4665 Business Center Drive
Fairfield, California 94534

MEETING Minutes

Meeting & Project Name: Quality Improvement Health Equity Committee (QIHEC)

Date: 7/21/2026 **Time**: 7:30 a.m. – 9:00 a.m.

Facilitator: Mohamed Jalloh, Pharm D

Coordinator: Bethany Hannah

Meeting Locations:

- Webex

Attendees: Aaron Brincko; Amanda Harrison; Anna Cambell; Anthony Sackett; Ben Spencer; Brandon Yadi; Candy Stockton; Bethany Hannah; Christine Smith; Dawn Cook; Denise Whitsett; Denise Rivera; Emily Wellander; Folo Akintan; Hannah O'Leary; Jesus Hermosillo; Kermit Jones; James Devan; Juan Godinez; Katherine Barresi; Kimberly Robertello; Kory Watkins; Kristine Gual; Lisa Wada; Liz Romero; Liat Vaisenberg; Manleen Randhawa; Mark Bontrager; Mark Netherda; Marshall Kubota; Michele Grupe; Melissa Schumann; Mohamed Jalloh, PharmD; Monika Brunkal; Naz Sattari; Nicole Curreri, MPH CHES; Rod Grace; Roni Schultz; Shahrukh Chishty; Shantal Shamoiel; Sunshine Jackson; Sydni Aguirre; Valerie Padilla; Stan Leung, Sue Lee; Robert Moore, MD; Sue Quichocho; Tiffany Tryan; Tony Hightower; Vicky Klakken; Wendy Starr;

Absent: Sonja Bjork; Whitney Haggerson; Amanda Smith; Hendry Ton, MD; Ian Kim; Kimberly Robertello; Noemi Doohan; Rachel Newman; Rocio Rodriguez; Rebecca Stark; Shannon Boyle; Latrice Innes; Nisha Guppta;; Robert Bides; Shahrukh Chishty; Nicole Escobar; Heather Eset; Greg Allen Freedman; Jaymee James; John Lemoine; Sue Quichocho; Dorian Roberts; Tim Sharp; Amy Turnipseed; Edna Villasenor; Bridget Gast; Dana Codron; Monica Ferguson; Priscila Ayala; Katheryn Power, Wendi Davis; Monica Ferguson; Chloe Ungaro; Kristina Coester; Ledra Guillory; Lisa Wada; Tiffani Thomas; Chloe Ungaro; Kristina Coester; Ledra Guillory; Dana Constantino; Sydni Aguirre; Eugene Durrah; Eva Julian; Jeffrey DeVido; Kelly YoungsStone; Liz Romero; Amanda Kim; Arlene Pena; Cathryn Couch; DeLorean Ruffin, DrPH, MPH; Isaac Brown; Jason Cunningham; Leila Romero; Lilly Merino

4665 Business Center Drive
Fairfield, California 94534

External Advisory Members

Name	Affiliation	Org Type	3/17/26	5/19/26	7/21/26	9/15/26	11/17/26
Jason Cunningham, MD Chief Executive Officer	West County Health Centers	FQHC	X	X	X		
Eugene Durrah Equity Services Manager	Solano County	County	X				
Ian Kim Family Physician	Communicare + Ole	FQHC					
Hendry Ton, MD Associate Vice Chancellor	UC Davis	Health System					
Shandi Fuller, MD Maternal Child and Adolescent Health	Solano County	Public Health Department					
Eva Julien Senior Manager, Quality Improvement	Providence	Health System					
Valerie Padilla Director of Quality and Patient Safety	Open Door Community Health	Health System	X	X	X		
Arlene Pena Senior Program of Quality Improvement	Aliados Health	Community Based Org	X	X			
Jeremy Plumb Systems Director, Quality Division	Northbay Medical Center	Hospital					
Lelia Romero Health Program Specialist -	Lake County	Public Health Department	X	X	X		

4665 Business Center Drive
Fairfield, California 94534

Health Equity							
Robin Schurig, MPH, CPH Executive Director	Health Alliance of Northern California	Community Based Org					
Candi Stockton, MD Health Officer of Humboldt County	Humboldt County	Public Health Department	X	X	X		
Tiffani Thomas Case Manager	Solano County Superior Court	Local Government					
Brandon Thornock Chief Executive Officer	Shasta Community Health Center	Health System					
Denise Whitsett Quality Improvement Coordinator	Community Medical Centers	Health System	X	X	X		
Cathryn Couch Chief Executive Officer	CERES Community Project	Community Based Org	X	X			

