCN)	Medical Group	96,414	36.5%
KAISER	HMO	34,231	13.0%
Total		**264,190**	**100.0%**

Figure 2 Provider Network by Type, Enrollment and Percentage

From 2017 to 2018, the percentage of members within each network has remained steady.

The Alliance offers a comprehensive health care delivery system, including the following scope of services:

- Ambulatory care
- Hospital care
- Emergency services
- Behavioral health (mental health and addiction medicine)
- Home health care
- Hospice
- Palliative Care
- Rehabilitation services
- Skilled nursing services - Skilled
- Managed long term services and support (MLTSS)
    - Community based adult services
    - Long Term SNF Care (limited)
- Transportation
- Pharmacy
- Care coordination along the continuum of care including arrangements for linked and carved out services, programs, and agencies.

These services are provided through a contracted network of providers that include a hospitals, nursing facilities, ancillary providers and contracted vendors. The providers are responsible for identified services through contractual arrangements and delegation agreements.

The Alliance provider network includes:

The Alliance Ancillary Network	
Hospitals	15
Behavioral Health Network	1
DME Vendor	1
Transportation Vendor	1
Pharmacies/Pharmacy Benefit Manager	Over 200
Radiology Consulting Services	1

Figure 3: Alliance Ancillary Network

Alliance members may choose from a network of over 550 primary care practitioners (PCPs), 6000 specialists, 17 hospitals, 73 health centers, 52 nursing facilities and more than 200 pharmacies throughout Alameda County. The Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan members. Our members' optimal health is always our first priority.

The Alliance Quality Improvement (QI) Program strives to ensure that members have access to quality health care services.

PURPOSE

The Alliance evaluates its QI Program annually to determine the overall effectiveness in meeting the goals and objectives of the QI Program and Work Plan, identifying improvement opportunities, and assessing progress toward improved network practices. The evaluation includes input from multiple departments. The Alliance uses the annual evaluation to identify goals, objectives, and activities for the QI Program in the coming year.

This evaluation assesses the following elements:

- Effectiveness of the QI structure;
- Overall effectiveness of the QI program;
- Completed and ongoing QI activities;
- Performance measure trends;
- Analysis of QI initiatives and barriers to improvement;
- Delegated entities' performance

The annual QI Program Evaluation is reviewed and approved by the Health Care Quality Committee (HCQC) prior to being submitted for review and approval by the BOG. The HCQC and the BOG also review and approve the QI Program Description and Work Plan for the upcoming year.

QI STRUCTURE AND RESOURCES

A. QI Structure

The structure of the QI Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate use of The Alliance health care delivery network. Additionally, the structure is designed to enhance communication and collaboration on QI issues that affect entities and multiple disciplines within the organization. The QI Program is evaluated on an on-going basis for efficacy and appropriateness of content by The Alliance staff and oversight committees.

B. Governing Committee

The Alameda County Board of Supervisors appoints the Board of Governors (BOG) of the Alliance, a 12-member body representing provider and community partner stakeholders. The BOG is the final decision making authority for all aspects of The Alliance programs and is responsible for approving the Quality Improvement Programs. The Board of Governors delegates oversight of Quality functions to The Alliance Chief Medical Officer (CMO) and the Health Care Quality Committee (HCQC) and provides the authority, direction, guidance and resources to enable Alliance staff to carry out the QI Program. QI oversight is the responsibility of the HCQC.

The HCQC recommends policy decisions, analyzes and evaluates the Quality Improvement, Utilization Management (UM) and Case Management Work Plan activities. HCQC also assesses the overall effectiveness of the QI, UM and CM Programs. The HCQC met a total of 7 times in 2018:

- January 4, 2018
- March 1, 2018
- April 12, 2018
- May 3, 2018
- July 19, 2018
- September 6, 2018
- November 15, 2018

C. Committee Structure

The Board of Governors appoints and oversees the HCQC and the Peer Review and Credentialing Committee (PRC) which, in turn, provide the authority, direction, guidance, and resources to enable The Alliance staff to carry out the Quality Improvement Programs. Committee membership is made up of provider representatives from The Alliance contracted networks and the community including those who provide health care services to Behavioral Health, Seniors and Persons with Disabilities (SPD) and Chronic Conditions.

The HCQC Committee provides oversight, direction, recommendations, and final approval of the QI Program. Committee meeting minutes are maintained summarizing committee activities and decisions, and are signed and dated.

HCQC charters a sub-committee, the Internal Quality Improvement Sub-Committee (IQIC) which serves as a forum for the Alliance to evaluate current QI activities, processes, and metrics. The IQIC also evaluates the impact of QI programs on other key stakeholders within various departments and when needed, assesses and plans for the implementation of any needed changes. HCQC assumes responsibility for oversight of the IQIC activities and monitoring its areas of accountability as needed. The structure of the committee meetings was redesigned to increase engagement from all participants.

On April 12, 2018, the 2017 QI Program Evaluation was presented to the HCQC and unanimously approved and on May 3, 2018 the 2018 Program Description and Work Plan were both presented to the HCQC and unanimously approved.

The major committees that support the quality and utilization of care and service include the HCQC, Pharmacy and Therapeutics Sub-committee, Utilization Management (UM) Subcommittee, Access and Availability Subcommittee, and Internal Quality Improvement Subcommittee (IQIC). Also, various joint operations meetings (JOMs) support the quality and utilization of care and service. Each committee meets at least quarterly, some monthly, and all committees / sub-committees reports directly to the HCQC. Additionally, the Peer Review and Credentialing Committee supports the quality and utilization of care and service and reports directly to the BOG. Each committee continues to meet the goals set forth in their charters. The HCQC membership includes practitioners, leadership, and staff.

D. **Evaluation of Senior-level Physician and Behavioral Health Practitioners**

The Board of Governors delegates oversight of Quality and Utilization Management functions to the Alliance Chief Medical Officer (CMO). The CMO provides the authority, direction, guidance and resources to enable Alliance staff to carry out the Quality Improvement Program. The CMO delegates senior level physician involvement in appropriate committees to provide clinical expertise and guidance to program development.

During 2018 Dr. Aaron Chapman, a psychiatrist and Medical Director of Alameda County Behavioral Health Care Services (ACBHCS), actively participated in the HCQC meetings and provided clinical input ensuring policies and reports considered behavioral health implications.

The active involvement of senior-level physicians including the psychiatrist from ACBHCS has provided consistent input into the quality program. Their participation helped ensure The Alliance is meeting accreditation and regulatory requirements.

E. **Program Scope and Structure**

The Alliance QI Program encompasses the quality of care across the continuum. QI Program activities include the following but are not limited to:

- Effectiveness of the QI structure;
- Overall effectiveness of the QI program;
- Completed and ongoing QI activities;
- Performance measure trends; and
- Analysis of QI initiatives and barriers to improvement.
- Delegated entities' performance.
- Monitoring and auditing delegated entities QI activities for compliance to contractual requirements with implementation of corrective action plans as appropriate
- Internal monitoring and auditing for compliance
- Departmental policies, procedures and processes with implementation of corrective action plans as appropriate

F. **QI Resources**

The Alliance QI Department is staffed with physicians, nurses and non-clinical support staff including clerical support and clinical support coordinators. The assignment of work to the team, whether working on site or remotely, for both clinical and non-clinical activities, is seamless to the process as it did not change the team member's job responsibilities or job description. The job descriptions with assigned tasks and responsibilities remained the same regardless of the geographical location of the team member.

During 2018 several key leadership roles in Health Services were hired:

- Chief Medical Officer
- Medical Director of Quality Improvement
- Director of Health Care Services
- Director of Pharmacy
- Temporary Quality Director
- Temporary Quality Manager
- Outpatient Manager of Utilization Management

The timelines for positions is noted below:

- Q1, 2018:
    - Chief Medical Officer was hired

    - Medical Director of Quality Improvement was hired
    - One Quality Improvement Nurse was hired
    - One Quality Improvement Project Specialist was hired
- Q2, 2018:
    - One Quality Improvement Project Specialist left the Alliance
    - One Quality Improvement Project Specialist was hired
    - Temporary Quality Director and Temporary Quality Manager were hired
    - Previous Interim Quality Director moved into a new role as the Director of Access and Availability at the Alliance
    - Facility Site Review Nurse began long-term leave
    - Certified Facility Site Review Nurse Master Trainer retired
- Q3, 2018:
    - One CM Nurse transferred to the role of QI Project Specialist
    - One Quality Improvement Project Specialist left the Alliance
    - Temporary Facility Site Review Nurse hired
- Q4, 2018:
    - One Quality Improvement Nurse left the Alliance
    - One Facility Site Review Coordinator left the Alliance
    - Facility Site Review Nurse returned from long-term leave
    - Temporary Director of QI completed their maximum hours and left the Alliance
    - Temporary Manager of QI completed their maximum hours and left the Alliance

In 2018, based on the established staffing ratios and roles, the QI Department continued to work towards timelier hiring for both department and leadership roles. As a result, QI staffs outside of their defined roles often performed to complete the necessary tasks. With the onboarding of new leadership, the Health Care Services Department teams will be reviewing the current organization goals and restructuring the Departments to achieve those goals. The Alliance continues to evaluate staff turn-over and strives to provide a positive work environment, thus, creating a more stable work force.

OVERALL PROGRAM EFFECTIVENESS

The Alliance's improvement efforts strive to impact the quality of care and service provided to our members and providers. Review of the Alliance's QI activities as described herein demonstrate the ability to successfully achieve the following:

- Improved focus on the importance of chronic condition management, and accessing appropriate care through initiatives to educate and connect with members, work with providers, and enhance our internal operations.
- Improved focus on the analysis of key drivers of access to care
- Expanded our knowledge of health disparities amongst Alliance members
- Promoted the awareness and concepts of inter-departmental organizational QI, including Plan-Do-Study-Act (PDSA), Inter-Rater Reliability (IRR), to create greater operational efficiency and capacity.
- Invested in quality measurement expertise.
- Identifying and categorizing Potential Quality Issues (PQIs) followed by assisting partners in root-cause analysis to identify and overcome barriers and roadblocks
- Exhibited improvement in HEDIS measures' performance including CCS, CDC, and IMA
- Ensuring that providers regularly are evaluated through the Facilty Site Review Process
- Continued focus on hiring new staff for the QI Department.

The Alliance is invested in a multi-year strategy to ensure that the organization adapts to health plan industry changes now and within 3 - 5 years. An effective QI program with adequate resources is essential to the Alliance's successful adaptation to expected changes and challenges.

A. Serving Members With Complex Conditions

The Alliance continues to identify members in need of supportive services based on complex health conditions. The Alliance links members to Asthma and Diabetes Disease Management, Complex Case Management and Transition of Care.

Members are identified as potential candidates for Asthma Disease Management and are mailed outreach materials explaining their illness and the process to enroll in Disease Management. Disease Management is optional so members who do not pursue Disease Management programs are also provided information related to community resources that support their conditions.

Members are identified as high risk through claims, encounter and referral sources. These members are forwarded to case management for follow up. Complex Case Management staff outreach to high risk members by telephone. When outreach attempts are successful, initial assessments are performed and care plans are developed. Members who agree to care are provided assistance with provision of services and recommendations to support managing their conditions. When outreach is attempted but unsuccessful, the case is closed.

Members are also identified for transition of care assistance. Transition of Care assistance occurs for members who are discharged from Medical or Surgical inpatient care settings. Case and Disease Management processes and outcomes are provided in the Case Management and Disease Management program documents.

PROVIDER OUTREACH

During 2018, the Provider Services department provided their continued outreach to all PCP, Specialists and Ancillary provider offices via in-person visits and the use of fax blasts.

