Fourth Annual Health Equity Award For Medi-Cal Managed Care Health Plans

October 2021

California Department of Health Care Services

2021

Award Winner

Blue Shield Promise

BlueSky: A multi-year initiative to enhance access, awareness and advocacy to youth mental health supports for California's youth through partnerships and philanthropy

And

Runner Up

Kern Health Systems

Mobile Mammography Event

The Fourth Annual Health Equity Award, October 27, 2021

Department of Health Care Services (DHCS) Managed Care Quality and Monitoring Division (MCQMD*)*

The intent of the Health Equity Award is to highlight interventions developed by the Medi-Cal Managed Care Health Plans (MCPs) that attempt to identify and reduce health disparities. By highlighting these efforts DHCS hopes to facilitate and encourage the sharing of promising practices.

MCPs are each allowed to submit two nominations for the Health Equity Award. The nominations must briefly describe a health disparity intervention that was conducted within the past two years. MCPs must collect qualitative and/or quantitative data from internal or external sources and identify a statistically significance health disparity. Additionally, MCPs must describe how a health disparity intervention was identified and customized to address the target population's needs. The MCP has to evaluate the intervention's effectiveness and provide outcome results if available, particularly any evidence of a reduction in the identified health disparity or improved outcome for the target population.

MCQMD staff review and score the submissions based on the criteria described above in order to determine a winner and runner up.

DHCS received fourteen nominations from ten MCPs.

Blue Shield Promise Health Plan

1. Black Maternal Health Outcomes - In collaboration with a Black, Indigenous, and People of Color (BIPOC)-owned community-based organization

Black Maternal Health Outcomes - In collaboration with a Black, Indigenous, and People of Color (BIPOC)-owned community-based organization, Blue Shield Promise is launching Black Maternal Health (BMH) Circles to hold monthly listening sessions with 20 - 30 Black women between the ages of 18-42 in their first trimester through one-year postpartum. According to the United States Department of Health and Human Services and the Centers for Disease Control and Prevention, Black mothers are three to four times as likely as White mothers to die from pregnancy-related causes, regardless of factors like higher education and financial means, and for women over 30, the risk is as much as five times higher. Black infants are more than twice as likely to die as White infants. Black mothers are also two point three times more likely than non-Hispanic White mothers to receive late or no prenatal care. The goals of the project are to cultivate trust with the women, and deepen our understanding of their experiences with providers, health plans, and Blue Shield Promise. With these women, we plan to co-design solutions that address health inequities. This will be a year-long project in Southern California. In six months, we will invite Blue Shield of California (BSC) teams working on Black maternal health initiatives to join the sessions. We will develop a final report that highlights the experiences of Black women in the perinatal process and provide recommendations on how we can support these women in having happier and healthier pregnancies.

When developing the BMH Circles, the team consulted with multiple stakeholders, such as health plans, statewide non-profits, and the University of California, Berkeley to understand state-level data on Black birthing women. In order to understand our member population and identify target counties, the team analyzed internal pregnancy data as well as public data from the California Department of Public Health to examine preterm birth, low birth weight, and infant mortality. Finally, the team consulted with internal stakeholders focused on Black maternal child health initiatives to understand current gaps in care.

Our team conducted empathy interviews to integrate lived experiences into the design of the project. During the interviews, we asked open-ended questions to a Doula and a BIPOC mother who had children in the last two years. The interviews provided us insight on their experiences and the continuum of care for Black birthing people. In addition, collaborating with a mother and a Doula highlighted the gaps in qualitative data on the lived experiences of Black birthing people. As next steps, the team will partner with community-based organizations to co-design and implement solutions. We will meet regularly with these partners to collaborate, share lessons learned, and identify opportunities.