Agenda Topic	Notes	Action Item
Agenda Item 1 **Welcome/ Introductions/Roll Call/ Minutes Review** *Speaker: Mohamed Jalloh, Pharm.D*	A. Dr. Jalloh welcomed everyone to the meeting as well as took a roll-call for external members. B. Bethany confirmed that quorum had been met, as 5 external members attended. C. Motion to approve meeting minutes from May 2026. 1st: Candy Stockton 2nd Valerie Padilla	Motion to approve meeting minutes from May 2026. 1st: Candy Stockton 2nd Valerie Padilla

4665 Business Center Drive
Fairfield, California 94534

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Agenda Item 2 **CMO Health Plan Updates** *Speaker: Kermit Jones MD, JD on behalf of Robert Moore, MD, MPH, MBA*	A. Organization updates are divided into 3 main areas; external factors and responses, internal strategies to improve quality, and compliance modernization initiatives that we are undergoing. B. On June 11th CMS released new guidance on its 1115 Medicaid demonstration budget neutrality policy that came into effect with HR1 last year. HR1 established the first statutory requirement for Medicaid 115 budget neutrality. The CMS guidance is designed to give states early notice of budget neutrality changes. This means that with this statute for the first time budget neutrality is codified in federal law. It is a requirement that the CMS Chief Actuary needs to certify that a section of 1115 demonstration is budget neutral before approval. The secretary may not approve new demonstrations or renew existing ones on or after January 1st, 2027, absent that certification. C. California has multiple years long section 1115 demonstrations. One example of this is the CalAim 1115 waiver demonstration which was approved December 2021 and is effective until December 31st of this year. Falling under CalAim are the community supports in lieu of services, housing navigation, incubative care, ECM, and justice involved reentry initiatives among others. D. The BH connect, approved in 2024 which is the behavioral health community-based organization networks of equitable care and treatment, which was DHCS's effort to build out community based behavioral health continuum for MediCal members with serious mental health illnesses and serious emotional disturbances. E. The practical effect of these certification requirements is that at the state level it is going to result in increased documentation. States will have to invest in much more time and resources, there will be less financial flexibility, fewer activities will be accepted.	

4665 Business Center Drive
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	F. Internally, Partnership Health Plan is nearing completion of its organization wide plan for quality, 2026-2029. In broad strokes, the purpose of this plan is to improve outcomes with our members, strengthen relationships with providers, align across departments within QI, and focus on greater quality impact in the communities we serve. G. With the modernization aspects of the organizational updates, a new claims processing system, HRP will be implemented.	
Agenda Item 3 **HEO Health Plan Health Equity Updates** *Speaker: Mohamed Jalloh, Pharm.D*	A. New guidance from CMS regarding HR1 for work requirements. Many of these requirements have been published regarding what are going to the requirements for these upcoming years. B. Community reinvestment: The health plans are obligated to reinvest a certain amount of their net income back into the community. $10 million that Partnership will be giving to its 14 counties. This is based on Partnership's 2024 net income. As of now, we have reviewed the information that the state has provided and met with respective counties, guiding them as well as encouraging them to work with their county leaders, specifically behavioral health and public health directors, they are ultimately the ones who have to sign off for each county's respective amount for community reinvestment. C. We have provided the funding amounts to the county leaders, as well as providing guidance on what they should consider. Counties had autonomy over choosing what they would decide, they have submitted that to Partnership and Partnership is in the process of getting ready to package it and submit it to DHCS. D. Dr. Jalloh directs the group to review the Committee Charter. Candy Stockton asks to clarify whether new members joining the committee would be subject to a majority vote. Dr. Jalloh clarifies that we would at least have a motion to vote someone in, and that they were likely	Motion to approve the Charter contingent on policy notating Simple Majority Vote for including new committee members and clarification of which types of analyses QIHEC will review. 1st: Candy Stockton 2nd Denise Whitsett

