



Aliados Health

Partners In Community Health

Aliados Health

Performance Improvement Program

Aliados Health

Performance Improvement Program FY2026-27

Table of Contents

Table of Contents	1
Program Overview.....	2
Guiding Principles	2
Eligibility	2
Support for Quality Improvement	2
Program Timelines.....	3
Governance.....	3
Code Sets and Reporting Instructions.....	4
Clinical Quality Measure Targets.....	4
Payment	5
Clinical Quality Improvement Measure Definitions.....	6
Controlling High Blood Pressure.....	6
Diabetes: Glycemic Status Assessment Less Than or Equal to 9%	8
Colorectal Cancer Screening	9
Six Well Child Checks by 15 Months of Age	10
Adolescent Depression Screening and Follow-Up.....	11
Access and Care Management Measure	12
Data Validation and Audit Procedures	14
Program Evaluation.....	15
Appendix A: Timeline for Data and Access & Care Management Submission.....	18

Program Overview

The Performance Improvement Program (PIP) offers financial incentives to health centers participating in the managed care contract with Partnership Health Plan through Aliados Health to improve clinical quality and outcomes, improve patient experience, build clinically integrated network infrastructure, and decrease total cost of care for the population that these health centers serve. The PIP program is a risk-pool based performance incentive program.

Guiding Principles

1. All incentive measures chosen are anticipated to:
 - a. Reduce unnecessary utilization of services and reduce patient costs
 - b. Improve the quality of health center care delivered
 - c. Improve patient experience
 - d. Increase utilization of preventive services
2. Measures are based on community need
3. Measures are aligned with state and/or national standard and goals

Eligibility

Health centers are eligible to participate in the PIP program if they participate in joint primary care contracting between Aliados Health and Partnership HealthPlan and the health center reports results as instructed in this document. Participating health centers must maintain adequate access to care and primary care utilization. To monitor this, health centers will provide access to their information on Partnership HealthPlan's Partnership Quality Dashboard (PQD).

Support for Quality Improvement

Health centers receive support for quality improvement through Aliados Health's quality improvement, population health, and informatics programs. These include:

- Medical Director/CMO peer meeting: the venue where standardized clinical guidelines are developed to improve clinical measures
- Consortium created shared clinical decision support tools to support standardized clinical guidelines within the electronic health record: templates, order sets, alerts, recalls, reports, etc.
- Analytics and reports custom built in Relevant, Aliados Health's population health management tool, to support health center reporting and evidence-based clinical initiatives
- Documented promising practices for health center quality measures: published to the consortium website

- Consortium lead or sponsored conferences and trainings
- Quality improvement peer group meeting and the QI Chatroom Podcast: the venue where best practices are captured and shared
- Data Standards and Integrity Council (DSIC): The Council's mission is to improve data governance, standardization, and management across the PHCs, and identify priority standard reports
- Data Workgroup peer meeting: the venue where health center data leads are trained on standard reports and data validation
- Clinical work groups are formed to address areas of health on an as needed basis. These groups are made up of consortium staff, content experts from health centers and other stakeholder organizations, and make recommendations to the Medical Directors for changes or additions to standards in clinical practice.

Program Timelines

- The PIP program runs from July 1, 2026, until June 30, 2027.
- Measurement periods for clinical quality measures are for the 12 months preceding the end of the reporting period unless otherwise noted in the measurement description.
- Health centers should validate all improvement measures by the due dates listed below. If a health center has an exception where data is not available in Relevant and the data must be submitted manually, the source query and supporting data may also be requested.

Due Dates

- October 22, 2026
- January 21, 2027
- April 22, 2027
- July 22, 2027
- Reporting Hardships: If any participating health center experiences a hardship in reporting PIP program deliverables, they may request an extension of 45 days consecutive to the original reporting due date in the program document to provide a correction to the affected quarter's quality measure program deliverables. Any funding associated with a correction will be paid to the health center prior to the next quarter's reporting deadline.