At BSC and Blue Shield Promise, we are taking deliberate and innovative action towards advancing health equity. Blue Tank, an internal innovation challenge, is an annual opportunity for employees to pitch creative ideas to a panel of leaders on ways to solve today’s pressing healthcare challenges. We provide the top finalists with coaches, mentors, and resources to develop their ideas over the course of the challenge. Participants then have ten minutes to pitch their ideas to the judges, followed by a short Question and Answer session. The presentations are scored on several criteria, including empathy, innovation, storytelling, strategic fit, and projected impact. The winning participants receive funding to launch their project. This year, the Blue Tank challenge focused on ways to build trust in marginalized communities as the Coronavirus Disease 2019 (COVID-19) pandemic highlighted the broken trust that often exists between marginalized

groups of people and the healthcare industry. We asked the participants to engage in the innovative process, apply an equity lens, and partner with internal and external stakeholders, particularly those most impacted. This employee-generated approach allowed for new ideas and partnerships across the organization to emerge, such as the BMH Circles project.

For the BMH Circles, our focus is to gather qualitative data to understand the experiences of Black birthing women. The team will conduct a pre- and post-survey in each session to understand the experiences of the women in three domain areas: interactions with health care providers, experiences with health plans, and awareness of and experience with BSC maternal health resources. We will also gather qualitative data on their experience of taking part in the BMH Circles. Lastly, we will conduct a survey to understand the backgrounds of the participating Black birthing persons/women prior to starting the listening sessions. From these surveys and listening sessions, we hope to better understand the status of our care and where there are opportunities to improve.

As we collect qualitative data throughout the BMH Circles project, we hope to deepen our understanding of the women's needs. Our hypothesis is that qualitative data will provide us a holistic understanding of the experiences of Black birthing persons and help us shape more effective solutions that address the perpetual racial health inequities and racially biased maternal care gaps.

2. BlueSky: A multi-year initiative to enhance access, awareness and advocacy to youth mental health supports for California's youth through partnerships and philanthropy (September 2019 - 2024)

BlueSky provides counseling for middle and high school students in 20 schools in San Diego and Alameda Counties with additional services offered statewide to support youth and educators. The youth served in the counseling program reflect the diversity of California's student population with over 50 percent of referred youth identifying as Latinx and over 12 percent identifying as African American.

As a not-for-profit health plan, BSC and Blue Shield of California Promise Health plan, is working to ensure a healthier California, integrating health equity and social justice into all its work. To advance that mission, our BlueSky initiative enhances access, awareness, and advocacy of youth mental health. The program's interventions include providing access to clinicians in middle and high schools, training educators to spot the signs of mental health issues, empowering students with culturally affirming mental health support resources, and supporting career development for professionals pursuing careers in mental health. Leading with equity, our BlueSky initiative is going beyond the traditional definition of healthcare to address this mental health crisis by providing mental health resources and support for California youth - regardless of insurance eligibility.

Multiple sources of quantitative data were used for the health disparity analysis. There is a mental health crisis among California's youth. Mental illness is the top reason kids in California are hospitalized. According to University of Michigan researchers, one in six youth in the United States, between ages six and 17, experience a mental health disorder each year. In California, too few of those affected receive the help they need. The COVID-19 pandemic has only exacerbated this crisis. According to a University of California Los Angeles (UCLA) Center for Health Policy research study, 45 percent of California youth between the ages of 12 and 17 reported having recently struggled with mental health issues. Additionally, nearly a third of those respondents reported serious psychological distress that could interfere with their academic and social functioning. The California Association of School Counselors reported the student to counselor ratios was 601:1 during the 2019-2020 school year. After BSC conducted a landscape health disparities analysis and identified youth mental health as a key focus area, gaps in school-based youth mental health care and supports were identified. Working with mental health data from the California Healthy Kids

Survey and local partners such as the San Diego County Office of Education and Oakland Unified School District behavioral health staff, BlueSky identified specific schools in the county with the greatest need for onsite mental health specialists.

Utilizing a community-participatory approach in developing the BlueSky Initiative, Blue Shield has so far committed over $10 million over five years to implement BlueSky in collaboration with the California Department of Education and nonprofit organizations such as Wellness Together and the National Alliance on Mental Illness California (NAMI) and Health Career Connection. We consulted with the California Department of Education and collaborated with Wellness Together to develop the following interventions: (1)Youth Counseling (two counties): 13-week therapy program in close collaboration with school staff at 10 middle and high schools in San Diego county and 10 middle and high schools in Alameda county with a combined student body of 20,000. Services also include crisis and family engagement sessions and classroom wellness presentations. (2) Educator Training (statewide): train educators and caring adults in an eight-hour course that covers the warning signs of mental health concerns in youth and teaches how to help youth experiencing mental health challenges. (3) Student-Led Clubs (statewide): scale clubs that raise mental health awareness, educate the campus community, and promote services and supports. (4) Supporting Pipeline Diversity (eight counties): provide 36 early-career professionals with internships, mentoring and educational opportunities to support their careers in mental health.