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	endorsed by a current QIHEC member. Candy suggests a simple majority vote or an endorsement from someone on the committee and she wants to clarify what is required in the vote. Dawn Cook asks to clarify who is responsible for analyzing and evaluating the results, to which Dr. Jalloh clarified that QIHEC is responsible for analyzing and evaluating the results of QI and Health Equity activities. Dawn feels there is a word or two missing that make it unclear. Dr. Jalloh suggests to separate those statements into two sentences.	
Agenda Item 4 **Tribal Engagement workgroup updates** *Speaker: Sunshine Jackson*	A. The Tribal Perinatal Program's goal is to support Tribal communities to achieve the best possible outcomes for Native Americans in Northern California. There are now 8 Tribal Health Programs fully contracted and 2 contracts in process. This upcoming year TPP will focus on PPC 1st visit within 21 days and two postpartum visits. B. Sunshine is working on a Partnership Prenatal and Postpartum Passport. She is also in the process of planning a Tribal Maternal Photoshoot. Sunshine is also working with Dr. Townsend to develop a detailed PP presentation that uses real-life PHPS case scenario to help TPP's better understand the services available through the program. Additionally, Sunshine is setting up a Tribal Perinatal Program Collaborative. C. This year we are holding a 4th Annual Partnership HealthPlan Tribal Convening. The convening will focus on vaping prevention and smoking cessation. Tribal singers from Butte County will provide the opening blessing and welcome. Dr. Cutcha Risling-Baldy, Daniel Calac and Roland Moore have confirmed as keynote speakers. Virgina Hedrick(California Rural Indian Health Board CEO) and Andrea Zubitate(Chief of the Office of Tribal Affairs) are presenting as well. There will be breakout sessions with Tribal Health programs. There will also be a Elder/Youth Panel. D. Medi-Cal & Partnership updates affecting Tribal Health:	

4665 Business Center Drive
Fairfield, California 94534

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	• Legislative update • TPP & other OB/GYN updates • QI/PI initiatives and presentation on Colorectal Project • HEDIS/Health Equity • CalAIM updates E. CMO updates: • BH: Traditional healing • Patient Experience • Partnership Leadership Academy F. Awards: • Most Improved & Highest Score QIP • Small but Mighty QIP • Maternal & Child Health Champion • Traditional Healing Integration • Excellence in Patient Care • Tribal Advocacy G. Sunshine states that they are being very intentional this at this years convening and will hire indigenous caterers and will have indigenous artwork on the SWAG.	
Agenda Item 5 **Grand Analysis** *Speaker: Hannah O'Leary*	A. Hannah reviews findings from the Population Health 2025 Impact Analysis. . • This grand analysis does not include the Population Program Description, Strategy, or the Annual Plan as in the previous year and was notated to be included in a future meeting B. The Growing Together Program has 3 pillars: • Healthy Babies (0-30 months) • Healthy Kids (ages 3-6)	

4665 Business Center Drive
Fairfield, California 94534

Agenda Topic	Notes	Action Item
	• Perinatal program (covers prenatal and postpartum period) C. Engaged members - members who qualified for the program, reached by phone and opted in to program participation • Declined – members who qualified for the program, reached by phone, and opted against program participation • Left message – members who qualified for the program, did not answer the phone, and were left a voice message encouraging a behavior • Unable to reach – members who qualified for the program but were not able to be reached via phone • Not referred - members who qualified for the program retrospectively but were not identified prospectively for campaign inclusion D. Partnership offers the Growing Together Prenatal outreach campaign, enrolling members identified as pregnant to receive targeted program outreach and support. PHM staff contacts these members and offers engagement in a campaign that supports prenatal care, reinforces the importance of Tdap vaccinations during pregnancy, and reminds them of the importance of post-partum care, as well as well-child visits and vaccinations in the first months following delivery. E. In addition to Partnership's Growing Together Prenatal outreach campaign, Population Health offers a campaign for members after delivery to encourage them to attend post-partum care visits as well as encourages early entrance to care by bringing their child to well-baby visits. F. The goal was for 75% of engaged members to attend a postpartum visit within 60 days of delivery. Postpartum visit attendance exceeded	

