ALAMEDA Alliance FOR HEALTH

Internal Quality Improvement Committee Meeting Agenda

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Meeting Name:	Internal Quality Improvement Committee Meeting		
Date of Meeting:	10/11/2023	**Time:**	1:00pm – 2:00pm
Meeting Coordinator:	Ashley Asejo	**Location:**	Microsoft Teams
Call in Number:	(510)210-0967	**Webinar:**	ID: 228 118 646 310

I. Meeting Objective

To oversee the quality of clinical care, patient safety, and customer service provided throughout Alameda Alliance for Health.

II. Members

Name	Title	Name	Title
Dr. Sanjay Bhatt, Co-Chair	Medical Director, Quality Improvement	Dr. Steve O'Brien	Chief Medical Officer
Michelle Nepomuceno Stott, RN, MSN	Senior Director of Quality	Dr. Beverly Juan	Medical Director, Utilization Management
Dr. Rosalia Mendoza	Medical Director, Clinical Services	Darryl Crowder	Director, Provider Relations & Provider Contracting
Dr. Donna Carey	Medical Director, Clinical Services	Cecilia Gomez	Sr. Manager, Provider Services
Julie Anne Miller	Director, Health Care Services	Tiffany Cheang	Chief Analytics Officer, Healthcare Analytics
Lilly Hunter	Director, Social Determinants of Health	Farashta Zainal	Manager, Quality Improvement Team
Grace St. Clair	Director, Compliance	Christine Rattray	Supervisor, Quality Improvement (PQI)
Sean Pepper	Compliance Special Investigator	Gil Duran	Manager, Population Health and Equity
Jennifer Karmelich	Director of Quality Assurance	Mao Moua	Manager, Cultural and Linguistic Services
Alma Pena	Manager, Grievances & Appeals	Annie Lam	
Linda Ayala	Director, Population Health		
Loc Tran	Manager, Access to Care		

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III. Meeting Agenda		
Topic	**Responsible Party**	**Notes**
Call to Order/Roll Call	F. Zainal	Meeting rescheduled due to the DHCS Audit on 10/18/2023.
1. Review agenda for 10/11/2023	F. Zainal	Informational
2. Policies & Procedures • Listed below	F. Zainal L. Ayala	Informational Reviewed the polices listed below.
3. Meeting Minutes - IQIC – 7/19/2023	F. Zainal	Informational

4. 2023 HEDIS Rates	F. Zainal	• Farashta went over the rates from 10/05.
		• Most claims were received through the end of September.
		• Below MPL on the FUM Measure at 27.09% (MPL 54.51%)
		• Children's Health Measures:
		  ○ Below MPL on Lead Screening at 58.20% (MPL 63.99%)
		  Rates are looking better compared to last year.
		  ○ W15 at 45.24%. Working on a lot of supplemental data to meet measure.
		  ○ Below MPL on WCV at 38.69% (MPL 48.93%) We need over 10,000 visits to meet MPL.
		• Chronic Disease:
		  ○ Below MPL on CBP at 39.23% (MPL 59.85%). We need over 4,000 members to meet MPL.
		  ○ A1C Poor Control we are at 51.26%. The lower our rate the better. We need over 1,700 members to meet MPL.
		• Women's Health Domain:
		  ○ Above MPL for Breast Cancer Screenings .
		  ○ Cervical Cancer Screenings, we are at 49.60% (MPL 57.64%) We need over 6,000 members to meet MPL.

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		○ Timeliness of Prenatal Care, we are at 83.25% (MPL 85.40%) • We are working on lots of QI activities around these measures. ○ Member Outreach: – HEDIS Crunch. Offering incentive for Well Care (Child) visits. Working with 18 CFMG providers. – Incentives for Lead Screening. – Birthday cards for Cervical Cancer Screening. – Mobile Mammography ○ Provider Support: – 1-on-1 meetings with CFMG Providers. Training staff in HEDIS Specifications. – Offered incentive for extended office hours and Staff Incentives. We have 9-12 providers participating. – Development of measure highlight tools as well as webinars to train on measure specifications. ○ Data: – Continuing to share Gap in Care reports. – Working on supplemental data. – Working with providers on utilizing the correct CPT codes. Questions/Comments: -Dr. O'Brien asked if point of care testing was one of our previous interventions. He added that Lead Screening is important because of the CHDP Program. We must really understand the measure. He also asked that the $5M (if