Topics covered in the visits and fax blasts included: use of the provider portal, the announcement of the Member Satisfaction survey, review of HEDIS measures, interpretive services, cultural sensitivity, Health Wellness, Provider Dispute Resolution (PDR) policy and procedure, updated drug formulary schedule change, announcement of the acupuncture benefit, instructions on discharging members from provider practices, Fraud Waste and Abuse reporting, Provider Appointment Availability Survey (PASS), the announcement of the Claims Editing System software, tobacco cessation counseling and Pay For Performance and DHCS' final rule impact on managed Medi-Cal plans.

In addition to ongoing quarterly visits, every newly credentialed provider received a new provider orientation within 10 days of becoming effective with the Alliance. This orientation includes a very detailed summary which includes but not limited to:

- Plan review and summary of Alliance programs
- Review of network and contract information
- How to verify eligibility
- Referrals and how to submit prior authorizations
- How to submit claims
- Filing of complaints and the appeal process
- Initial Health Assessment
- Coordination of Care, CCS, Regional Center, WIC program
- Members Rights and Responsibilities
- Member Grievances

Overall, there were approximately 465 provider visits completed during the 2018 calendar year.

MEMBER OUTREACH AND MEMBER SERVICES

The Alliance Member Services (MS) Department has a strong focus on providing high-quality service. Quarterly call center metrics are presented below in the member services dashboard; the dashboard represents blended (MediCal and Group Care) customer service results.

Alliance Member Services Staff	Q1, 2018	Q2, 2018	Q3, 2018	Q4, 2018
Incoming Calls (MS)	48458	41545	40474	36573
Abandoned Rate (MS)	3%	3%	3%	2%
Answered Calls (MS)	47078	40396	39334	35708
Average Speed to Answer (ASA)	00:25	00:25	00:20	00:16
Calls Answered in 30 Seconds (All)	85.0%	86%	87%	90%
Calls Answered in 10 Minutes (goal: 100%)	100.0%	100.0%	100.0%	100.0%
Recordings/Voicemails	Q1	Q2	Q3	Q4
Incoming Calls (R/V)	7051	6030	2639	2381
Abandoned Rate (R/V)	0.0%	0.0%	0.0%	0.0%
Answered Calls (R/V)	7051	6030	2639	4081
Calls Answered in 30 Seconds (R/V)	100%	100%	100%	100%
Blended Results	Q1	Q2	Q3	Q4
Incoming Calls (R/V)	55599	47575	43113	38954
Abandoned Rate (R/V)	2%	2%	3%	2%
Answered Calls (R/V)	54129	46426	41973	38089
Average Speed to Answer (ASA)	00:25	00:25	00:20	00:16
Calls Answered in 30 Seconds (R/V)	87%	88%	87%	91%

Targets:

1. **To answer 80% or more calls within 30 seconds**
2. **Abandoned Rate of 5% or less.**

In 2018, Member Service staff met target call service metrics to answer 80% or more calls within 30 seconds and experience less than 5% abandonment.

A. Member Advisory Committee (MAC)

The Member Advisory Committee's function is to provide information, advice, and recommendations to the Alliance on educational and operational issues in respect to the administration of the Alliance's cultural and linguistic services. These advisory functions include, but are not limited to, providing input on the following:

1. Culturally appropriate service or program design
2. Priorities for the health education and outreach program
3. Member satisfaction survey results
4. Findings of health education and cultural and linguistic group needs assessment
5. The Alliance's outreach materials and campaigns
6. Communication of needs for provider network development and assessment
7. Community resources and information

The Member Advisory Committee shall also receive information from the Alliance on public policy issues, including financial information and data on the nature and volume of grievances and their disposition.

The MAC met four times in 2018:

- March 15, 2018
- June 14, 2018
- September 20, 2018
- December 20, 2018

Some of the key topics discussed in 2018 include:

- Cultural and Linguistics Work Plan and Report
- Grievances & Appeals
- Health Risk Assessment
- Communications & Outreach collateral, events and activities
- Health Education Report
- Outreach Report
- Quality Improvement and HEDIS results
- Opioids Program
- Member Ambassador Program
- Member Listening Sessions
- Web-based provider survey
- Preventive Care handout review
- Questions & Answers for member concerns

B. Member Newsletter

The Alliance Spring/Summer and Fall/Winter *Member Connect* newsletter was published and shared with more than 165,000 member households and provider offices in 2018. The newsletter contained a variety of disease self-management and preventive care topics such as asthma, diabetes, heart disease, pregnancy, exercise, appropriate ER use, smoking cessation, immunizations, healthy eating, physical activity, blood lead testing and preventive care visits.

SAFETY OF CLINICAL CARE

The Alliance has an organizational focus on maintaining safety of clinical care for its membership.

A. Substance Abuse Disorder

The Alliance is in the process of partnering with our providers and other local leaders to develop an Opioid Management Program. This approach includes a focus on:

1. Developing a comprehensive opioid educational program and materials for Alliance providers
2. Ensure members have access to alternative medications and therapies to reduce opioid use
3. Establish appropriate use criteria for using over 120 milligrams of morphine per day and subsequent dose increases
4. Ensure appropriate use of long-acting opioids and prevention of inappropriate dose escalation
5. Reduce potentially inappropriate use of multiple long-acting opioids together
6. Remove/restrict use of medications commonly abused with opioids that have formulary alternatives
7. Reduce use of opioids for treatment of low-evidence conditions in accordance with CDC Guidelines

The 3 phases of the pharmacy intervention are detailed below:

Phase Ia (1/1/2018): Dose Increase Limitation

- All members who are increasing opioid dose greater than 120 Morphine Equivalent per Day (MED) will be required to provide explanation for dose increase.
    - Prescribers will fill out a standardized form to include with prior authorization request that will highlight patient's:
        - Current MED
        - Proposed MED and explanation for dose increase
        - Diagnosis and duration of treatment
        - Alternative treatments already used (non-narcotic drugs, surgery, acupuncture, physical therapy, etc.)
        - Attestation from prescriber that PDMP was accessed, complete assessment for pain and function performed, and benefits and potential harm of opioids has been discussed with patient
- All members already on 120 MED or greater will not be allowed to have any dose increase without an explanation for it.
- Quantity limit restrictions will be set in place on all formulary opioids for each single-dose strength, not to exceed a maximum daily dose of 120 MED.
    - Given new quantity limit, will convert the following single dose strengths to non-formulary status:
        - Morphine 100mg and 200mg extended-release tablets

- Methadone 40mg soluble tablet

Phase Ib (1/1/2018): Reduction of stable high dose opioids

- Prescribers will be required to provide explanation for all patients on stable, high dose opioids.
- Documentation of a "taper plan" will be required for patients on stable, high dose opioids who do not have a proper justification for continuing on high dose. Taper plan should document exact process on de-escalating patient's opioid dose over a proposed period of time.
- Create a registry to monitor all high dose opioid patients and track progress in reducing daily morphine equivalent doses.

Phase II (4/1/2018): Opioid New Start (Acute Pain)

- Quantity limits will be placed for all patients who are new to opioid therapy
  - Short acting opioids: 30 units per 90 days
  - Liquid/solution/syrup opioids: 240 ml per 90 days
- Prescriptions exceeding these quantity limits will require explanation for higher quantity needed.
- Plan will not allow more than 1 short acting opioid to be prescribed at the same time.

Alongside the pharmacy team, the QI team is in the process of implementation of a 3-prong approach to addressing members with Substance Abuse Disorder along the continuum of care. The 3 Prong approach focuses on:

1. Prevention – includes Provider Education, Community Outreach, Pharmacy Safeguards
   a. Provider Education has / will continue to have a focus on an Introduction Letter specifically addressing Best Practices, encouraging X-Waivers, assisting providers to understand their local network, and upcoming pharmacy UM Limits. Additionally, education will focus on regular provider outlier report that identifies changes in prescribing habits and outliers to under and over-prescribing. Additionally, evidence based use of opioids will be promoted through the planned 2019 Pay-For-Performance Program. This program was finalized in 2018.
   b. Community Outreach with local partnerships (including Emergency Departments, Hospital Leadership, Medical Organizations, Department of Public Health, and County Leadership
   c. Pharmacy Safeguards which includes removing the prior authorization (PA) for most non-opioid pain medications (see below table), removing commonly over-used / abused drugs from the formulary, implementing a pharmacist review of all long-acting opioid PAs to ensure that treatment diagnosis are consistent with CDC guidelines (and does not include chronic lower back pain, migraines, neuropathic pain, osteoarthritis). Pharmacists also ensure the co-prescription of naloxone. Finally, formulary limits were implemented in a step-wise approach; this will continue into 2019.

Below is a table that exhibits AAH step-wise approach to ensure the safe and effective use of opioids.

Substance Abuse Program	2017	Dec, 2017	June, 2018	Dec, 2018	June, 2019
"New Start" SAO Limit	None	None	None	14 days	14 days
SAO QL per month	#180	#180/30d	#180/30d	#90/30d	#60/30d
PA for all LAOs	No	Yes	Yes	Yes	Yes
LAO increase limit	No	Yes	Yes	Yes	Yes
Cover Alprazolam	Yes	No	No	No	No
Cover Carisoprodol	Yes	No	No	No	No
Lorazepam Limits	No	3/day	3/day	3/day	3/day
Clonazepam Limits	No	3/day	3/day	3/day	3/day
Oxazepam Limits	No	No	1/day	1/day	1/day

Key achievements of goals include (see above table):

- Removal of PA for most NSAIDs and neuropathic agents (see below table)
- SAO (Short acting opioids) have a 14 day limit on their initial start.
- SAO have / will continue to have step-wise quantity restriction limits.
- All long acting opioids (LAO) require a prior authorization (PA).
- Concurrent prescription of benzodiazepines and opioids require a PA and the prescription of naloxone.
- LAO require the concurrent prescription of naloxone.
- Monitoring of Member Grievances

Class	Drug	Limit	Notes
NSAIDs	Ibuprofen		No restrictions.
	Naproxen		
	Nabumetone		
	Diclofenac		
	Indomethacin		
	Sulindac		
	Meloxicam		
	Etodolac		
	Celecoxib (Celebrex)	QL	Limited to 60 capsules per 30 days
	Diclofenac Gel (Voltaren)	QL	Limited to 200g (two boxes) per 30 days
	Diclofenac soln. (Pennsaid)	PA	Reserved for trial and failure of Voltaren Gel.
Neuropathic Agents	Gabapentin		
	Amitriptyline, Nortriptyline		
	Venlafaxine IR / XR		
	Duloxetine (Cymbalta)		
	Milnacipran (Savella)	NF	
	Pregebalin (Lyrica)	PA	Reserved for treatment failure of gabapentin at dose larger than 1800mg/day for at 2 months and two other neuropathic pain medications
Other	Lidocaine (Lidoderm) 5% patches	PA	Reserved for treatment failure of gabapentin at dose larger than 1800mg/day for at 2 months and two other neuropathic pain medications

2. Intervention and Treatment – Includes Member Education, Access to MAT and Adjunctive Therapies
3. Recovery Support – Includes Integrated Care and Complex / Care Management – Limited given limited Case Management Staff; see 2018 UM/CM Evaluation

B. Drug Recalls

The Pharmacy Department monitors all drug recalls. In 2018, pharmacy recall information is as below:

Total number of safety notices/recalls	64
Total number of withdrawals	0
The number of notifications where PBM completed a claims data review	25

In 2018, there were 64 recalls. Recalls were monitored for adversely affected members.

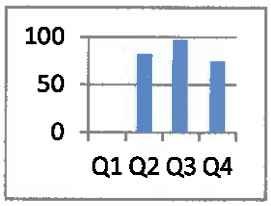
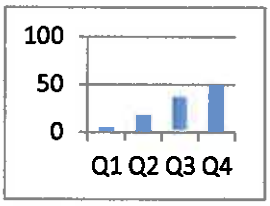
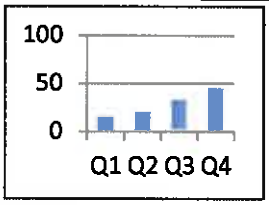
The Alliance website has a continuous flow of safety resources for members and providers and includes FDA recalls, Risk Evaluation and Mitigation Strategies, a Patient Safety Resource Center, and Drug Safety Bulletins.