Agenda Topic	Notes	Action Item
	the goal at 79% among engaged members. Engagement clearly drives better outcomes, as all other groups performed significantly lower. G. Goal 2 is to attend a well child visit within the first 60 days of life. The target was met with a 76% completion rate among engaged members. Engagement again showed a strong positive impact, with higher rates than other groups. Unlike other measures, we didn't see significant differences across racial groups here, suggesting a more uniform effect. Overall, this is another strong indicator that the program is working. H. Population Health enrolls infants under 24 months of age in the Healthy Babies Growing Together Program the month they become Partnership members. The program provides health education and promotion of well-child visits and the importance of timely vaccinations to support the child's lifetime of immunity. Incentives are also offered for completing well-care visits with immunizations throughout the duration of the program. I. Healthy Babies goal outcome: 80% of engaged members will complete 50% or more of their vaccinations during the program period. This goal was met at 83% of engaged members. Goal 2: 65% of engaged members would be compliant with well-child visits. The goal was met at a rate of 89% compliance. Goal 3 J. This was the most ambitious Healthy Babies goal, completing *all* well-child visits, and engaged members exceeded the target by a wide margin, achieving a 60% completion rate. The 26-point gap between	

4665 Business Center Drive
Fairfield, California 94534

Agenda Topic	Notes	Action Item
	engaged and unreachable families reinforces that engagement is the key lever. While overall performance is strong, recurring equity differences point to opportunities for more tailored outreach. K. The biggest gap is around contact and not program effectiveness . L. For Healthy Babies vaccinations, engaged members achieved an 83% completion rate, the highest of any group. All other categories performed significantly worse, including members who were not referred. Even voicemail contact improved outcomes, but live engagement clearly drives the strongest results. M. 60% of families who engaged with the outreach team completed all recommended visits, the highest rate by far. N. The Healthy Kids program aims to reach all children between the ages 3 through 6 that have not had a well-child visit in the last 11 months or longer. Once identified, these members are offered an incentive to encourage the completion of their annual well-child visits prior to their next birthday. O. Healthy Kids goals outcomes: The first goal for this intervention is for 50% of members engaged in the program to have a well-child visit within 120 days of the phone call outcome referred to as “Agreed to Participation.”	

4665 Business Center Drive
Fairfield, California 94534

Agenda Topic	Notes	Action Item
	P. Goal 1: 70% of engaged members will have a well-child visit between July 2024 – June 2025. This goal was met at a rate of 80%. Engaged members had a statistically significantly higher rate of completing well child visits than any of our other campaign categories. Q. Transitional Care Services (TCS) focuses on members who are transitioning across settings or benefit structures with a high-risk of poor outcomes. R. The criteria for members identified (Adults) are > 20 and are discharging home from an inpatient admission with any length of stay and meet the criteria for high-risk transitioning members. (Pediatric) criteria are under age 21 and discharging home from an inpatient stay with an admission date > 60 days from their date of birth and having any length of stay. S. The program is performing well from a member experience standpoint, demonstrating effective care transitions and strong care team impact. T. Transitional Care Services Goals: Goal 1 is that 75% of members surveyed agree with each statement of the Adult TOC or TCS satisfaction Survey. This goal was met. Goal 2 is that 75% of members surveyed agree with each statement of the Pediatric TCS satisfaction survey. This goal was also met.	

4665 Business Center Drive
Fairfield, California 94534

Agenda Topic	Notes	Action Item
	U. Complex Case Management is support for members who have multiple chronic conditions, social determinants of health barriers and/or have difficulty navigating the healthcare system without the intensive support of a care coordinator and an individualized care plan. The criteria for members is that they have multiple chronic conditions, social determinants of health barriers and/or difficulty navigating the healthcare system, and/or CCS condition. Member satisfaction with the complex case management program is ascertained via telephonic survey by a Partnership designee either annually (for multi-year interventions) or upon case closure, if the case is active for less than one year. V. Complex case management goals: Goal 1 is that 75% of members surveyed agree with each statement of the Adult CCM satisfaction survey. This goal was met. Goal 2 is that 75% of members surveyed agree with each statement of the Pediatric CCM satisfaction survey. This goal was met. W. Lessons learned have shown that the most effective programs utilize multiple modalities of reaching members, such as combining mailings with phone calls and with incentives to maximize engagement. A significant finding that has carried on through 2025 is feedback from members about the ongoing challenges around scheduling well child visits due to the lack of provider availability to serve the member population in a timely manner.	