BlueSky represents a new model of collaboration and partnership between school districts, nonprofits, and a managed care plan to support a school-based approach that will allow communities to connect with youth with mental health needs and further empower them to develop resilience regardless of insurance eligibility. BlueSky's vision is to improve access, awareness, and advocacy to improve health and educational outcomes and create a more racially equitable California. BlueSky unites community resources for youth, embraces youth stories and elevates youth resiliency through social media messaging, resiliency themed art murals, and virtual art projects. BlueSky offers mini-investments to innovative community organizations focused on youth development for BIPOC communities by helping young people find their voice, advocate for themselves, and stand up and be counted. BlueSky supported the annual Directing Change Program Awards Ceremony where youth filmmakers across California were given awards for their one-minute shorts to raise awareness about mental health and suicide prevention. Using a holistic approach, BlueSky provides training to educators and caring adults in Youth Mental Health First Aid (YMHFA). BlueSky addresses diversity in the mental health workforce by creating career pathways for mental and behavioral health professionals, who can provide culturally affirming services for members of the BIPOC community through a $500,000 grant.

BlueSky uses the interventions to produce rigorous evidence on what works and needs to improve with respect to school-based mental health services. A research team from the University of California, San Francisco's (UCSF) Philip R. Lee Institute for Health Policy Studies evaluates the BlueSky initiative's impact on student and school level outcomes. The UCSF team approaches the evaluation as a learning community that engages in understanding not just why the results are a certain way but also how to engage to better understand the implications of the findings for quality improvement over time. A participatory evaluation process is used that includes collecting clinical data from partners and interviews and surveys with school staff and youth to consider multiple perspectives. Both qualitative and quantitative methods are used to triangulate the findings and consider multiple perspectives. During the first two years UCSF conducted both a process and outcome evaluation of the BlueSky program examining the implementation of the model as it is rolled out in the target schools. Evaluations looked at the following process: providers hired, youth serviced, sessions provided, trainings, adults trained, youth referrals, clubs formed, participants, and student ambassadors; and outcome measures: mental health indicators among clients,

confidence in recognizing and referring youth in mental health crises, leadership skills, mental health awareness, and literacy.

The UCSF team found, in first two years, BlueSky served 945 youth in 7,893 counseling sessions and held 67 in classroom wellness sessions. Pre and post data for 2020-2021 school year show improvements over time measured by: Affective strengths, related to accepting affection from and expressing feelings toward others (41 percent to 50 percent); Intrapersonal strengths, related to internal emotional strengths, and outlooks on their own competence and accomplishments (33 percent to 40 percent); and Interpersonal strengths, which are strengths in relating to others (57 percent to 62 percent). After 10 or more counseling sessions, youth self-reported wellbeing indicators showed improvement. Self-reporting results I believe in myself (19 percent), I trust at least one person very much (12 percent), I feel close to others (nine percent). The percentage of students reporting they had caring adults and support (Behavioral and Emotional Rating Scale-two) improved after 10 or more counseling sessions. Self- reporting results: I have somewhere to go when I need help or support (88 percent to 93 percent) and there is an adult who cares about me at school (88 percent to 95 percent). BlueSky conducted 162 YMHFA trainings for 3,435 educators and adults. Nearly 97 percent of the 396 trainees surveyed felt the lessons were helpful in supporting youth during the COVID-19 pandemic and distant learning challenges. In 2020-21, BlueSky and NAMI California supported 70 on campus clubs with 1,271 participants in 13 counties across California. Given the early success, there is an opportunity to assess the model for improvement and expansion.

California Health and Wellness

Provider Cultural Competency Education Series (February 2021 - November 2021).