Governance

Aliados Health staff develop and administer the PIP program to be consistent with industry performance incentive programs, including selection of the outcomes measurement set with defined targets. In the development and administration of the PIP program, Aliados Health adheres to federal and state laws and guidance. Aliados Health staff collaborates

with internal and external stakeholders for program feedback including the following groups:

- Membership – CEOs of health centers
- Medical Directors/CMOs of health centers
- Quality Improvement Peer Group – Quality Leads of health centers
- Partnership HealthPlan of California

Code Sets and Reporting Instructions

All clinical quality improvement measures utilize standard code sets. If available, the measurement specifications align with CMS eMeasure code set which can be obtained through the National Library of Medicine at [Value Set Authority Center](#) and are posted on the Aliados Health website. Measures not included in the eMeasure code set are standardized using HEDIS specifications and code sets. All measures are reviewed, standardized, and clarified as needed by Aliados Health’s Data Standards and Integrity Council. This reporting manual is published annually and is available on the Aliados Health website.

Clinical Quality Measure Targets

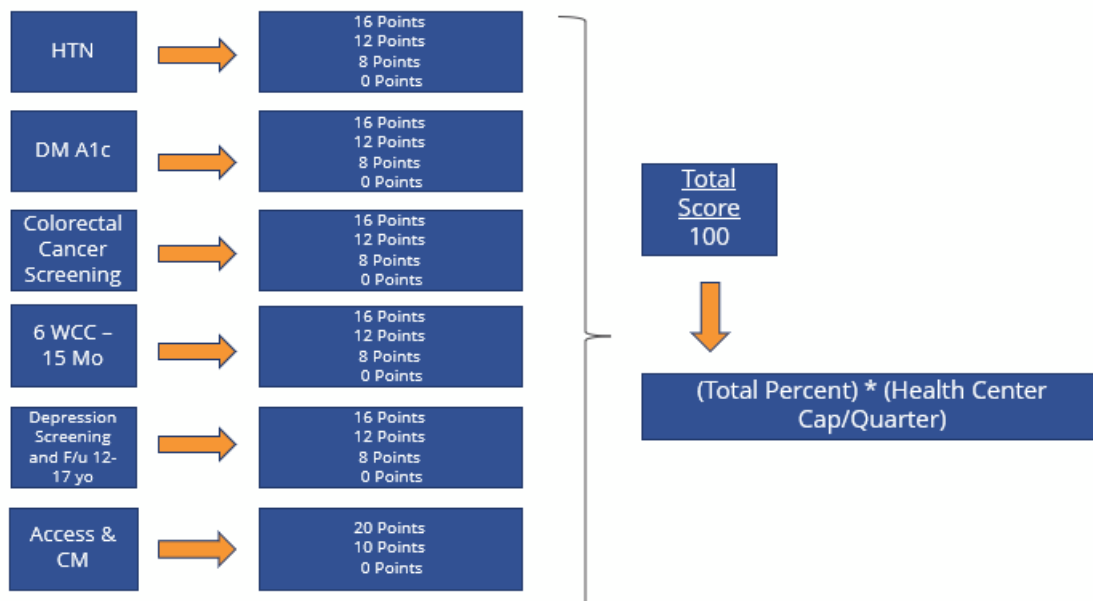
Measure/ Results	Controlling High Blood Pressure	Diabetes: Glycemic Status Assessment Less Than or Equal to 9%	Colorectal Cancer Screening	Six Well Child Checks by 15 Months of Age	Adolescent Depression Screening and Follow- up
TARGETS					
2024 Targets	65% full points 63% ¾ points 60% half points	65% full points 63% ¾ points 60% half points	42% full points 38% ¾ points 35% half points	60% full points 55% ¾ points 50% half points	55% full points 50% ¾ points 45% half points
FY 25-26 Targets	67% full points 64% ¾ points 60% half points	65% full points 63% ¾ points 60% half points	47% full points 44% ¾ points 35% half points	60% full points 55% ¾ points 50% half points	60% full points 55% ¾ points 45% half points
FY 26-27 Targets	70% full points 65% ¾ points 60% half points	70% full points 65% ¾ points 60% half points	50% full points 45% ¾ points 35% half points	65% full points 55% ¾ points 50% half points	60% full points 55% ¾ points 45% half points
BENCHMARKS					
QIP Targets 2026	75.43% (full points) 90 th Percentile	76.40% (full points) 90 th Percentile	53.31% (full pts) 90 th Percentile	71.71% (full pts) 90 th Percentile	N/A
UDS CA 2024	65.99%	70.82%	42.55%	N/A	N/A
HEDIS Medicaid MY2024 90 th percentile	72.75%	72.99%	N/A	69.67%	N/A

Payment

1. Quarterly payment

Aliados Health will calculate a maximum payment to each participating health center based on the health center patient counts reported on the Uniform Data System report from the prior calendar year. Payment amounts for the PIP program are calculated by adding the total points achieved for each quality measure. The individual points earned are divided by 100 to calculate the percent of total funds available to each health center that will be paid.