4665 Business Center Drive
Fairfield, California 94534

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Agenda Item 6 **Grand Analysis discussion and vote** **Speaker: All**	A. Marshall Kubota shares feedback that you can't stratify a historic group retrospectively, but you can take the total group data after the intervention and compare it to no intervention. Candy Stockton comments that if we are focusing on cost effective interventions, we need to be careful not to confirm our own biases.	Motion to approve the inclusion of an additional analysis of a total group historical data comparison 1st Candy Stockton 2nd Valerie Padilla Motion to approve the 2025 Grand analysis. (Population Health) 1st Candy Stockton 2nd Valarie Padilla
Agenda Item 7 **Behavioral Health Presentation** *Speaker: Brandon Yadi*	A. Starting with the Access Line, Back in 2025, Partnership made a decision to bring some member-facing responsibilities in-house instead of leaving them fully with Carelon Behavioral Network — that included access, care coordination, G&A, and UM. B. The goal was to directly improve the experience our members were having while at the same time making sure the referrals going into the network were actually good ones – because that increases chances of closing the loop on a referral.	*Motion to approve the Grand Analysis.(Behavioral Health)* *1st Candy Stockton* *2nd Denise Whitsett*

4665 Business Center Drive
Fairfield, California 94534

Agenda Topic	Notes	Action Item
	C. Outreach and Education: The goal is to engage staff and providers in promoting service delivery, and most importantly, making sure our members actually understand their mental health benefits. A lot of underutilization isn't about access; it's that people just don't know what's available to them. D. Each year will start with a utilization review to spot disparities and service gaps. The review tells where to focus for the upcoming year. Then the review and action plan are put together in an annual report, which goes to DHCS every year . E. Member Experience is more formally addressed through NCQA measure ME7 E&F, where the health plan is reviewed against 2 areas: grievance & appeals and member survey. F. The cycle looks like: distributing questions through an annual member experience survey, review G&A data for behavioral health, and bring both data sources together to write a Grand Analysis Report. G. DHCS requires us to do an annual utilization assessment for non-specialty mental health, identify where utilization is low, and build a outreach plan to close those gaps. H. For 2026, input was received from several different groups; the Consumer Advisory Committee, the Quality Improvement Health	

4665 Business Center Drive
Fairfield, California 94534

Agenda Topic	Notes	Action Item
	Equity Committee, PCPs through an engagement survey, and our Tribal partners. I. PCP engagement around a new BH Access Line, perinatal mental health outreach, community events, and specific work in Modoc County around school-based referral coordination for youth. Sierra County is also exploring MH telehealth through their County Office of Education. And social media and text campaigns are running throughout the year. J. Data capture: dividing utilization by race and ethnicity, collect SDoH and demographic data, and separating survey results by population. K. Targeting strategy: looking at underutilization by demographic and by county, Tribal outreach and hold an annual convening, and building language and cultural responsiveness directly into our messaging . L. Interventions: the text messaging pilot in Solano and Modoc, follow-up outreach for members after an ED discharge, quarterly social media and in-person MH fair presence, and monthly COE meetings along with Tribal outreach. M. Utilization trends : non-specialty mental health utilization rose to 8.6% in 2024, up from 7% in 2023. With adding specialty mental health, utilization climbs past 12%, compared to 9% in 2023. And when primary care data is added in too, there is an even bigger jump —	

Agenda Topic	Notes	Action Item
	which likely reflects the safety-net role our medical system is supporting our members who aren't otherwise directly engaging BH services. N. Breakdown by race and ethnicity: White members have the highest utilization at 12%. Asian members have the lowest, at 1.7%. Hispanic members sit at 6.4%. Black members increased slightly to 7.6% in 2024, up from 5% the year before. Native American members — utilization jumped to 10.2% in 2024, up from 5.5% in 2023 O. Geographically: Shasta County has the highest utilization at 15%. That's likely driven by strong FQHC-integrated behavioral health there, plus North American Mental Health Services has a large clinic in-county. Modoc County is one of our lowest utilizers at 3.5%, P. Candy Stockton asked if we had more mental health support services which look like the communities that we served. Brandon didn't have that data but will circle back and see if that is something they have implemented in the last year or so. Q. Dr. Kubota would like some data about Spanish speaking behavioral health practitioners and PHC panels.	