C. Potenial Quality Issues - Quality of Care

Potential Quality Issues are defined as a suspected deviation from expected provider performance, clinical care or outcome of care which requires further investigation; further investigation can determine whether an actual quality issue exists.

The QI Department investigates all Potential Quality Issues (PQIs). These may be submitted by members, practitioners, or internal staff. When a PQI is identified, it is forwarded to the Quality Department and logged into a database for tracking. Quality Review Nurses investigate the incident and summarize the findings. The Medical Director reviews all PQI summaries where a quality of care issue is identified. A Medical Director will refer cases to the Peer Review and Credentialing Committee (PRCC) for resolution, if found to be a significant quality of care issue (Clinical Severity 3, 4).

Alameda Alliance for Health's Quality department received two-thousand nine-hundred and fifteen (2915) Potential Quality Issues (PQIs), during measurement year 2018. The quarterly frequencies are listed in the table below:

Indicator 1: Compliance with the 90 day turn-around time	**Q1, 2018**** Denominator: N/A Numerator: N/A	**Q2, 2018** Denominator: **107** Numerator: **87** Rate: **81%** Goal Met: **No** Gap to goal: **9%** points	**Q3, 2018** Denominator: **134** Numerator: **128** Rate: **96%** Goal Met: **Yes**	**Q4, 2018** Denominator: **83** Numerator: **63** Rate: **76%** Goal Met: **No** Gap to goal: **14%**	
Indicator 2: QOC PQIs	**Q1, 2018** Denominator: **1135** Numerator: **60*** Rate: **5%** Goal Met: No Gap to goal: **55%** points	**Q2, 2018** Denominator: **1,289** Numerator: **107** Rate: **17%** Goal Met: **No** Gap to goal: **63%** points	**Q3, 2018** Denominator: **358** Numerator: **134** Rate: **37%** Goal Met: **No** Gap to goal: **43%** points	**Q4, 2018** Denominator: **133** Numerator: **65** Rate: **49%** Goal Met: **No** Gap to goal: **11%** points	
Indicator 3: QOC PQIs leveled at severity C2-4	**Q1, 2018** Denominator: **60*** Numerator: **9** Rate: **15%** Goal: N/A	**Q2, 2018** Denominator: **107** Numerator: **21** Rate: **20%** Goal: N/A	**Q3, 2018** Denominator: **134** Numerator: **44** Rate: **33%** Goal: N/A	**Q4, 2018** Denominator: **65** Numerator: **29** Rate: **45%** Goal: N/A	

*Approximate number given changes in data source, reporting, and backlog issue

**2 Backlog issues caused a delay in QI referral; Over an additional 1,000 PQIs were identified through the below mentioned IT backlog glitch.

In 2017, the Quality Improvement (QI) team received about **300** PQIs; in December of 2017, the QI team trained all AAH staff and changed the referral criteria. As a result, in 2018, the QI team received almost **3000** PQIs. Independently, in Q1 of 2018, the team identified an IT glitch that caused 2 backlogs of over 1000 cases. These were identified and disclosed to our auditors; they were then reviewed and closed by the QI team.

In 2018, the QI team has undergone 2 independent PDSA (Plan-Do-See-Act) cycles.

First, the team devised a method to 1) provide oversight of exempt and standard grievances 2) encourages *clinical* referrals and 3) ensures that services and access issues are addressed through other existing channels. Given this change, the QI team is staffed to receive **600** PQIs in 2019 – this number is more consistent with plans of our size.

The second PDSA cycle is around the technological support of the QI team. In 2017 and 2018, the team heavily relied on Microsoft Excel. In Q4 2018, phase 1 of the PQI Application was introduced, and subsequent phases will allow the QI team to transition from Excel to a home-built application.

As quality is our top priority, PQIs that result in potential or actual member harm are a top priority. In the past 1.5 years, the team has undergone significant transitions, however, through 2 PDSA cycles, the team effectively addresses PQIs. It also works closely with partners to perform root-cause-analysis to improve patient care. Finally, it has created a path to ensure that cases that significant deviate from the standard of care are reviewed by our Peer Review Committee.

D. Consistency in Application of Criteria (IRR)

The Alliance QI Department assesses the consistency with which physicians, pharmacist, UM nurses, Retrospective Review nurses and non-physician reviewers apply criteria to evaluate inter-rater reliability (IRR). A full description of the testing methodology is available in the QI Program and Quality Improvement policy 133. QI has set the IRR passing threshold as noted in Figure 6.

Inter-rater Reliability Thresholds

Score	Action
High – 90%-100%	No action required
Medium – 61%-89%	Increased training and focus by Supervisors/ Managers
Low – Below 60%	Additional training provided on clinical decision-making. If staff fails the IRR test for the second time, a Corrective Action Plan is required with reports to the Director of Health Services and the CMO. If staff fails to pass the IRR test a third time, the case will be escalated to Human Resources which may result in possible further disciplinary action.

The IRR process for PQIs uses actual PQI cases. IRRs included a combination of acute and/or behavioral health IRRs. All new hire staffs are trained and participate in the IRR process upon completion of their training. Results will be tallied as they complete the process and corrective actions implemented as needed. When opportunities for improving the consistency in applying criteria, QI staff addresses corrective actions through requiring global or individualized training or completing additional IRR case reviews.

For 2018, IRR testing was performed for QI clinical staff to establish consistency in practice and outcomes for members. Of the clinical nurses and physician, all passed on the initial review with 100%.

E. Facility Site Review

Facility Site Review (FSR), Medical Record Review (MRR) and Physical Accessibility Review (PAR) is mandated for each Health plan under Plan Letter 14-004 and 15-023 every 3 years. Mid-cycle follow-up

is required for FSR and MRR. Corrective Action Plans are required depending on the site FSR and MRR scores. Site reviews are another way the QI Department ensures safety within the provider office environment. In 2018, the QI Department lost a Master Trainer Review Nurse; while FSRs were completed through a temporary nurse, a new Master Trainer was hired and efficiently and effectively completed the requires FSRs.

In 2018, there were 68 site reviews. The total number of FSR / MRR / Mid-Cycle FSR / Mid-Cycle MRR are as detailed in the table below:

Year: 2018	Q1	Q2	Q3	Q4
FSR: Full Scope	6	1	3	32
FSR: Initial	0	2	4	1
MRR: Initial	0	2	0	0
MRR: Follow Up	1	0	0	0
FSR/MRR: Mid-cycle	8	2	0	5
FSR: Mid-cycle	0	0	0	1
Total Reviews	15	7	7	39

These reviews resulted in 52 corrective action plans and follow-up with the practice sites.

Year: 2018	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Total CAPs	13	5	2	30
Open CAPs	0	1	0	0
Closed CAPs	13	4	2	29

PEER REVIEW AND CREDENTIALING COMMITTEE (PRCC)

The PRCC met monthly and conducted a comprehensive review of each practitioner before credentialing or re-credentialing was complete. If any issues were identified, a thorough review by the committee was completed to ensure that there were not quality or safety issues.

Any practitioner that was not board certified was reviewed by the committee. In 2018, 27 practitioners were reviewed for lack of board certification. If there were complaints about a practitioner's office, facility site reviews were conducted and the outcome was reviewed by the PRCC. There was no site reviews conducted based on complaints in 2018. All grievances, complaints, and PQIs that required investigation were forwarded to this committee for review. In 2018, 62 practitioner grievances, complaints, or PQIs were investigated by the committee. There were no practitioners that required reporting to National Practitioner Data Bank (NPDB) by the Alliance.

In 2018, the PRCC granted one year reappointment for three practitioners and a two year reappointment for grievances filed regarding office procedures. Additionally, one practitioner was terminated from the Alliance network for not disclosing correct information on original attestation and NPDB. The table below shows evidence of practitioner review by the PRCC prior to credentialing and re-credentialing decisions.

Count of Practitioners Reviewed
Quality Issues At PRC in 2018

PRC Date	NPDB Record Identified	Attestation	Malpractice (pending or dismissed)	Facility Site Reviews	Grievance, Complaints, PQI	License Action	Board Certification	Total
1/18/2018	1							1
2/20/2018			4		8		3	15
3/20/2018	4		1		6		2	13
5/15/2018	2		1		7		1	11
6/26/2018	2		1		3		1	7
7/17/2018					4		2	6
8/21/2018	3				8		4	15
9/18/2018	1		1		4		4	10
10/16/2018	2		2		10		1	15
11/27/2018	2	1	2		8		8	21
12/18/2018	1				4		1	6
	18	1	12	0	62	0	27	120

DELEGATION OVERSIGHT

The Alliance conducts quarterly and annual delegation oversight in compliance with Department of Health Care Services (DHCS), DMHC, and the National Committee for Quality Assurance (NCQA) regulations. Annual delegation oversight reviews were conducted in 2018.

Results from the reviews are reported to the Compliance Committee. The QI delegation audit results were also reported to the HCQC.

In addition to the annual oversight audits, the Alliance holds quarterly Joint Operations Meetings with delegates. It also holds regular Executive Team meetings with CHNC and AHS Leadership. Both the Alliance and the delegate contribute to the agenda items. The agenda includes a discussion of claims, information technology, provider relations, member services, quality issues/progress, and new legislation. Also, weekly or biweekly calls are often held with the delegates to resolve any immediate concerns. The Alliance places a high degree of importance on problem solving and communicating with delegates.

The Alliance conducted Joint Operations meetings with the delegated groups to review HEDIS performance specific to their group and to identify opportunities for improvement, strategies for improvement of scores, and HEDIS timelines for reporting year 2019.

The following delegated groups were audited in 2018:

2018 AAH Delegation Audit Schedule											
Delegate Name		Service Type	Product Line		Quality Improvement	Utilization Management	Credentialing/ Re-Credentialing	Rights and Responsibilities	Claims	Case Management	BHT
			MCAL	GC							
1	KAISER	Fully Delegated	X		11/06/18	11/06/18	NCQA	11/06/18	11/06/18	11/06/18	11/06/18
2	BEACON HEALTH STRATEGIES LLC	Mental Health, Partially Delegated	X	X	8/16/18	8/16/18	NCQA	N/A	8/16/18	8/16/18	11/06/18
3	COMMUNITY HEALTH CENTER NETWORK (CHCN)	Partially Delegated	X	X	N/A	10/09/18	N/A	N/A	10/09/18	10/09/18	N/A
4	CHILDREN'S FIRST MEDICAL GROUP (CFMG)	Partially Delegated	X		N/A	9/10/18	7/01/17	N/A	9/10/18	N/A	N/A
5	PERFORMRX	Pharmacy	X	X	N/A	1/01/18	1/01/18	N/A	1/01/18	N/A	N/A
6	MARCH VISION CARE GROUP, INC.*	Vision	X		N/A	N/A	7/01/17	N/A	11/01/18	N/A	N/A
7	CALIFORNIA HOME MEDICAL EQUIPMENT (CHME)	DME	X	X	N/A	8/30/18	N/A	N/A	N/A	N/A	N/A

8	EVICORE*	Specialty Radiology	X	X	N/A	11/01/18	N/A	N/A	N/A	N/A	N/A
9	PHYSICAL THERAPY PROVIDER NETWORK (PTPN)	Physical Therapy	X	X	N/A	N/A	4/01/17	N/A	N/A	N/A	N/A
10	LUCILLE PACKARD	Medical Group	X	X	N/A	N/A	9/01/17	N/A	N/A	N/A	N/A
11	UCSF	Medical Group	X	X	N/A	N/A	10/01/17	N/A	N/A	N/A	N/A

The Alliance will continue to conduct oversight of the delegated groups, review thresholds to ensure they are aligned with industry standards, and will issue corrective actions when warranted. After review of the QI delegates, no actions were specifically identified or taken. The QI Delegates Program Evaluation will be reviewed by the HCQC in Q1 of 2019.