Funds will be distributed quarterly to health centers no later than 45 days after the reporting period closes.



2. Relative improvement points

At the end of the fourth quarter, any participating health center that ends the reporting year at 70 - 89% of points are eligible to earn additional funds if the health center achieves >10% relative improvement in any one qualifying clinical measure. Qualifying measures are any of the six clinical measures that the health center did not achieve full points for in the fourth quarter. Qualified health centers that achieve the improvement threshold receive 50% of the funds in reserve for that health center.

Calculation:

$$\frac{(\text{Current year performance}) - (\text{previous year performance})}{100 - (\text{previous year performance})}$$

3. Unearned funds

Unearned funds during the program year roll over each quarter and are maintained for each individual health center to earn in each following quarter until the end of the calendar year.

Unearned funds at the end of the program year are aggregated in a pool that is utilized for projects and programs which will support quality improvement related to the PIP program. Funds are used to address challenges to meet measure thresholds and are aligned with the PIP program.

Clinical Quality Improvement Measure Definitions

Controlling High Blood Pressure

Rationale

Uncontrolled hypertension leads to coronary heart disease, congestive heart failure, stroke, ruptured aortic aneurysm, renal disease, and retinopathy. For every 20-mmHg systolic or 10 mmHg diastolic increase in blood pressure, there is a doubling of mortality from both ischemic heart disease and stroke (Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure 2003).

Heart disease is the leading cause of death the United States in 2024 according to the Centers for Disease Control (CDC). The incidence rates of heart disease in Sonoma County 2019-2021 are 7.8% (Sonoma County Department of Health Services (2025)).

Better control of blood pressure has been shown to significantly reduce the probability that these undesirable and costly outcomes will occur. The relationship between the control of hypertension and long-term clinical outcomes is well established. In addition to preventing cardiovascular events and deaths, controlling hypertension would also result in cost savings to the total cost of care for patients with hypertension (Moran 2015).

Measure alignment: UDS 2026 ([CMS165v14](#))

Measure description: Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six

months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90 mmHg) during the measurement period

Program Performance Thresholds:

- 70% Full points
- 65% $\frac{3}{4}$ points
- 60% Half points

Denominator definition: Patients 18-85 years of age by the end of the measurement period who had an eligible countable visit during the measurement period and diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period

Numerator definition

- Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period
- The following blood pressure readings are acceptable:
 - Readings performed by a clinician or trained staff member as part of an office visit.
 - Readings from a remote monitoring device transmitted to the health center electronically.
 - Readings taken by the patient in the context of a telehealth visit where the reading is visualized (photo or video) or otherwise verified by the provider or trained staff member directly.
 - Self-reported blood pressure readings where the measurement cannot be independently verified by the provider or trained staff member.
- The following blood pressures should not be reported:
 - Those taken during an inpatient or ED visit

Exclusions

- Patients with evidence of end-stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period
- Patients who have been pregnant during the measurement period
- Patients who were in hospice or palliative care at any time during the measurement year. Patients aged 66 or older who were living long-term in an institution any time on or before the end of the measurement period
- Patients aged 66-80 years old and older with a frailty diagnosis in the measurement period and either:
 - Advanced illness diagnosis during the measurement period or the year prior
 - OR taking dementia medications during the measurement period or the year prior

- Patients aged 81 and older with frailty

Diabetes: Glycemic Status Assessment Less Than or Equal to 9%

Rationale

People with diabetes are at increased risk of serious health complications including vision loss, heart disease, stroke, kidney failure, amputation of toes, feet or legs, and premature death. Average medical expenditures among people with diagnosed diabetes were 2.6 times higher than what expenditures would be in the absence of diabetes (ADA, 2022).

The percentage of persons living in Sonoma County aged 20 and above living with a diagnosis of diabetes increased from 7% in 2020 to 8% in 2022. (County Health Rankings & Roadmaps) Sonoma County Health Centers' average rate of control of diabetes ($A1c \leq 9$) in 2025 was 75.4%.

Randomized clinical trials have demonstrated that improving control of A1c levels correlates with a reduction in microvascular complications (retinopathy, nephropathy, and neuropathy) in both Type 1 and Type 2 diabetes (Diabetes Control and Complications Trial Research Group 1993). Improved diabetes control also results in decreased cardiovascular complications and potentially reduces the cost associated with them.