California Health and Wellness (CH&W), in partnership with Physicians for a Healthy California (PHC), designed a cultural competency education series for medical providers in California. The comprehensive series focuses on educating providers on how to deliver culturally competent care in diverse communities. The goal of the series is to better equip providers to overcome health disparities that are driven by language barriers, misunderstanding of culturally based concepts and practices, unconscious bias in healthcare settings, and lower levels of health literacy.

The education series, developed by CH&W's Health Equity team, will be released monthly beginning with the topic of cultural awareness. Subsequent months will include topics with a cultural focus on: Adverse childhood experiences (ACEs); childhood immunizations and support for vaccine hesitant parents; reproductive health care; diabetes management; supporting patients with developmental and physical disabilities; and culturally competent care for Black, Indigenous and People of Color (BIPOC) and Lesbian, Gay, Bisexual, Transgender and Questioning or Queer (LGBTQ+) patients.

Qualitative data used for this intervention included social determinants of health and educational needs of medical providers expressed by CH&W staff and our partnering organization, PHC. Current Performance Improvement Projects (PIPs) for specific quality measures such as Childhood Immunization Status (CIS) and reproductive health measures such as Breast Cancer Screenings (BCS) were also considered when determining topics to address. Based on the findings, the two agencies identified eight topics to include in the educational series.

The topics included in the educational series were selected and customized based on the needs of the partnering agency, PHC. Each topic was researched and developed based on cultural relevance and recommendations on best practices. CH&W's Health Equity team will develop educational material and distribute the content to internal and external stakeholders and subject matter experts, including PHC, to review and provide feedback. CH&W will incorporate all

feedback to ensure the content meets the needs of the target population and to confirm the cultural and linguistic information is accurate and relevant.

CH&W utilized an innovative approach to educate California providers by providing culturally specific health information on key health disparities in diverse communities. “A key component to new care delivery models is the ability to engage and educate patients about their health status,” says Dr. Ramiro Zuniga, Vice President, Medical Director of Medi-Cal at CH&W. This culturally competent educational series provides health disparity trends and specific cultural best practices for vulnerable groups such as Blacks, Latinos, Asians, women and people with disabilities. The information provided will encourage providers to apply cultural best practices into routine care with patients and implement culturally appropriate standards of care in their practice.

The impact and effectiveness of the intervention will be evaluated based on the number of providers reached. Metrics will be tracked on the numbers of clicks, downloads, and number of providers on distribution lists to measure the reach of each educational material in the series. The education materials are posted in a downloadable format on CH&W’s Provider Library, Bridging the Divide microsite, and emailed out to a statewide database from PHC. To increase access to important cultural and linguistic related information, a new page was added to the Provider Portal titled “Health Equity, Cultural and Linguistic Resources.” The materials are also downloadable on CH&W’s Bridging the Divide microsite. The microsite is dedicated to informing policymakers and Medi-Cal stakeholders about the company's commitment to serving Medi-Cal members across the state.

Outcome results are not yet available, as the program was recently implemented. Outcome results will be available during the first quarter of 2022.

CalViva

Breast Cancer Screening Disparity Project with the Greater Fresno Health Organization (August 2020-December 2022).

The target population is the Hmong/Laotian/Cambodian speaking members at a high volume, low performing Federally Qualified Health Center (FQHC) in Fresno County. The first intervention is a Hmong Sisters Education Event at The Fresno Center. Members will be invited to attend the dinner event by the Greater Fresno Health Organization (GFHO) and prizes have been identified for a raffle. A video will be shown in Hmong on the importance of breast cancer screening and how it is performed. A local female Hmong physician will present the video and speak to the issue. Designated Hmong women will provide testimonials regarding their mammogram experience and their experiences as a breast cancer survivor. The Women's Imaging center will participate in the project. They will review their processes at the imaging center. The Women’s Imaging center will focus on addressing the scheduling gap between the FQHC and the Imaging Center. CalViva will utilize a member-friendly approach; utilizing interpreters, addressing transportation, assisting with scheduling, and assisting with completing forms.

Qualitative data such as key informant interviews and focus groups, as well as quantitative data using administrative claims, encounter data surveys, and social determinants of health data were used for the health disparity analysis.

This event, known as the Hmong Sister Educational Event, will take place at Fresno Center which is a cultural hub for the Hmong community. The intervention was specially targeted to this population because of the low Breast Cancer Screening (BSC) rates at the targeted FQHC. During the event there will be a video and educational materials, all in the Hmong language. There will also be interpreters, and a physician from within the community, who will speak with members.