QUALITY IMPROVEMENT PROJECTS

In 2018, the Alliance cooperated with the Department of Health Care Services (DHCS) and Health Services Advisory Group (HSAG) to improve the process for three quality measures. The following quality improvement projects were conceived in late 2017 and have an expected completion date of June 2019. The projects were based on HEDIS 2017 reporting year data. DHCS encourages plans to adopt the Institute for Health Improvement's (IHI) model for improvement. This approach frames the improvement project to clarify and focus the project before the Plan-Do-Study-Act (PDSA) model is used. The project cycle is 18 months and will run through 2018. The outcomes for the quality improvement projects are stated below.

Quality Improvement Projects:

1. HEDIS Measure CDC: Improve the rate of HbA1c Testing in African American Men.

   Each Performance Improvement Project (PIP) cycle, DHCS requires one PIP to be centered on addressing a health disparity. 2016 Census data estimates that approximately 11% of Alameda County population identifies as African American whereas Alameda Alliance data revealed that 22% of our diabetic members are African American, which represents a greater disease burden. For reporting year 2017 (2016 calendar year), Alameda Alliance HbA1c testing rate for African American men of 73.12% was below the total plan rate of 85.89%, Additional communication with provider partners across the network revealed that Alameda Health System was making HbA1c Poor Control (>9.0%) a focus for 2018. Through this partnership, a goal was developed to increase the rate of HbA1c testing among African American men from 73.12% to 79%. The intervention focused on providing point-of-care testing at Highland Outpatient, one of the largest providers of care in the AAH network. During 2018, Alameda Alliance met with Highland clinical staff six times to develop, plan and implement the intervention. Highland began using point-of-care testing in a pilot phase in December 2018. This project will run through June 30, 2019.

2. HEDIS Measure CAP: Increase the Alameda Alliance overall rate of Children and Adolescent Access to Primary Care

   Physicians for ages 12-19 (CAP4). Using MY 2017 data, Alameda Alliance CAP4 rate was 85.47%, which fell under the Minimum Performance Level (MPL) of 85.73%. Additional analysis showed that Tri-City clinics, which include Liberty, Mowry 1 and Mowry 2, had a CAP4 rate of 81.12%, significantly lower than the Alameda Alliance overall rate and well below the MPL. Conversations with Tri-City clinical staff and a thorough literature revealed monetary incentives to be an effective intervention with this age group. Alameda Alliance met with providers and support staff from Tri-City seven times in 2018 to discuss intervention strategies, plan and implementation. Tri-City staff committed to calling all members who were non-compliant with this measure three times and then send them a follow up text if they were not reached by

phone. Alameda Alliance committed to sending these members a mailed letter and providing a $25 gift card to all members who completed a compliant visit during the pilot. Tri-City began outreach phone calls in December 2018. The goal is to increase the rate of primary care visits for 12-19 year olds assigned to Tri-City clinics from 81.12% to 86%. This project will run through June 30, 2019, at which time data collection and analysis will be finalized in order to determine if the intervention should be abandoned or adopted for a larger group of members.

3. HEDIS Measure MPM: Managing members on persistent medications.

Screening rates for members on persistent medications were below the minimum performance level three years in a row. The rates of screening for members on the following medications: angiotensin converting enzyme (ACE) inhibiters or angiotensin receptor blockers (ARB) and diuretics (DIU) were ACE/ARB= 83.12% in RY 2015,84.27% in RY 2016 and 86.06% in RY 2017 and DIU= 81.67% in RY 2015,83.22% in RY 2016 and 85.14% in RY 2017. Due to consistently falling below the Minimum Performance Level for this measure, DHCS requested that Alameda Alliance participate in a pilot to rapidly improve the rates for this measure using a SWOT methodology: Strengths, Weaknesses, Opportunities and Threats. Alameda Alliance completed a data analysis of delegate performance and reached out to clinics with low performance. Leadership at Tiburcio Vasquez clinics in the Community Health Center Network (CHCN) expressed an interested in partnering on improving this measure. Tiburcio Vasquez clinics had 556 eligible members and a compliance rate of 85.9% for ACE/ARB and 88.9% for diuretics. The interventions developed included texting members to alert them that they were due for a lab and needed to see their provider as well as a 'soft stop' put on members' pharmacy refills to encourage pharmacists to counsel members to get their labs. Alameda Alliance allocated $25 to pharmacies for each member that successfully completed their lab within the measurement period, which is scheduled to run through June 30, 2019. Text messaging was completed through Tiburcio Vasquez using their text messaging application and began in December 2018. Text messaging in December prioritized members who had not seen their provider in over a year and had multiple gaps in care in addition to missing their MPM lab. This intervention will continue and the soft stop will be put in place in 2019 at which time data analysis of results can be completed to determine the efficacy of the interventions.

Additional Projects:

4. HEDIS Measure None: Increasing rates of Tdap vaccines in pregnant women in the third trimester

In 2018, over 300 cases of pertussis were identified in Alameda County, five of which were infants younger than 4 months old. Immunizing pregnant women with the Tdap vaccine between 27-36 weeks gestation is the most effective practice to protect infants from pertussis. The Alliance and the Immunization Division of Alameda County's Public Health Department (ACPHD) have partnered to implement a Quality Improvement Project to improve rates of

prenatal Tdap vaccination. The Alliance completed a baseline data analysis of claims submitted for deliveries between 5/1/2017 to 4/30/2018 and claims data for any Tdap received within 10 months prior to delivery. As a result, 19 PCP's were identified with 30 deliveries or more and Tdap vaccination rates of 80% or lower. Among these providers thus far, Ob/Gyn leadership at Lifelong Medical Care and Alameda Health Systems have expressed interest with improving their rates. ACPHD will be presenting best Tdap practices to these sites at upcoming staff meetings between March and June 2019. Next steps include: continued provider outreach and Tdap training by ACPHD, and a repeat data analysis In October 2019 and January 2020 by the Alliance.

5. Improving Initial Health Assessment (IHA) Rates

The past 1 year of IHA rates is outlined below.

Q3, 2017	Q4, 2017	Q1, 2018	Q2, 2018
Denominator: 15489	Denominator: 13358	Denominator:13841	Denominator: 14477
Numerator: 4110	Numerator: 3228	Numerator: 3186	Numerator: 2925
Rate: 27%	Rate: 24%	Rate: 23%	Rate: 20%
Goal Met: N	Goal Met: N	Goal Met: N	Goal Met: N
Gap to goal: 7% points	Gap to goal: 6% points	Gap to goal: 7% points	Gap to goal: 10% points

On average, an IHA is completed for 24% of new members (7/1/17 – 6/30/18); the table below identifies IHA completion rates by network.

Network	New Enrollees	With IHA Completed	IHA Compliant Rate
AHS	17,033	2,819	17%
ALLIANCE Excl. AHS	9,821	2,830	29%
CFMG	8,182	1,944	24%
CHCN	16,208	4,641	29%
KAISER	5,921	1,215	21%
ALL NETWORK	57,165	13,449	24%

In an effort to improve IHA compliance rates, the Alliance is working to:

- Ensure member education – through mailings and member orientation
- Improve provider education – through faxes, the PR team, provider handbook, and P4P program
- Improve data sharing – by sharing gaps in care lists with our delegates and providers
- Incentivize IHA completion rates – by including IHA completion rates as an incentivized program
- Update claims codes – to ensure proper capture of IHA completion
- Monitor records to ensure compliance with all components of the IHA

Given the 6 month claims lag, data will be reviewed and analyzed in Q3 – Q4 of 2019.

6. Substance Abuse Disorder – see above section on patient safety

CLINICAL IMPROVEMENT TRENDS: HEDIS

The Alliance is committed to ensuring the level of care provided to all enrollees meets professionally recognized standards of care and is not withheld or delayed for any reason. The Alliance adopts and evaluates recognized standards of care for preventive, chronic and behavioral health care conditions. The Alliance also approves the guidelines used by delegated entities. Guidelines are approved through the HCQC. Adherence to practice guidelines and clinical performance is evaluated primarily using standard HEDIS measures. HEDIS is a set of national standardized performance measures used to report on health plan performance in preventive health, chronic condition care, access and utilization measures. DHCS requires all Medicaid plans to report a subset of the HEDIS measures. Three years of Medicaid hybrid and administrative rates are noted below. Reporting year is noted and reflects prior calendar year. Minimum Performance Level and High Performance Level are determined by the Medi-Cal Managed Care Division.

Medicaid Hybrid HEDIS Measures

2018 EAS and Accreditation Measures		2017 Results	2018 Rates	State Metrics	
NCQA Acronym	Measure	Hybrid Final - June 2017	Current Rate	2018 MPL	2018 HPL
ABA	Adult BMI Assessment	86.23%	83.09%	*78.83%*	*93.68%*
CCS	Cervical Cancer Screening	60.34%	60.00%	*51.88%*	*70.80%*
CDC	CDC HbA1c	85.89%	87.59%	*84.32%*	*92.82%*
CIS	CIS - COMBO3	74.45%	73.97%	*65.25%*	*79.32%*
PPC	PPC - Prenatal	84.43%	85.52%	*77.66%*	*91.67%*
W34	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	73.13%	79.27%	*66.18%*	*82.77%*
CBP	Controlling High Blood Pressure	65.21%	65.69%	*47.69%*	*71.69%*
CDC	CDC Poor Control	37.96%	34.31%	*48.57%*	*29.07%*
CDC	CDC Good Control <8	50.12%	53.77%	*41.94%*	*58.82%*
CDC	CDC Eye	55.23%	58.64%	*47.57%*	*68.27%*
CDC	CDC Neph	88.81%	89.54%	*88.56%*	*93.28%*
CDC	CDC BP<140/90	61.80%	61.80%	*52.74%*	*75.91%*
IMA	IMA - Combo 2	30.17%	47.69%	*15.87%*	*30.39%*
PPC	PPC - Postpartum	67.15%	68.31%	*59.59%*	*73.67%*
WCC	WCC - BMI	83.21%	72.27%	*60.19%*	*87.50%*
WCC	WCC - Counseling for Nutrition	79.56%	74.45%	*58.56%*	*82.53%*
WCC	WCC - Counseling for Phys Activity	74.70%	76.01%	*49.06%*	*75.40%*

Medicaid Administrative HEDIS Rates

2018 EAS Measures		2017 Results	2018 Rates	State Metrics	
NCQA Acronym	Measure	Admin Final - April 2017	Current Rate	2018 MPL	2018 HPL
AAB	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	38.05%	41.23 %	*24.91 %*	*39.12 %*
ADD	Initiation Phase	37.55%	40.04 %	*39.02 %*	*57.05 %*
ADD	Continuation and Maintenance (CM) Phase	48.48%	54.55 %	*48.18 %*	*69.47 %*
AMM	Effective Acute Phase Treatment	66.89%	66.70 %	*48.22 %*	*64.15 %*
AMM	Effective Continuation Phase Treatment	52.61%	51.97 %	*32.58 %*	*50.41 %*
AMR	Asthma Medication Ratio	60.65%	62.85 %	*55.33 %*	*72.38 %*
AWC	Adolescent Well-Care Visits	46.04%	48.24 %	*43.06 %*	*68.06 %*
BCS	Breast Cancer Screening	62.52%	63.88 %	*52.71 %*	*70.29 %*
CAP	12-24 Months	92.00%	91.90 %	*93.27 %*	*97.89 %*
CAP	25 Months - 6 Years	84.40%	84.53 %	*84.94 %*	*93.16 %*
CAP	7-11 Years	87.19%	87.55 %	*87.58 %*	*96.09 %*
CAP	12-19 Years	84.75%	85.54 %	*85.73 %*	*94.78 %*
CHL	Chlamydia Screening in Women - Total	56.08%	59.99 %	*50.39 %*	*71.33 %*
CWP	Appropriate Testing for Children With Pharyngitis	60.27%	66.48 %	*67.15 %*	*88.00 %*
LSC	Lead Screening in Children	64.74%	64.50 %	*59.65 %*	*86.37 %*
LBP	Use of Imaging Studies for Low Back Pain	76.28%	81.99 %	*66.23 %*	*78.29 %*
MMA	Total Medication Compliance 50%	64.92%	67.73 %	*51.75 %*	*72.33 %*
MMA	Total Medication Compliance 75%	43.64%	46.12	*27.58*	*51.21*