Measure alignment: UDS 2026 ([CMS122v14](#)) inverted

Measure description: Percentage of patients 18-75 years of age with diabetes who had a glycemic status assessment (Hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) $\leq 9.0\%$ during the measurement period

Program Performance Thresholds:

- 70% Full points
- 65% $\frac{3}{4}$ points
- 60% Half points

Denominator definition: Patients 18-75 years of age by the end of the measurement period, with diabetes with a visit during the measurement period

Numerator definition: Patients whose most recent glycemic status assessment (HbA1c or GMI) (performed during the measurement period) is $\leq 9.0\%$

Exclusions

- Patients who were in hospice or palliative care at any time during the measurement year
- Patients aged 66 or older who were living long-term in an institution any time on or before the end of the measurement period.
- Patients aged 66 and older with a frailty diagnosis in the measurement period and either:
 - Advanced illness diagnosis during the measurement period or the year prior
 - OR taking dementia medications during the measurement period or the year prior

Colorectal Cancer Screening

Rationale

Colorectal cancer is the third leading cause of cancer death in the United States (American Cancer Society 2019). If the disease is caught in its earliest stages, it has a five-year survival rate of 91%. Colorectal cancer screening of individuals with no symptoms can identify polyps whose removal can prevent more than 90% of colorectal cancers. Studies have shown that the cost-effectiveness of colorectal cancer screening is \$40,000 per life year gained (American Cancer Society 2015).

The incidence of colon cancer for people over 50 years of age in Sonoma County is higher than the state average (Healthy Communities Institute 2016). The average colon cancer screening rate for Sonoma County health centers in 2025 was 57.2%.

Measure alignment: UDS 2026 ([CMS130v14](#))

Measure description: Percentage of adults 45-75 years of age who had appropriate screening for colorectal cancer

Program Performance Thresholds:

- 50% Full points
- 45% $\frac{3}{4}$ points
- 35% Half points

Denominator definition: Patients 46-75 years of age by the end of the measurement period with an eligible countable visit during the measurement period

Numerator definition:

Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria:

- Fecal occult blood test (FOBT) during the measurement period

- FIT-DNA (Cologuard) during the measurement period or the two years prior to the measurement period-DNA
- Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period
- CT Colonography during the measurement period or the four years prior to the measurement period
- Colonoscopy during the measurement period or the nine years prior to the measurement period

Exclusions

- Patients with a diagnosis or history of total colectomy or colorectal cancer
- Patients who were in hospice or palliative care for any part of the measurement period
- Patients aged 66 or older who were living long-term in an institution any time on or before the end of the measurement period.
- Patients aged 66 and older with a frailty diagnosis in the measurement period and either:
 - Advanced illness diagnosis during the measurement period or the year prior
 - OR taking dementia medications during the measurement period or the year prior

Six Well Child Checks by 15 Months of Age

Rationale

Assessing a child's physical, emotional, and social development is important. Behaviors established during childhood, such as eating habits and physical activity, often extend into adulthood. Well child visits provide health centers with an opportunity to provide prevention services like immunization screenings and counseling to influence health and development. (NCQA 2019)

Measure alignment: PHP QIP 2025, HEDIS W30 2025

Measure description: Percentage of children who turned 15 months old during the measurement period who had 6 well-child visits with a primary care physician during the first fifteen months of life.

Program Performance Thresholds:

- 65% Full points
- 55% $\frac{3}{4}$ points
- 50% Half points

Denominator definition: Children who have had at least one medical visit after 2 months of age and who turned 15 months old during the measurement year.

Numerator definition: Denominator patients who received six or more well-child visits with a PCP during their first 15 months of life. (Well-child visits are defined by procedure and diagnosis codes. There must be at least 14 days between each date of service. Well-child visits may be performed in-person, virtually by phone or video, or a combination of these, depending on the judgement of the clinician balancing the local public health implications of in-person visits and the individual needs of the patient.

Adolescent Depression Screening and Follow-Up

Rationale

Depression in adolescents has been linked to long term anxiety disorders, increased risk of substance use and increased risk of suicide attempt (Garber 2009). During the pandemic, more adolescents and young adults (ages 18-24) reported symptoms of anxiety and/or depression (56%). Even prior to the pandemic, young adults were at higher risk of poor mental health (Sonoma County MSHA Plan 2022).