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		approved) will be allocated to what measure QI thinks will make an impact. -F.Zainal added, we will see where the $5M will be allocated. Once we find out the details, we will update the group. -M. Stott asked the group if they noticed anything QI related that is missing or that they think needs to be continued/pursued? We are going to see sanctions and withholds that could affect our bottom lines. -A. Moses asked if QI is just speaking with staff or providers when visiting provider's offices. F.Zainal: Depending on the practice, we speak to either the provider, staff, or both. -A. Moses: Is the staff mainly MA or Nurses? Do you follow up that meeting with a summary that can be used for further education? A simple 1 pager? -F.Zainal: We usually speak with the office manager. We do follow up with meeting minutes and our slide deck which shares our data. We share their Gap in Care reports and offer follow-up meetings. -J. Karmelich: We have been seeing grievances on specific children who are having issues on access to care. Would it be helpful for us to send you a list of providers who are having access issues? -F. Zainal: agreed that it would be helpful to receive the list. -S. Bhatt: The access to care would live with the AA team to please include the AA team.

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		-H. Lee: Are you engaging First 5 to drive up the numbers? They have been resolving the delay in access. Are you adding any additional outreach vendors if needed? -F. Zainal: we asked First 5 to focus on more outreach. We have been working with them to do the outreach on the provider side. We can ask First 5 but Providers also must be willing to participate. We also utilize a vendor for additional outreach.
5. Nonutilized Outreach Pilot	M. Hils	• Megan shared the claims data that came in along with results and shared the poster she built for the DHCS Quality Conference. • Went over the totals for the 3 outreach attempts. • 50% overall success rate. • Successful disposition includes changing the PCP, leaving a voicemail, sharing general information, speaking with the member, transferring to PCP, • 40% Success for Adults 55% for Children. • 44% resulted in a voicemail. • 142 Member had a PCP visit following a successful contact. • Lessons Learned and what to test in Cycle 2: – Some members had Kaiser, already had an appointment scheduled. – Refine unclear and overlapping dispositions. – Work on tracking call backs. – Xaqt agents switched to a local line. – Add evening calls. – High # of incorrect numbers. – Not knowing what happens after members stay on the call after transfer to PCP. – Voicemail is successful. However, limited on how much information to leave. Questions/Comments:

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		-R. Mendoza asked if we are surprised at the amount of incorrect or disconnected numbers. It is roughly 22% of the sample size. Is there any attempts to work with member services to improve/correct the numbers? -F.Zainal responded that it is not a surprise. The challenge is unless the provider or member contacts us with updated information, there is no way for us to contact the member. -S. Bhatt added that it is valuable to have the data of members with incorrect information shared at the DHCS Conference. -G. Degrano added that it is not unusual. We do share data with Social Services twice a month when the member calls with information updates on the 1st and 15 of the months. We hold the updated information for 6 months and then it gets overridden by the State after that. We encourage members to contact Social Services to update their information.
6. P4P Update	S. Bhatt J. Pedden	• We are just about to finalize the 2024 P4P Measures. We will show the final measures at the next IQIC. • We have already started talking with AHS and CHCN on what the proposed metrics are so that there is a vested interest in the metrics. • We will create an electronic version as a guide, and we will distribute it to directs and delegates by the end of the year.
7. Alameda Alliance for Health $5M QI Investment	S. Bhatt M. Stott	• Quality Investment of **$5M a year for 3 years**. • Pending BOG approval on 10/13. • The ask is for focus on 5 areas: – Provider Engagement – Member Engagement