			%	%	%
			86.52	*85.93*	*92.77*
MPM	ACE Inhibitors or ARBs	86.06%	%	%	%
			85.60	*85.52*	*92.48*
MPM	Diuretics	85.14%	%	%	%
	Non-Recommended Cervical Cancer Screening in Adolescent				
NCS	Females	0.32%	0.27%	*2.83%*	*0.55%*
			77.76	*72.76*	*85.65*
SPC	SPC - Received Statin Therapy 21-75 Male	76.90%	%	%	%
			82.24	*56.00*	*74.04*
SPC	SPC - Statin Adherence 80% 21-75 Male	77.57%	%	%	%
			66.04	*66.82*	*81.82*
SPC	SPC - Received Statin Therapy 40-75 Female	64.72%	%	%	%
			72.49	*53.73*	*73.44*
SPC	SPC - Statin Adherence 80% 40-75 Female	71.94%	%	%	%
			69.16	*57.76*	*67.74*
SPD	SPD - Received Statin Therapy	66.33%	%	%	%
			76.20	*53.07*	*71.41*
SPD	SPD - Statin Adherence 80%	77.77%	%	%	%
	Diabetes Screening for People With Schizophrenia or Bipolar		82.24	*77.48*	*87.41*
SSD	Disorder Who Are Using Antipsychotic Medications	80.34%	%	%	%
	Diabetes Monitoring for People With Diabetes and		63.89	*64.44*	*78.92*
SMD	Schizophrenia	60.48%	%	%	%
	Cardiovascular Monitoring for People With Cardiovascular		68.00	*73.03*	*88.33*
SMC	Disease and Schizophrenia	67.86%	%	%	%
	Adherence to Antipsychotic Medications for Individuals With		28.53	*54.12*	*71.67*
SAA	Schizophrenia	28.61%	%	%	%
			81.30	*76.54*	*89.94*
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack	83.05%	%	%	%
			63.65	*61.82*	*77.72*
PCE	Systemic Corticosteroid	60.88%	%	%	%
			85.82	*78.13*	*88.48*
PCE	Bronchodilator	84.90%	%	%	%
	Appropriate Treatment for Children With Upper Respiratory		97.38	*86.38*	*95.98*
URI	Infection	97.14%	%	%	%
			21.03	*56.11*	*72.46*
W15	W15 - Six or More visits	21.66%	%	%	%

Analysis of HEDIS Medicaid External Accountability Set (EAS)

The above tables represent the Medicaid HEDIS measures for the DHCS Accountability measure set. Of the trended measures (including individual sub measures), 39/53 measures showed improvement while 12 showed a minimal decline. 2 measures (WCC – BMI and WCC – Nutrition) showed more significant decline but continue to be significantly above the MPL.

The Aggregated Quality Factor Score (AQFS) is a single score that accounts for plan performance on all DHCS-selected Health Effectiveness Data and Information Set (HEDIS) indicators. It is a composite rate calculated as a percent of the National High Performance Level (HPL). The Alliance goal is to increase Aggregated Quality Factor Score rates by 5% each year. In 2018, the Alliance met the target goal when evaluated in the aggregate. The Alliance met minimum performance goals for all measures. If a minimum performance level is not met, an in depth analysis occurs to identify barriers to access and care.

Based on the HEDIS data presented, potential focus areas for 2019 may include the following:

Clinical Quality Measure Category	
1	Childhood Immunization Status – Combo 3
2*	Children and Adolescents' Access to Primary Care Physicians
3	Children/Adolescents' Weight Assessment and Counseling - Nutrition
4	Asthma Medication Ratio (Total Rate)
5	Cervical Cancer Screening
6	Comprehensive Diabetes Care (18-75 y/o) – HbA1c Testing
7*	Controlling High Blood Pressure
8	Annual Monitoring for Patients on Persistent Medications (>18 y/o) - ACE or ARB
9	Annual Monitoring for Patients on Persistent Medications (>18 y/o) -Diuretics

Other Non-HEDIS related measures of focus may include:

Other Measure Category	
10R*	Opioids Intervention Education
11*	Initial Health Assessment (DHCS measure)
12	ED Visits per 1000 Member
13	Pharmacy Utilization - % of Generic Usage

HEALTH PLAN ACCREDITATION

In September 2016, Alameda Alliance participated in the triennial reaccreditation survey for Health Plan Accreditation (HPA) sponsored by NCQA. NCQA HPA is a voluntary recognition program consisting of a triennial desktop review of program materials, policies and procedures and on-site file review. The standards evaluate Quality Improvement, Utilization Management, Pharmacy, Rights and Responsibilities, Credentialing, Network Management and Member Related Services. Annually, the score and award are reevaluated based on the fixed survey standards score and an annual reevaluation of audited HEDIS and CAHPS scores. NCQA grants the following decisions: Excellent (90-100 points), Commendable (80-89.99 points), Accredited (65-79.99 points), Provisional (55-64.99 points), and Denied (less than 54.99 points).

Based on increased HEDIS and CAHPS scores, Medicaid earned "Commendable" status, both Medicaid and Group Care products were brought forward in 2018.

Medicaid

The total points earned by Medicaid were 81.23/100 points.

Standards score earned by Medicaid were 46.23/50. Medicaid HEDIS scores were 26.6/37 points, and CAHPS scores were 8.4/13 points. In 2018, HEDIS and CAHPS scores will be submitted for annual NCQA reevaluation and added to the Standards score of 46.23.

Group Care

The next triennial standards survey scheduled for September, 2019.

QUALITY OF SERVICE

Analyses of member experience information helps managed care organizations identify aspects of performance that do not meet member and provider expectations and initiate actions to improve performance. Alameda Alliance for Health (AAH) monitors multiple aspects of member and provider experience, including:

- Member Experience Survey
- Member Complaints (Grievances)
- Member Appeals

A. Member Experience Survey

The MediCal and Commercial member experience survey is administered by an NCQA certified HEDIS survey vendor. SPH Analytics was selected by AAH to conduct the 2018 Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.0 survey. The survey method includes mail and phone responses. Members in each population line are surveyed separately.

Survey Response Rates for CY 2017 – 2018

Survey Population	AAH 2018 Response Rate	AAH 2017 Response Rate
MediCal General Child	24.3%	19.5%
MediCal Adult	20.9%	26.1%
Commercial Adult	27.9%	31.6%

MediCal Child Trended Survey Results

Summary Rate Scores – MediCal Child	AAH 2018 Results	2017 Quality Compass All Plans*	AAH 2017 Results	Year Over Year Tend
Getting Needed Care	81.0%	84.5%	81.7%	↔
Getting Care Quickly	82.8%	88.8%	83.6%	↓
How Well Doctors Communicate	91.6%	93.5%	94.4%	↓
Customer Service	84.6%	88.1%	85.2%	↓
Shared Decision Making	75.3%	78.7%	79.7%	↓
Rating of Health Care (8+9+10)	85.9%	86.7%	90.1%	↓
Rating of Personal Doctor (8+9+10)	89.6%	89.3%	92.9%	↓
Rating of Specialist (8+9+10)	86.3%	87.3%	88.7%	↓
Rating of Health Plan (8+9+10)	88.3%	85.8%	88.4%	↔

*The 2017 Quality Compass All Plans benchmark is the mean summary rate from the Medicaid and Commercial samples that submitted to NCQA in 2017.

MediCal Child Trended Survey Results – Delegates

Summary Rate Scores – MediCal Child Delegates	CFMG 2018	CFMG 2017	Year Over Year Trend	CHCN 2018	CHCN 2017	Year Over Year Trend	Kaiser 2018	Kaiser 2017	Year Over Year Trend	2017 Quality Compass All Plans*
Getting Needed Care	81.4%	81.6%	↔	78.9%	75.8%	↑	92.4%	86.5%	↑	81.0%
Getting Care Quickly	89.9%	87.1%	↑	76.8%	82.6%	↓	93.1%	84.6%	↑	82.8%
How Well Doctors Communicate	93.9%	95.8%	↓	86.4%	91.7%	↓	99%	96.8%	↑	91.6%
Rating of Health Care (8+9+10)	86.4%	90.8%	↓	81.4%	86.2%	↓	93.9%	97.7%	↓	85.9%
Rating of Personal Doctor (8+9+10)	93.3%	96.8%	↓	87.2%	90%	↓	94.7%	93.9%	↔	89.6%
Rating of Specialist (8+9+10)	93.8%	95.7%	↓	89.7%	68.8%	↑	83.3%	100%	↓	86.3%
Rating of Health Plan (8+9+10)	85.6%	86.3%	↔	89%	87.2%	↑	92.6%	91%	↔	88.3%

*The 2017 Quality Compass All Plans benchmark is the mean summary rate from the Medicaid and Commercial samples that submitted to NCQA in 2017.

MediCal Adult Trended Survey Results

Summary Rate Scores – MediCal Adult	AAH 2018 Results	2017 Quality Compass All Plans*	AAH 2017 Results	Year Over Year Tend
Getting Needed Care Composite	76.1%	82%	75.3%	↔
Getting Care Quickly	73.2%	81.8%	70.3%	↑
How Well Doctors Communicate	90.5%	91.4%	90.3%	↔
Customer Service	86.7%	88.2%	82.6%	↑
Shared Decision Making	70.8%	79.8%	77.3%	↑
Rating of Health Care (8+9+10)	73.5%	74.4%	66.2%	↑

Rating of Personal Doctor (8+9+10)	80.3%	81.2%	74%	↑
Rating of Specialist (8+9+10)	77.8%	81.8%	86.1%	↓
Rating of Health Plan (8+9+10)	73%	75.9%	69.3%	↑

*The 2017 Quality Compass All Plans benchmark is the mean summary rate from the Medicaid and Commercial samples that submitted to NCQA in 2017.

MediCal Adult Trended Survey Results – Delegates

Summary Rate Scores – MediCal Adult Delegates	CFMG 2018	CFMG 2017	Year Over Year Trend	CHCN 2018	CHCN 2017	Year Over Year Trend	Kaiser 2018	Kaiser 2017	Year Over Year Trend	2017 Quality Compass All Plans*
Getting Needed Care	100%	50%	↓	78.3%	72.3%	↑	88.3%	91.2%	↓	82%
Getting Care Quickly	83.3%	50%	↑	65.7%	70.4%	↓	72.3%	86.4%	↓	81.8%
How Well Doctors Communicate	100%	100%	↔	94.4%	90.5%	↑	85%	100%	↓	91.4%
Rating of Health Care (8+9+10)	100%	100%	↔	70.4%	65.6%	↑	90.9%	100%	↓	74.4%
Rating of Personal Doctor (8+9+10)	100%	100%	↔	79.2%	84.2%	↓	70.6%	81.8%	↓	81.2%
Rating of Specialist (8+9+10)	100%	0%	↑	88.9%	86.4%	↓	57.1%	100%	↓	81.8%
Rating of Health Plan (8+9+10)	50%	0%	↑	74.8%	73.9%	↔	82.6%	87.5%	↓	75.9%

*The 2017 Quality Compass All Plans benchmark is the mean summary rate from the Medicaid and Commercial samples that submitted to NCQA in 2017.