Suicide is the 10th leading cause of death for Americans overall and the second leading cause of death among young people aged 10–34. Suicide deaths per 100,000 population are higher in Sonoma County than US and California rates. (CDC 2008)

USPSTF recommends screening for depression in adolescents ages 12-18. (USPSTF 2022) Participating health center screening rates for depression and follow-up for adolescents 12-17 years of age in 2025 was 62.3%.

Measure alignment: UDS 2026 ([CMS52v15](#)) adjusted to age range 12 to 17 years of age

Measure description: Percentage of patients aged 12 through 17-year-olds screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter

Program Performance Thresholds:

- 60% Full points
- 55% $\frac{3}{4}$ points
- 45% Half points

Denominator definition: All patients aged 12 through 17 years old at the beginning of the measurement period with at least one qualifying encounter during the measurement period.

Numerator definition: Patients screened for depression on the date of the qualifying encounter or up to 14 days prior to the date of the qualifying encounter using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter.

Exclusions Patients who have ever been diagnosed with bipolar disorder at any time prior to the qualifying encounter.

Denominator Exceptions:

- Patient refuses to participate in or complete the depression screening
- Documentation of medical reason for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status)

Access and Care Management Measure

1. Value Based Care

Rationale

To support value-based care efforts, Aliados Health's network of participating health centers will engage in activities to optimize eConsult workflows. Optimizing eConsult supports value-based care by facilitating timely specialist input, reducing unnecessary in-person visits, and enhancing primary care capacity. These improvements align with the goals of value-based models promoted by CMS, which emphasize better health outcomes, improved patient experience, and lower costs through coordinated, high-quality care delivery (CMS, 2023).

Health Centers will implement activities to improve eConsult utilization.

Reporting

- **2026 Jul – Sep:** Health Centers will participate in eConsult guideline development.
- **2026 Oct – Dec:** Health Centers will identify an eConsult utilization improvement area and submit a SMART AIM and process improvement plan.

- **2027 Jan – Mar:** Health centers will submit a brief report on activities in their work plan and provide a brief update on activities for this plan; 1-3 paragraph(s) detailing an update on the project, achievements to date, challenges, and any re-direction if needed. See project template for guidelines
- **2027 Apr – Jun:** Health Centers will have completed sharing the results, findings, and any ongoing activities for their eConsult utilization project. Health Centers may share results by presenting at a stakeholder meeting, QI chatroom, completing a promising practice template or as designated by the Aliados Health QI Team. Health Centers will have completed Hierarchical Condition Category (HCC) coding training for all primary care providers and submit the signed attestation form. The attestation form will be sent to each health center via email and posted to the Aliados Health website. The training must be complete by June 30, 2027 while the attestation form must be submitted by July 22, 2027.

Program Performance Thresholds:

- Full 10 points - Completed the activity listed by reporting period above

1. Health Equity

Rationale According to the CDC, Health Equity is when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances” (CDC 2020.) Health disparities are differences in outcomes by population. In order to improve quality of care, patient experience and utilization of preventive care services health centers will need to address health disparities in the populations they serve. For the FY26-27 participating health centers will select from one of the two project options outlined below, report on activities, and share results and findings with Aliados Health members.

Option #1: Health centers that participated in Million Hearts in PY25-26 will continue to participate to meet this measure.

Reporting

- **2026 Jul – Sep:** Health centers will submit a SMART AIM statement and plan that includes in any health equity focused area within the Million Hearts project.
- **2026 Oct - Dec:** Health Centers will meet with Aliados Health staff to review project progress and identify opportunities for additional support from Aliados Health Quality Improvement team.
- **2027 Jan – Mar:** Health centers will submit a brief report on activities in their work plan and provide a brief update on activities for this plan; 1-3 paragraph(s) detailing an update on the project, achievements to date, challenges, and any re-direction if needed. See project template for requirements.
- **2027 Apr – Jun:** Health Centers will have completed sharing of the results, findings, and any ongoing activities. Health Centers may share results by presenting at a

stakeholder meeting, QI chatroom, completing a promising practice template or as designated by the Aliados Health QI Team.

Option #2: Participating health centers will perform data analysis to identify a disparity within PIP/QIP or UDS measure sets and implement an intervention to address this disparity.