4665 Business Center Drive
Fairfield, California 94534

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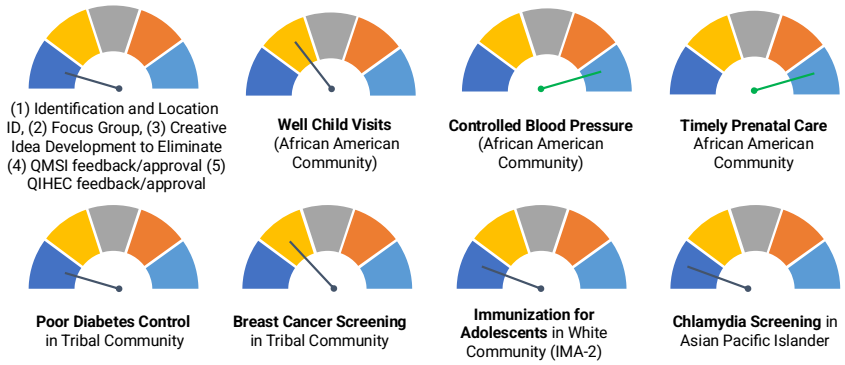
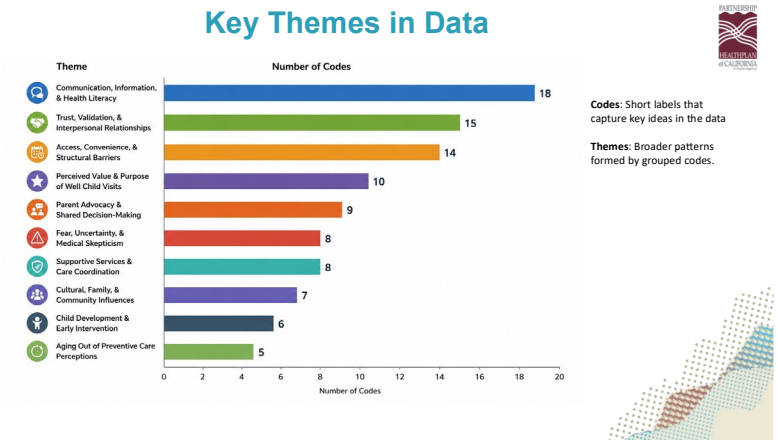
Agenda Item 8 **Health Equity Tracker** *Speaker: Mohamed Jalloh, Pharm.D*	A. Dr. Jalloh shared the Health Disparities Equity Action Score. **HEALTH DISPARITIES EQUITY ACTION SCORE (25%)**  	
Agenda Item 9 **Health Equity Policy Review** *Speaker: Mohamed Jalloh, Pharm.D*	A. Dr. Jalloh shares the QIHETP program description. B. The Program Description Name was changed from the "Quality Improvement and Health Equity Transformation Program Description" to the "Health Equity and Community Reinvestment Strategy and Program Description" to increase ease of communication to internal team members C. Health Equity Accreditation Name Change on Page 10: The Program Description changed the NCQA HEA name to HOA to reflect NCQA's changes. D. Quality Improvement Priorities on Page 11, 13: The Program Description was updated to include the top Quality Improvement Priorities and how Partnership clarified it's health disparity priorities. E. Health Disparity Measures on Page 14: The Program Description was updated to reflect which annual QIHETP administrative measures will	*Policy will be sent out, and will be discussed as old business in the next meeting due to low amount of time to review.*

4665 Business Center Drive
Fairfield, California 94534

Agenda Topic	Notes	Action Item
	be measured per department (e.g. Quality Improvement, Population Health, Human Resources, etc) F. Community Reinvestment Updates on Page 17: The Program Description was updated to reflect the updated change of the community reinvestment management. Specifically, it was changed to reflect that Public Health Directors and Behavioral Health Directors per county will lead county selection efforts versus Partnership providing a specified list for the counties to pick. G.	
Agenda Item 10 **Focus Group Updates** **Health Disparities Action Review (Focus group and Project Updates** *Speaker: Jesus Hermosillo, MPH*	A. Jesus conducted two focus groups in the Fairfield region on the topic of Well Child Visits on 5/22/26 and 6/16/26.  B. Top themes that came out of the focus groups were: communication, information, and health literacy. C. Findings were that members don't connect with the term Well Child Visits, and don't understand the purpose of the visit. There is a lack of understanding of the purpose of these WCVs. Families that participate in WCVs don't really know that they are engaging in a WCV.	

4665 Business Center Drive
Fairfield, California 94534

Agenda Topic	Notes	Action Item
	D. Parents see these visits as not urgent. They don't know what to expect at these visits. Families are asking for some type of flyer that explains the WCV and a checklist that they could use during the WCV.	
Agenda Item 11 **Adjournment** *Speaker: Mohamed Jalloh, Pharm.D*	Next meeting: **September 15, 20267:30 a.m. - 9:00 a.m. PST**	