Commercial Adult Trended Survey Results

Summary Rate Scores – Commercial Adult	AAH 2018 Results	2017 Quality Compass All Plans*	AAH 2017 Results	Year Over Year Tend

Getting Needed Care Composite	72.3%	86.3%	65%	↑
Getting Care Quickly	69.5%	84.5%	65.5%	↑
How Well Doctors Communicate	85.8%	95.1%	84.6%	↔
Customer Service	86.5%	88.2%	70%	↑
Claims Processing	91.5%	88.1%	88.3%	↑
Shared Decision Making	84.3%	81.8%	81%	↑
Rating of Health Care (8+9+10)	66.8%	77.2%	62.2%	↑
Rating of Personal Doctor (8+9+10)	73.3%	84.7%	76.6%	↓
Rating of Specialist (8+9+10)	75.9%	84.6%	79.5%	↓
Rating of Health Plan (8+9+10)	66.5%	63.4%	63.4%	↑

*The 2017 Quality Compass All Plans benchmark is the mean summary rate from the Medicaid and Commercial samples that submitted to NCQA in 2017.

MediCal Child Three-Point Scores

CAHPS Results – MediCal Child	AAH Three-Point Scores	CAHPS 25th Percentile	Plan Percentile Threshold
Getting Needed Care	2.36	2.38	<25th
Getting Care Quickly	2.44	2.54	<25th
Customer Service	2.45	2.50	<25th
Coordination of Care	2.37	2.35	25th
Rating of Health Care	2.60	2.49	90th
Rating of Personal Doctor	2.68	2.58	75th
Rating of Specialist	NA	2.53	NA
Rating of Health Plan	2.66	2.51	75th

NA = denominator was less than 100 and the points are redistributed among the remaining required measures.

MediCal Adult Three-Point Scores

CAHPS Results – MediCal Adult	AAH Three-Point Scores	CAHPS 25th Percentile	Plan Percentile Threshold
Getting Needed Care	2.19	2.33	<25th
Getting Care Quickly	2.22	2.37	<25th
Customer Service	NA	2.48	NA
Coordination of Care	NA	2.36	NA
Rating of Health Care	2.36	2.35	25th
Rating of Personal Doctor	2.60	2.43	90th
Rating of Specialist	NA	2.48	NA

Rating of Health Plan	2.42	2.39	25th

NA = denominator was less than 100 and the points are redistributed among the remaining required measures.

Commercial Adult Three-Point Scores

CAHPS Results – Commercial Adult	AAH Three-Point Scores	CAHPS 25th Percentile	Plan Percentile Threshold
Getting Needed Care	2.08	2.37	<25th
Getting Care Quickly	2.07	2.39	<25th
Customer Service	NA	2.44	NA
Claims Processing	NA	2.36	NA
Coordination of Care	2.05	2.29	<25th
Rating of Health Care	2.23	2.33	<25th
Rating of Personal Doctor	2.38	2.47	<25th
Rating of Specialist	2.44	2.49	<25th
Rating of Health Plan	2.25	2.02	75th

NA = denominator was less than 100 and the points are redistributed among the remaining required measures.

Analysis

The 2018 CAHPS survey results year-over-year trends show variation amongst population line. General Child's composite scores saw a majority decrease (7/9); Adult (6/9) and Commercial Adult (7/10) both saw majority increases.

A large percentage of AAH's membership belongs to delegate networks. As of 12/31/17 AAH had a total of 244,206 members. Breakdown of enrollment by delegates is as follows: Children First Medical Group (CFMG) 36%, Community Health Center Network (CHCN) 36%, and Kaiser 13%. CFMG saw majority of decreases with their composite scores for General Child (4/7) and variation within the Adult (3-increased, 3-flat, 1-decreased) population. CHCN saw majority of decreases with their composite scores General Child (4/7) and variation within the Adult (3-increased, 3-decreased, 1-flat) population. Kaiser saw variation within their General Child (3-increased, 2-decreased, 2-flat) and Adult saw all decreases within the composite scores.

Three-point scores are utilized for the annual accreditation score provided by NCQA. AAH usually utilized the General Child survey to address this portion of the annual score. Four composites are at or below the 25th percentile. The others are 75th percentile or above.

Barriers contributing to CAHPS Results

The Quality Improvement and Member Services Departments have experienced vacancies and need to add administrative capacity to better serve the needs of Alameda Alliance members. High turnover and

high vacancies for some of these positions delayed the implementation of new programs in 2018. Quality and Member Services are working collaboratively with Human Resources to recruit and retain resources in these departments.

Moving into 2019, the Alliance will work towards identified barriers including provider and member communication, improving access to care including child services, appropriately addressing grievances, and performing RCAs on PQIs; the goal of 2019 is to see a majority increase in composite scores. Additionally, these items will be brought to the Cross-Functional Workgroup for further analysis and action.

B. Grievance and Appeals

Alameda Alliance for Health reviews and investigates all grievance and appeal information submitted to the plan in an effort to identify quality issues that affect member experience. The grievance and appeals intake process are broken down into two processes, exempt grievances and non-exempt grievances. In both instances, the details of the member's complaints are collected, processed, and reviewed and actions are taken to resolve the issue.

An **Exempt Grievance** is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination received over the telephone that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the close of the next business day. Exempt grievances are tracked via the Informal Complaints Dashboard.

A **Non Exempt Grievance** is a written or oral expression of dissatisfaction regarding the Plan and/or provider, including quality of care or service concerns, including any breaches of confidentiality surrounding protected health information, and may include a complaint, dispute, or a request for reconsideration made by a Member or the Member's authorized representative. Where the Plan is unable to distinguish between a grievance and an inquiry, it will be considered a grievance. The Plan appropriately categorizes appeals by definition. Non Exempt Grievance information is tracked using the Grievance and Appeals Grievance Log.

An **Appeal** is defined as a review of an Adverse Benefit Determination. The state regulations do not explicitly define the term "Appeal", they do delineate specific requirements for types of Grievances that would fall under the new federal definition of Appeal. These types of Grievances involve the delay, modification, or denial of services based on medical necessity, or a determination that the requested service was not a covered benefit.

The Alliance's Grievance and Appeals (G&A) department monitors grievances (complaints) and appeals on a quarterly basis to identify issues affecting quality of care and service within the provider network. Providers exceeding the maximum amount of complaints are subject to disciplinary action.

Medical Grievances:

Medicaid Complaint Volume				
Category	2017 Compliant Total	2017 Complaints per 1,000 Members	2018 Compliant Total	2018 Complaints per 1,000 Members
Quality of Care	767	0.24	**2513**	0.8
Access	442	0.14	**1790**	0.57
Attitude/Service	445	0.14	**1190**	0.57
Billing/Financial	1638	0.52	1175	0.37
Quality of Practitioner Office Site	14	0.004	45	0.014
Total Number per 1,000	3,301	1.04	6,713	2.13

The Alliance initiated an update to our exempt and non-exempt grievance process in 2017 which continued into 2018. We identified that in addition to not reporting exempt grievances to Committee for review we were grossly under reporting exempt grievances in general. Workflows and training was conducted with Member Services and G&A staff to ensure that all expressions of dissatisfaction were being captured. In addition, the Alliance updated the tracking system for capturing exempt grievances effective Q4 2018 to allow for accurate reporting. As a result, all Committee and Joint Operations Meetings will include exempt grievance data along with Non Exempt Grievances and Appeals effective Q4 2018 and onward. We have also seen a significant increase of grievances throughout the quarters due to training and better tracking of grievances.

The Alliance identified a significant trend of increased grievances against our durable medical equipment (DME) vendor, California Home Medical Equipment (CHME). There were a total of 35 grievances in 2017. In January 2018, there were 48 grievances received alone with a total of 444 grievances for all of 2018. The grievances involved customer service, telephone access, and delay in receiving supplies. Grievance data and trends were presented to CHME leadership during Joint Operations Meetings and on an ad-hoc basis. In Q4 2018, the Alliance Compliance Department issued a Corrective Action Plan and the Alliance has begun to meet with CHME bi-weekly starting in 2019 to resolve issues. CHME has reported that they have increased their call center staff and operational team in order to improve telephone wait times. The Alliance continues to monitor grievances against CHME.

Medicaid Appeals

In accordance with 28 CCR 1300.68(a)(1), the Alliance follows the Department of Managed Health Care's definition of a Grievance, which is, "A written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative". Therefore, Alameda Alliance does not distinguish between a complaint and an appeal. Appeals will be included in UM coverage appeals addressed in UM 8–UM 9.

Commerical Grievances

Commercial Complaint Volume				
Category	2017 Compliant Total	2017 Complaints per 1,000 Members	2018 Compliant Total	2018 Complaints per 1,000 Members
Quality of Care	24	0.35	161	2.31
Access	18	0.26	99	1.42
Attitude/Service	18	0.26	51	0.73
Billing/Financial	168	2.45	115	1.65
Quality of Practitioner Office Site	0	0	2	0.03
Total Number per 1,000	228	3.32	428	6.13

The Alliance initiated an update to our exempt and non-exempt grievance process in 2017 which continued into 2018. We identified that in addition to not reporting exempt grievances to Committee for review we were grossly under reporting exempt grievances in general. Workflows and training was conducted with Member Services and G&A staff to ensure that all expressions of dissatisfaction were being captured. In addition, the Alliance updated the tracking system for capturing exempt grievances effective Q4 2018 to allow for accurate reporting. As a result, all Committee and Joint Operations Meetings will include exempt grievance data along with Non Exempt Grievances and Appeals effective Q4 2018 and onward. We have also seen a significant increase of grievances throughout the quarters due to training and better tracking of grievances.

We continue to see a large amount of billing and financial grievances with 168 grievances in 2017 and 115 grievances in 2018 related to commercial members being balanced billed from out-of-network providers for emergency services. The Alliance covers twenty-four (24) hour care for emergencies, both in and outside of Alameda County. Although we cannot avoid these grievances, the Alliance works closely with our claims department and provider service department to resolve the complaints.

Commercial Appeals

In accordance with 28 CCR 1300.68(a)(1), the Alliance follows the Department of Managed Health Care's definition of a Grievance, which is, "A written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative". Therefore, Alameda Alliance does not distinguish between a complaint and an appeal. Appeals will be included in UM coverage appeals addressed in UM 8–UM 9.

QUALITY OF ACCESS

A. Standards and Education of Standards

AAH has adopted, educated providers on, monitored, and enforced the following standards:

Primary Care Physician (PCP) Appointment	
Appointment Type:	**Appointment Within:**
Non-Urgent Appointment	10 Business Days of Request
Initial **OB/Gyn Pre-natal** Appointment	2 Weeks of Request
Urgent Appointment that *requires* Prior Authorization (PA)	96 Hours of Request
Urgent Appointment that *does not* require PA	48 Hours of Request

Specialty / Other Appointment	
Appointment Type:	**Appointment Within:**
Non-Urgent Appointment with a **Specialist** Physician	15 Business Days of Request
Initial **OB/Gyn Pre-natal** Appointment	2 Weeks of Request
Non-Urgent Appointment with a **Behavioral Health** Provider	10 Business Days of Request
Non-Urgent Appointment with an **Ancillary Service**	15 Business Days of Request
Urgent Appointment that *requires* Prior Authorization (PA)	96 Hours of Request
Urgent Appointment that *does not* require PA	48 Hours of Request

All Provider Wait Time / Telephone / Language Practices	
Appointment Type:	**Appointment Within:**
In-Office Wait Times	Within 60 Minutes
Call Return Time	Within 1 Business Day
Time to Answer Call	Within 10 Minutes
After Hours Telephone Access	Provide 24 Hours Coverage
Emergency Instructions	Ensure Proper Emergency Instructions
Language Services	Provide 24 Hour Interpretive Services

Each of these standards are monitored as per the below table. In 2018, the Alliance made changes to the CG-CAHPS instrument to ensure that the collected data was consistent with the Alliance standards. These changes will be implemented in the 2019 Surveys.