Reporting

- **2026 Jul – Sep:** Health Centers will Conduct an analysis to identify a disparity within PIP/QIP or UDS measure sets and implement process improvement activities to address the identified disparity. Health centers will submit a SMART AIM statement, and plan that addresses their population of focus intervention.
- **2026 Oct – Dec:** Health Centers will meet with Aliados Health staff to review project progress and identify opportunities for additional support from Aliados Health Quality Improvement team.
- **2027 Jan – Mar:** Health centers will submit a brief report on activities in their work plan and provide a brief update on activities for this plan; 1-3 paragraph(s) detailing an update on the project, achievements to date, challenges, and any re-direction if needed. See project template for requirements.
- **2027 Apr – Jun:** Health Centers will have completed sharing of the results, findings, and any ongoing activities. Health Centers may share results by presenting at a stakeholder meeting, QI chatroom, completing a promising practice template or as designated by the Aliados Health QI Team.

Program Performance Thresholds:

- Full 10 points – Completed the activity listed by reporting period above.

Data Validation and Audit Procedures

Aliados Health will validate data against prior program performance for each quarter. Aliados Health will randomly audit health center values throughout the year. In cases when Aliados Health staff have direct access to health center data systems and electronic health record, Aliados Health staff will conduct the audit independent of the health center and notify the health center if there are any issues that need to be corrected. In cases when Aliados Health staff does not have direct access to the health center data, Aliados Health staff will request the source query and supporting data from the health center. Aliados Health may choose to contract with a third party to conduct data validation and audit functions. Health centers that fail to comply with validation and audit or who have open or unresolved validation or findings will not be eligible to receive funds from the PIP program until they are in compliance.

Program Evaluation

Aliados Health will conduct a program evaluation following the end of the program year. The evaluation findings will be used by Aliados Health to inform the design of the following year's PIP program.

Aliados Health may change program deliverables during the program year when drastic circumstances prevent the ability of health centers or Aliados Health to be able to complete all or part of the PIP program. If this should occur, Aliados Health staff will put forth a reasonable alternative that is consistent with the PIP guiding principles above. Any changes will be documented as a program addendum and published to health center program staff, CMOs and CEOs. Changes will be published on the Aliados Health website prior to the end of the first affected quarter.

References

American Cancer Society. (2015). *Cancer Prevention & Early Detection Facts & Figures 2015-2016*. Retrieved from URL [Cancer Prevention & Early Detection 2015-2016](#)

Centers for Disease Control and Prevention (2020). Social Determinants of Health. *Health Equity*. Retrieved from URL <https://www.cdc.gov/chronicdisease/healthequity/index.htm>

Centers for Disease Control and Prevention (2024). State Cancer Profiles. *Incidence Rates Report for California by County Colon and Rectum, 2017-2021*. Retrieved from URL <https://statecancerprofiles.cancer.gov/incidencrates/index.php?stateFIPS=06&cancer=020&race=00&sex=0&age=136&year=0&type=incd&sortVariableName=rate&sortOrder=desc#results>

Centers for Disease Control and Prevention (2017). National Diabetes Statistics Report 2017: Estimates of Diabetes and its Burden in the United States. Retrieved from URL <https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf>

Centers for Disease Control and Prevention (2008). *CDC Wonder*. Retrieved from <https://wonder.cdc.gov/ucd-icd10.html>

Diabetes Control and Complications Trial Research Group. The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. *N Engl J Med* 1993; 329:977-986.

Garber, J. et al. (2009). *Prevention of Depression in At-Risk Adolescents: A Randomized Controlled Trial*. *Journal of the American Medical Association* 301(21):2215–24.

Health Resources and Services Administration (2017). *2016 Health Center Program Grantee Profiles: Health Center Program Grantee Data*. Retrieved from URL <https://bphc.hrsa.gov/uds/datacenter.aspx?q=d&year=2016&state=CA#glist>

Sonoma County Department of Health Services. (n.d.). *Chronic Disease | Community Health Dashboard*.

Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. (2003). *Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure*. NIH Publication No. 035233.

Moran AE, Odden MC, Thanataveerat A, Tzong KY, Rasmussen PW, Guzman D, et al. Cost-effectiveness of hypertension therapy according to 2014 guidelines. *N Engl J Med*. 2015;372:447–55.