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		– Data Collection & Sharing – Funding/Resources – Organizational Alignment • The goal is to have sustainable funding over time. • $3.5M will be allocated to P4P. • A portion can be incorporated into Health Equity as an incentive. • Eventually, in 2026 it will move towards a Population Health approach. • Increase member outreach. • Manifest Metrics (Analytics) • We want to hire more to work on projects and other measures with focus on providers. • Practice Coaching consultants to train Staff. • Coordinated campaigns across the whole organization that aligns with member engagement strategy.
8. FUM Follow Up/ Care Coordination Project	S. Bhatt	• April 1st AAH insourced Mental Health Services. • One of the HEDIS Measures is FUM. 30-day follow up after ED visit for Mental Illness. • Numerator is when do we follow up with a member. Denominator is the members who made an ED visit. • Historical PIP, 6-7 years ago AAH was below the MPL on PPC measure. LVN performed care coordination aimed at this measure. • Beacon was in the process of launching a project to reach out to members to increase the FUM Metric. • Problem with data, most members were delegated to Alameda County Behavioral Health. State held both the Health Plan and County accountable to the MPL. • On average about 200 visits (not members) per month excluding Kaiser.

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		• Expect an increase with Anthem Blue Cross Members. • **BH QI Project** will have 1 staff member who will focus on reaching out to the 200 members a month to coordinate their care within 30 days. • Anticipate improvement in 2024. Questions/Comments: -P. Currie mentioned that these 2 measures are opportunities for us to impact members and connect them with care at a time where they are in crisis. Usually marks a crisis point. It's well worth the effort if we can intervene. -S. Jones asked how many of those 200 members are homeless and is there a role that Community Health can help with the lift? -S. Bhatt: We have not done a deep dive on the member's social determinants. There is certainly an opportunity to incorporate the Community Health team. -S. O'Brien asked if there is a plan to merge everything together if the funding is approved for an outreach representative. -S. Bhatt: They will be separate. The outreach team will be less clinical and focus on care coordination without the clinical requirement. More to come.
9. Population Health and Health Education Updates	G. Duran	• The aim of Population Health Management id to ensure all members achieve optimal health and well-being. The challenge and opportunity is that not all members need or receive the same care that they need when they need it.

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		• This leads to poor outcomes among populations with different needs.
		• As we apply Population Health Management to our work, it enables us and providers to better understand and meet the needs of members through targeted deployment of resources to members according to their needs/risks.
		  – Improved care coordination .
		  – Care management.
		  – Access to Wellness Prevention and Health Education.
		• In 2022, the Alliance counted approx. 285,000 Medi-Cal and Group Care members of very diverse backgrounds.
		• As we implement our Population Health program, we will be able to better determine who will need more support through our programs.
		• Proactively identify gaps in care.
		• Population Health Management framework consists of using data from analytics to identify the health risks of each member to determine the risk tiers (Low, Medium-Rising Risk, High Risk).
		• Having a better understanding of member populations will allow us to focus our resources where they will have the greatest impact.
		• Improved coordination will help drive collaborations with providers and community partners.
		• Effective Population Health Management will require monitoring and data collection.
		• This year, 3 primary strategies have been identified across the care continuum of services.
		  – Various campaigns and incentives to identify and address primary care gaps.

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		– Support members managing health conditions. – Connect members in need to whole person care. • 4 critical factors and areas of focus (NCQA PHM) – Keeping members healthy. – Managing members with emerging risk. – Managing multiple chronic illness. – Patient safety or outcomes across settings. • DHCS Quality Strategy Clinical Areas of Focus. – Children's Preventative Care. – Behavioral Health Integration. – Maternity Outcomes and birth equity. • Workplan Update – Disease Management: ○ Implementation of member letter outreach to members with asthma and diabetes programs by November 2023. ○ CVD and Depression outreach will begin in January 2024. – Diabetes Prevention Program: ○ Working with a new network provider HabitNu. ○ Working of implementing 2 new network providers. ○ Developing DPP engagement and enrollment strategy coming in October/November 2023. – Maternal Mental Health: ○ Completed DMHC filing. ○ Program description and deliverables are in the process.
10. **Adjournment**		Next meeting: 1/17/2024

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Policies & Procedures

QI-135: Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)

QI-XX: Clinical Practice Guidelines

HED-XX: Doula Services

HED-001: Health Education Program

PH-004: Community Health Workers