Primary Care Physician (PCP) Appointment	
Appointment Type:	**Measured By:**
Non-Urgent Appointment	PAAS, CG-CAHPS (Q8 edited)
Initial OB/Gyn Pre-natal Appointment	PAAS
Urgent Appointment that *requires* Prior Authorization (PA)	PAAS, CG-CAHPS (new question added)
Urgent Appointment that *does not* require PA	PAAS, CG-CAHPS (new question added)

Specialty / Other Appointment	
Appointment Type:	**Measured By:**
Non-Urgent Appointment with a Specialist Physician	PAAS Survey
Initial OB/Gyn Pre-natal Appointment	PAAS Survey
Non-Urgent Appointment with a Behavioral Health Provider	PAAS Survey
Non-Urgent Appointment with an Ancillary Service	PAAS Survey
Urgent Appointment that *requires* Prior Authorization (PA)	PAAS Survey
Urgent Appointment that *does not* require PA	PAAS Survey

All Provider Wait Time / Telephone / Language Practices	
Appointment Type:	**Measured By:**
In-Office Wait Times	Internal Survey, CG-CAHPS (Q32 edited)
Call Return Time	Internal Survey, CG-CAHPS (new question added)
Time to Answer Call	Internal Survey, CG-CAHPS (new question added)
After Hours Telephone Access	After Hours Survey / Confirmatory Survey
Emergency Instructions	After Hours Survey / Confirmatory Survey

Alameda Alliance and the QI team adopted a PDSA approach to the access standards.

- Plan: The standards were discussed and adopted and surveys were then aligned with our adopted standards
- Do: The surveys were then administered as per our policies and procedures; surveys methodologies, vendors, and processes are outlined in P&Ps
- Study: Survey results along with QI recommendations were brought forward to the A&A sub-committee; the sub-committee formalized recommendations and were forwarded to the HCQC Committee and Board of Governors
- Act: Dependent on non-compliant providers and study / decision of the A&A Sub-Committee, actions included re-education, discussions with providers and delegates, and corrective action plans (CAPs).

B. Cultural and Linguistic Needs of Members

The Alliance QI Department conducts an annual assessment of the Alliance's membership cultural and linguistic makeup as well as the provider network with respect to member accessibility. The assessment is meant to enhance the Alliance's ability to provide access to high quality healthcare to our members and focuses on the following areas:

- Cultural and Linguistic needs of members;
- Provision of interpreter services
- PCP language capacity

The Alliance strives to ensure members have access to a PCP who can speak their language or to appropriate interpreters. For members who have not chosen a PCP upon enrollment, the Alliance will assign a member to a PCP based on characteristics, including language. In 2018, the Alliance identified the following threshold languages.

Medi-Cal	English	155,975	60.91%
	Spanish	49,879	19.48%
	Chinese	24,900	9.72%
	Vietnamese	8,487	3.31%
Group Care	English	3,552	60.36%
	Chinese	1,297	22.04%
	Spanish	278	4.72%*

* Just under threshold criteria, but given variations in membership over the year, the Alliance chooses to treat Spanish as a threshold language for Group Care.

Member Ethnicity

MEDI-CAL	Prior Year	YTD	Difference	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY ETHNICITY	Jan - Dec 2017	Jan - Dec 2018	% YTD Membership in Jan - Dec 2018 (minus) % of Membership in Jan - Dec 2017	Dec 2018	Dec 2018 %
Hispanic	28.82%	28.78%	-0.04%	73,159	28.57%
Black	19.44%	19.09%	-0.35%	49,074	19.17%
Other	12.18%	12.93%	0.75%	33,667	13.15%
Other Asian / Pacific Islander	12.18%	11.89%	-0.29%	30,132	11.77%
Chinese	10.76%	10.95%	0.20%	28,255	11.03%
White	11.23%	10.83%	-0.40%	27,415	10.71%
Vietnamese	4.27%	4.29%	0.03%	11,011	4.30%
Unknown	0.84%	0.96%	0.12%	2,658	1.04%
American Indian Or Alaskan Native	0.29%	0.27%	-0.02%	684	0.27%
Total Members				256,055	

Medi-Cal Ethnicity Discussion: 2018 saw only slight changes in ethnicities as a percent of the Medi-Cal membership. Hispanic members make up almost 30%, all Asian members combined make up over 25%, and Black members almost 20% of our Medi-Cal membership.

GROUP CARE	Prior Year	YTD	Difference	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY ETHNICITY	Jan - Dec 2017	Jan - Dec 2018	% YTD Membership in Jan - Dec 2018 (minus) % of Membership in Jan - Dec 2017	Dec 2018	Dec 2018 %
Unknown	43.69%	39.81%	-3.88%	2,232	37.93%
Other Asian / Pacific Islander	22.65%	25.23%	2.58%	1,533	26.05%
Chinese	10.01%	10.93%	0.92%	673	11.44%
Black	10.94%	11.17%	0.23%	670	11.38%
Other	4.79%	4.95%	0.17%	304	5.17%
Hispanic	3.19%	3.16%	-0.03%	192	3.26%
Vietnamese	2.61%	2.70%	0.09%	160	2.72%
White	1.97%	1.94%	-0.03%	116	1.97%
American Indian Or Alaskan Native	0.15%	0.10%	-0.05%	5	0.08%
Total Members				5,885	

Group Care Ethnicity Discussion: The largest group who identified their ethnicity was the Other Asian/Pacific Islander, at almost one-fourth of the Group Care membership, of which 21% are of Asian

Indian ethnicity. The percent of Group Care members with unknown ethnicity continues to decline, although still higher than desired.

Member and Provider Languages Spoken

MEDI-CAL	Prior Year	YTD	Difference	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY LANGUAGE	Jan - Dec 2017	Jan - Dec 2018	% YTD Membership in Jan - Dec 2018 (minus) % of Membership in Jan - Dec 2017	Dec 2018	Dec 2018 %
English	61.92%	61.16%	-0.76%	155,975	60.91%
Spanish	19.04%	19.42%	0.38%	49,879	19.48%
Chinese	9.39%	9.60%	0.21%	24,900	9.72%
Unknown	4.07%	4.11%	0.03%	10,575	4.13%
Vietnamese	3.21%	3.28%	0.06%	8,487	3.31%
Other Non-English	1.71%	1.77%	0.06%	4,514	1.76%
				256,055	

Medi-Cal Language Discussion: Our Medi-cal members are approximately 3/5 English-speaking, 1/5 Spanish-speaking, 1/10 Chinese-speaking 3/100 Vietnamese-speaking.

GROUP CARE	Prior Year	YTD	Difference	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY LANGUAGE	Jan - Dec 2017	Jan - Dec 2018	% YTD Membership in Jan - Dec 2018 (minus) % of Membership in Jan - Dec 2017	Dec 2018	Dec 2018 %
English	61.58%	60.72%	-0.86%	3,552	60.36%
Chinese	20.53%	21.63%	1.10%	1,297	22.04%
Unknown	5.07%	4.84%	-0.23%	286	4.86%
Spanish	4.74%	4.78%	0.04%	278	4.72%
Vietnamese	3.40%	3.34%	-0.06%	195	3.31%
Other Non-English	2.75%	2.85%	0.10%	173	2.94%
				5,885	

Group Care Language Discussion: Group Care members continue to speak predominately English 2/5 of the Group Care members, followed by Chinese-speaking (almost 1/5) and Spanish-speaking (1/20).

Practitioner Language Capacity

During 2017, the Alliance's Provider Relations staff conducted in-person surveys during provider office visits to verify languages spoken by providers. The chart below is a comparison of identified languages

spoken by the plan's members to its provider network at the end of Quarter 4 2018. Please note, multi-lingual providers are counted for each language spoken by the individual.

	2017Q4			2018Q4			Change			
Language	PCPs	Members	Members per PCP	PCPs	Members	Members per PCP	# PCPs	% PCPs	# Members	% Members
English	501	135,124	269	509	131,489	258	8	2%	-3,635	-3%
Spanish	113	45,571	403	115	45,318	394	2	2%	-253	-1%
Chinese	47	23,701	504	78	23,541	301	31	66%	-160	-1%
Unknown	7	10,818	1,545	7	9,785	1,397	0	0%	-1,033	-10%
Vietnamese	16	8,289	518	16	8,218	513	0	0%	-71	-1%
Other Non-English	133	2,212	16	173	2,153	12	40	30%	-59	-3%
Arabic	2	2,069	1,034	3	2,000	666	1	50%	-69	-3%
Farsi	6	1,656	276	7	1,640	234	1	17%	-16	-1%
Total	825	229,440		908	224,144		83	10%	-5,296	-2%

Source: Q4 2017 and Q4 2018 Provider Impact Reports

* A number of PCPs do not have a primary language designated in the data we receive. Also, multi-lingual providers are counted for each language they speak.

The Alliance also identified and reviewed significant changes and trends related to provider language capacity. In 2018 the Plan experienced overall improvement in the ratios of members per provider for all languages. All languages are in a favorable range.

	2017Q4	2018Q4	Change
Language	Members per PCP	Members per PCP	Difference
English	269	258	Improvement ↓11
Spanish	403	394	Improvement ↓9
Chinese	504	301	Improvement ↓203
Vietnamese	518	513	Improvement ↓5
Arabic	1034	666	Improvement ↓ 69
Farsi	276	234	Improvement ↓ 16

In addition, the Alliance continues to monitor provider language capacity levels and trends quarterly though the following:

1. Review of provider and member spoken language capacity comparison
2. Review of grievances related to provider language capacity
3. Monitoring of interpreter services provided

In the absence of a practitioner who speaks a member's preferred language, the Alliance ensures the provision of interpreter services at the time of appointment. In order to meet the language demand increase in 2018, the Alliance contracted with a second interpreter vendor. In 2018, the Alliance

provided over 17,000 telephonic interpreter services. In addition, we completed just under18,000 requests for interpreter services at the time of appointment. This represents over 99.5% fulfillment with prescheduled interpreter requests.

C. Provider Capacity

The Alliance reviews network capacity reports monthly to determine whether primary care providers are reaching network capacity standards of 1:2000. In 2018, no providers exceeded the 2,000 member threshold. The Network Validation department flags the provider at 1900 and above to ensure member assignment does not reach the 2,000 capacity standard. If a provider is close to the threshold, the plan reaches out to confirm if the provider intends to recruit other providers. If not, the panel is closed to new assignment. During this time the plan and the provider are in communication of such changes.

D. Geo Access

The geographic access reports are reviewed quarterly to ensure that the plan is meeting the geographic access standards for provided services in Alameda County. For PCPs, the Alliance has adopted standards of one provider within 30 minutes / 15 miles. For specialists, the Alliance has adopted standards of one provider within 30 minutes / 15 miles.

In 2017, the rural areas near Livermore and the southern border of Alameda were the only areas in which the plan is facing geographic access issues for certain specialties. These areas were in need of access to a hospital which will enable them to meet the geographic access standards for both lines of business (IHSS and Medi-Cal). In the past due to the lack of hospitals located in the rural area, plan submitted an alternative access standard proposal to the Department of Managed Health Care which has been approved for a distance of 25 miles for both Medi-Cal and IHSS networks.

In August of 2018, the Alliance finalized a physician and hospital contract agreement with a local and major health system that will provide geographic access for those members residing in the Livermore and Pleasanton areas.

In the remainder of 2018, the plan met the geographic access standards for provided services in Alameda County.

E. Provider Appointment Availability

The Alliance annual Provider Appointment Availability Survey for MY2018 was used to review appointment wait times for the following provider types:

- Primary Care Physicians
- Specialists:
    - Allergists
    - Cardiologists
    - Endocrinologists
    - Gastroenterologists

    - Psychiatrists
    - Child & Adolescent Psychiatrists
- Non-Physician Mental Health Providers (PhD-level and Masters-level)
- Ancillary Providers offering Mammogram, MRI and/or Physical Therapy appointments

The Alliance reviewed the results of its annual Provider Appointment Availability Survey for MY 2018 in order to identify areas of deficiency and areas of potential improvement. The Alliance defines *deficiency* as a provider group scoring less than seventy-five percent (75%) for the compliance rate on any of the survey questions related to appointment wait times.