NCQA (2019). *Child and Adolescent Well Care Visits*. Retrieved from URL [Child and Adolescent Well-Care Visits \(WCV\) - NCQA](#)

Myers, E., K.H. Warner, J.D. Wright, J.S. Smith. 2008. "The current and future role of screening in the era of HPV vaccination." *Gynecologic Oncology* 109:S31-S39.

Sonoma County Mental Health Services Act (2021). *Program & Expenditure Plan Update for FY22-23 With FY 20-21 Annual Program Report*. Retrieved from URL <https://sonomacounty.ca.gov/Main%20County%20Site/Health%20and%20Human%20Services/Health%20Services/Documents/Behavioral%20Health/mental-health-services-act/Sonoma-County-MHSA-Plan-Update-FY-22-23-and-Program-Report-FY-20-21.pdf>

United States Preventive Services Taskforce (2022). *Depression and Suicide Risk in Children and Adolescents: Screening*. Retrieved from NCQA HEDIS MY2024 Measures and Descriptions W30, page 11
Retrieved from URL: [HEDIS MY 2024 Measures and Descriptions](#)

National Cancer Institute (NIH). Community Dashboard, *STATE CANCER PROFILES*
Retrieved from URL: [Interactive Maps](#)

North Bay Cancer Alliance (NBCA), Local Reports *Breast Cancer Stats*
Retrieved from URL: [North Bay Cancer Alliance | Data, Stats and Research](#)

Centers for Medicare & Medicaid Services (CMS)(2023), *CMS Framework for health equity 2022 – 2032*. Retrieved from URL: [Home - Centers for Medicare & Medicaid Services | CMS](#)

New County Health Rankings & Roadmaps, *Diabetes Prevalence Dashboard*
Retrieved from URL: [Diabetes Prevalence* | County Health Rankings & Roadmaps](#)

Appendix A: Timeline for Data and Access & Care Management Submission

On or after the dates below, Aliados Health will pull the data for the clinical quality measures from Relevant. Any data not available through Relevant will need to be submitted by this date.

Complete Program Activities By	Clinical Data Submission, and Access & Care Management Reporting Due Date	Materials to be submitted
Q1 September 30, 2026	October 22, 2026	<p>Clinical Data:</p> <ul style="list-style-type: none"> • Controlling High Blood Pressure (1 year) • Six Well Child Checks by 15 Months of Age (1 year) • Diabetes: Glycemic Status Assessment Less Than or Equal to 9% • Colorectal Cancer Screening (1 year) • Adolescent Depression Screen and Follow-Up (1 year) <p>Access and Care Management:</p> <ul style="list-style-type: none"> • Health Equity Reporting (2026 Jul-Sep) • Value-Based Care Reporting (2026 Jul-Sep)
Q2 December 31, 2026	January 21, 2027	<p>Clinical Data:</p> <ul style="list-style-type: none"> • Controlling High Blood Pressure (1 year) • Six Well Child Checks by 15 Months of Age (1 year) • Diabetes: Glycemic Status Assessment Less Than or Equal to 9% • Colorectal Cancer Screening (1 year) • Adolescent Depression Screen and Follow-Up (1 year)

		<p>Access and Care Management:</p> <ul style="list-style-type: none"> • Health Equity Reporting (2026 Oct-Dec) • Value-Based Care Reporting (2026 Oct-Dec)
Q3 March 30, 2027	April 22, 2027	<p>Clinical Data:</p> <ul style="list-style-type: none"> • Controlling High Blood Pressure (1 year) • Six Well Child Checks by 15 Months of Age (1 year) • Diabetes: Glycemic Status Assessment Less Than or Equal to 9% • Colorectal Cancer Screening (1 year) • Adolescent Depression Screen and Follow-Up (1 year) <p>Access and Care Management:</p> <ul style="list-style-type: none"> • Health Equity Reporting (2027 Jan-Mar) • Value-Based Care Reporting (2027 Jan-Mar)
Q4 June 30, 2027	July 22, 2027	<p>Clinical Data:</p> <ul style="list-style-type: none"> • Controlling High Blood Pressure (1 year) • Six Well Child Checks by 15 Months of Age (1 year) • Diabetes: Glycemic Status Assessment Less Than or Equal to 9% • Colorectal Cancer Screening (1 year) • Adolescent Depression Screen and Follow-Up (1 year) <p>Access and Care Management:</p> <ul style="list-style-type: none"> • Health Equity Reporting (2027 Apr-Jun) • Value-Based Care Reporting (2027 Apr-Jun)