A review and analysis of the data could not be completed as the results have not yet been validated.

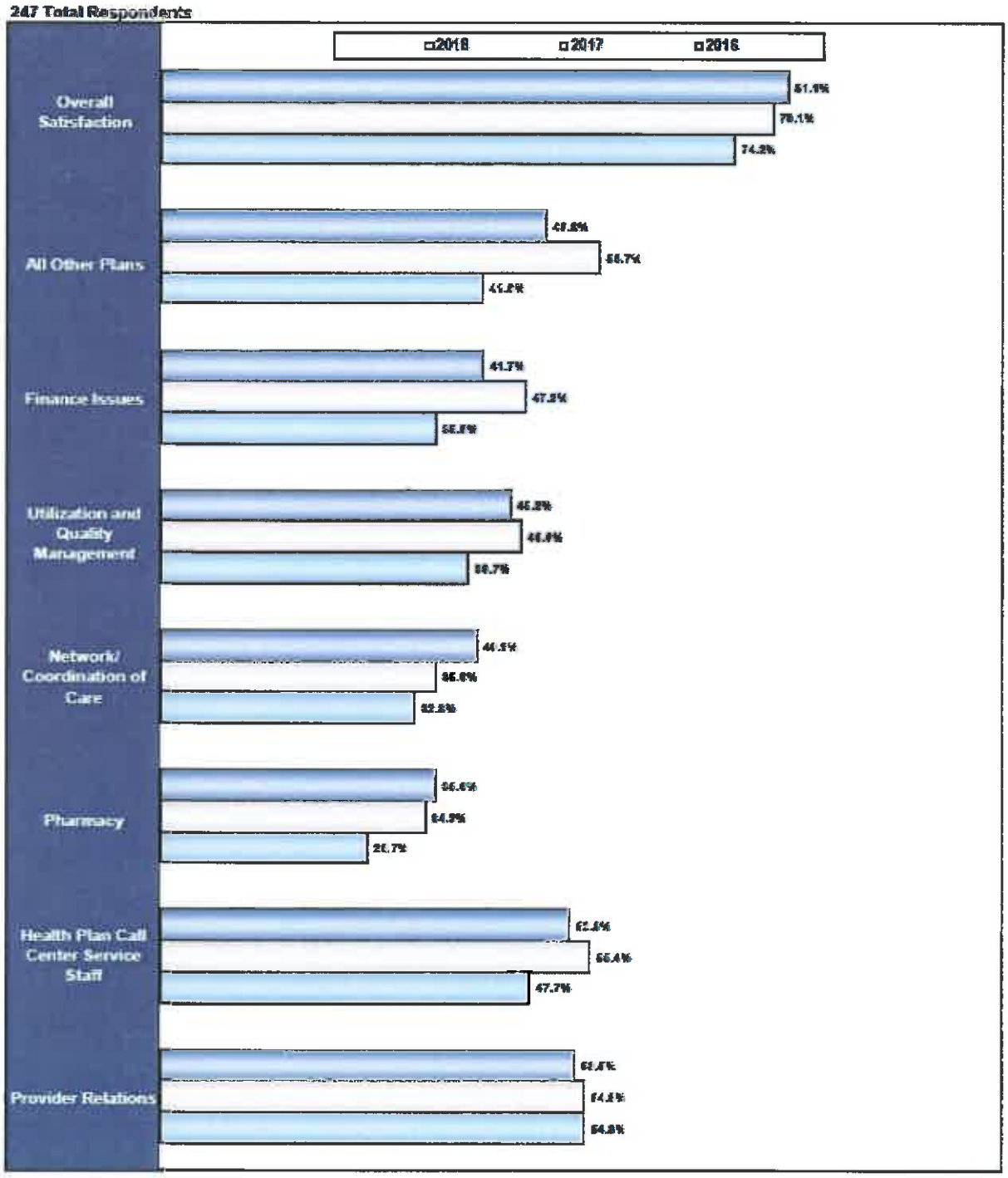
PROVIDER SATISFACTION SURVEY OVERVIEW

Alameda Alliance for Health (AAH) contracted to conduct a Provider Satisfaction Surveys for measurement year 2018. AAH provided the vendor with a database of 5,372 Primary Care Physicians, Specialists and Behavioral Health Care Practitioners. The database was cleaned by removing any records with duplicate NPIs. From the database of unique providers, a sample of 815 records was drawn based on specialty. A total of 247 surveys were completed (128 mail, 24 internet and 95 phone), yielding a response rate of 19.9% for the mail/internet component and 30.4% for the phone data component.

Below is an overview of the survey results broken down by provider satisfaction composites.

247 Total Respondents

Composites and Key Questions	Current						2017 SPH Book of Business Benchmarks**	
	2018		2017		2016			
	Valid n	Summary Rate*	Valid n	Summary Rate	Valid n	Summary Rate	Commercial	Aggregate
Overall Satisfaction		81.7%		78.9%		74.5%	78.8%	79.1%
5A. Would you recommend Alameda Alliance for Health to other physicians' practices?	206	87.7%	214	86.8%	201	87.1%	87.4%	82.9%
5B. Please rate your overall satisfaction with Alameda Alliance for Health.	212	81.1%	225	78.1%	209	74.2%	78.8%	79.1%
5C. Please rate your overall satisfaction with Other managed Medi-Cal plans in your county.	186	81.8%	174	80.3%	177	81.0%	79.5%	84.3%
All Other Plans (Comparative Rating)								
1A. How would you rate Alameda Alliance for Health compared to all other health plans you contract with?	230	48.2%	240	68.7%	233	41.6%	44.9%	37.9%
Finance Issues		41.7%		47.2%		36.8%	34.9%	32.8%
2A. Consistency of reimbursement fees with your contract rates.	210	38.6%	215	47.5%	196	31.0%	32.8%	30.8%
2B. Accuracy of claims processing.	204	46.1%	218	50.7%	194	38.7%	37.6%	34.4%
2C. Timeliness of claims processing.	200	43.5%	218	44.5%	192	38.0%	36.0%	34.5%
2D. Resolution of claims payment problems or disputes.	175	38.9%	193	46.1%	181	31.5%	32.3%	29.1%
Utilization and Quality Management		46.2%		44.8%		38.7%	36.7%	34.7%
3A. Access to knowledgeable UM staff.	196	40.8%	184	45.7%	197	38.6%	37.4%	32.5%
3B. Procedures for obtaining pre-certification/referral/authorization information	196	46.7%	217	44.7%	198	40.4%	38.4%	34.1%
3C. Timeliness of obtaining pre-certification/referral/authorization information.	197	46.7%	214	43.5%	194	37.6%	38.4%	34.2%
3D. The health plan's facilitation/support of appropriate clinical care for patients.	186	48.9%	198	46.5%	185	39.2%	38.4%	33.8%
3E. Access to Case/Care Managers from this health plan.	178	40.6%	159	45.3%	178	38.8%	37.5%	32.3%
3F. Degree to which the plan covers and encourages preventive care and wellness.	178	52.4%	182	53.8%	184	48.7%	47.8%	41.2%
Network/Coordination of Care		46.8%		46.8%		42.8%	42.4%	41.4%
4A. The number of specialists in this health plan's provider network.	178	37.6%	179	30.7%	171	32.4%	33.8%	29.4%
4B. The quality of specialists in this health plan's provider network.	164	44.6%	174	39.1%	175	37.5%	41.8%	34.8%
4C. The timeliness of feedback/reports from specialists in this health plan's provider network.	171	40.4%	160	36.9%	160	30.6%	33.6%	30.1%
Pharmacy		55.8%		54.3%		50.7%	53.8%	54.9%
5A. Consistency of the formulary over time.	165	54.5%	128	54.9%	165	50.1%	50.1%	45.5%
5B. Extent to which formulary reflects current standards of care.	161	57.8%	128	54.4%	163	57.8%	50.2%	46.2%
5C. Variety of branded drugs on the formulary.	163	54.6%	125	52.5%	165	51.5%	47.8%	43.8%
5D. Ease of prescribing your preferred medications within formulary guidelines.	162	57.6%	125	56.8%	167	55.1%	50.4%	45.7%
5E. Availability of comparable drugs to substitute those not included in the formulary.	161	54.4%	123	52.5%	163	45.2%	47.5%	43.5%
Health Plan Call Center Service Staff		52.8%		55.4%		47.7%	48.8%	46.8%
6A. Ease of reaching health plan call center staff over the phone.	187	49.2%	219	51.9%	194	47.9%	47.3%	45.8%
6B. Process of obtaining member information (eligibility, benefit coverage, co-pay amounts).	190	56.8%	208	59.1%	195	55.4%	48.9%	42.3%
6C. Helpfulness of health plan call center staff in obtaining referrals for patients in your care.	190	51.6%	151	53.5%	169	42.0%	43.9%	43.0%
6D. Overall satisfaction with health plan's call center service.	201	54.7%	226	56.8%	232	48.5%	48.9%	46.8%
Provider Relations		53.0%		54.2%		54.2%	48.2%	47.9%
7A. Do you have a Provider Relations representative from this health plan assigned to your practice?	196	54.6%	212	44.3%	195	57.4%	37.8%	46.7%
7B. Provider Relations representative's ability to answer questions and resolve problems.	98	68.7%	93	70.8%	107	69.2%	54.8%	48.6%
7C. Quality of provider orientation process.	146	42.9%	158	36.8%	142	50.7%	31.4%	30.5%
7D. Quality of written communications, policy bulletins, and manuals.	187	48.6%	185	43.5%	174	48.4%	34.8%	32.8%



The above information does recognize an upward trend from 2017 to 2018 in overall provider satisfaction, network, coordination of care, and pharmacy.

The above information does recognize a downward trend from 2017 to 2018 in comparative rating to other plans, finance issues, utilization and quality management, health plan call center service staff, and provider relations.

While our goals were upward trends in the majority of satisfaction composites, this data will be shared with all relevant stake holders to identify and improve future scores and outcomes.

QUALITY PROGRAM BARRIERS

The Alliance has identified the challenges and barriers to improvement throughout the 2018 QI Evaluation. Recommended activities and interventions for the upcoming year consider these challenges and barriers in working towards success and achievement of the Alliance's goals in 2019.

Some of the challenges encountered throughout 2018 included, but are not limited to:

- Vacancies and employee turnover in the QI Department
- Changes in the Grievance and Appeals system
- Reliance on annual HEDIS outcome measurements results impedes rapid and strategic PDSA cycles.
- Mixed results in member experience as measured through CAHPS and grievances.

Some successful outcomes for 2018 include:

- The HCQC met 7 times this year and remained active in ensuring requirements of the QI Program were met
- There continues to be Senior Level Physician involvement and Appropriate External and Internal Leadership
- The QI Program was evaluated and discussed by the HCQC Committee
- Improved HEDIS performance for most measures; above the MPL for all accountable HEDIS metrics
- Focus on provider education - including more frequent visits and regular meetings with network and delegated providers that resulted in Improved 'Overall Satisfaction' of network providers
- Continued focus on health promotion and education that resulted in some of the higher CAHPS scores
- Improved turn-around times and root cause analysis of PQIs
- Introduction of a PQI Application
- Ongoing / successful performance improvement projects
- Robust Health Education and Cultural and Linguistic Programs
- Cost effective approach to quality and safety by utilizing community resources such as:
    - Substance Abuse Disorder Program
    - Ongoing Performance Improvement Projects
    - Early Start Program that serves infants and toddlers who have significant developmental delays.
    - California WIC Program that helps pregnant, breastfeeding or postpartum women and children.
    - Partnering with the Breastfeeding Coalition and Black Infant Health

- Improved Member Services processes and hiring new staff, resulting in improved telephone response times.
- Comprehensive monitoring of all practitioners during credentialing / re-credentialing to ensure high quality network.