The BCS completion rates will be tracked by a Provider Profile (a list of the non-compliant members) by the clinic, imaging center, and the health plan. A monthly Run Chart will also be

monitoring the BCS rates. CalViva will track the following: (1) the percentage of members who are able to be reached by GFHO staff; (2) the percentage of members who attend the Hmong Sisters Health Educational Event; (3) the percentage of members who made an appointment for a mammogram among those who attended the Hmong Sisters Health Educational Event; (4) the percentage of members who completed mammograms among those who attended the Hmong Sisters Health Educational Event; (5) the percentage of members who found the Hmong Sisters Health Education Event to be convenient; (6) the percentage of members who were likely to complete their next mammogram after attending the Hmong Sisters Health Educational Event.

The outcome results are not yet available; we are having the first Hmong Sister Educational Event on September 24, 2021, but we will be utilizing the "Member Friendly Approach" that was previously successful for another BCS Project. The "Member Friendly Approach" consists of addressing the needs of the Hmong population: interpreters, educational materials on the importance of BCS screening, and providing a welcoming and warm atmosphere.

CenCal Health

1. The Food Rx Pilot (September 2020 – October 2021)

The Food Rx Pilot addresses childhood obesity and food insecurity in the city of Santa Maria located in Santa Barbara County. Families receive a 20 pound box of seasonal produce delivered weekly for six months. The Food Rx Pilot collaborates with the Santa Maria Health Care Center and the Santa Barbara Food Bank, who help with enrollment for each family and deliver the seasonal produce contributing to program sustainability. Each child's Body Mass Index (BMI) and family's food insecurity are monitored throughout the course of the program using pre and post surveys and the use of educational cards. The pilot is complete once each participating family completes their six months, and to-date, 78 families have successfully enrolled.

The Food Rx pilot aims to improve food insecurity and reduce childhood obesity amongst CenCal Health's pediatric population. CenCal Health used a number of quantitative and qualitative data sources, including diagnostic and claims data, community stakeholder interviews, and County and state assessments and data reports. By using social indicators of health, once the data was gathered, it was identified that there is a high rate of obesity amongst the pediatric population in the city of Santa Maria located in Santa Barbara County. Cottage Hospital, located in Santa Barbara, predicted that 21 percent of people living in Santa Barbara are estimated to live with food inequity compared to the national Healthy People 2020 target goal of 6 percent. Within the estimated 21 percent, 16 percent of the food insecurity rate is found in Santa Maria. According to the California Department of Education and Physical Fitness Testing Research Files, the percentage of childhood obesity by grade level in Santa Barbara was at 40 percent for fifth, seventh and ninth grade boys and girls. To address the high prevalence of both obesity and food insecurity, members whose BMI was above the 90th percentile and who were determined to be food insecure, were enrolled into the six month Food Rx pilot. Seventy-five pediatric members ages one to eighteen and their families successfully enrolled in the Food Rx pilot, receiving nutrition education and weekly fresh produce delivery to help supplement a family of up to four for the duration of the pilot.

The idea for the Food Rx Pilot started early summer of 2020. Initially, the Population Health team was working with CenCal Health’s Community Relations team to create vouchers for qualifying families to use for fresh produce at their local farmers market. Another idea was to help our members use their Electronic Benefits Transfer (EBT) cards to purchase fresh produce at the San Luis Obispo Farmers Markets. Unfortunately, the planning of these programs happened around the same time as the start of the COVID-19 pandemic shutdowns, and we had to adapt our proposed strategy. It remained important for the Food Rx pilot to maintain the goal of providing fresh produce to the identified members while minimizing barriers during COVID-19. CenCal Health

began conversations with community partners to identify how we might use established community organizations to provide services for the identified target population, while ensuring program sustainability and minimizing in-person contact during the pandemic.

Collaborating with the Santa Barbara Food Bank and the Santa Barbara Public Health Department's nutritionist helped provide sustainability to the pilot and linked services to the community. The Santa Barbara Food Bank allocated volunteers who used their own cars to deliver the produce boxes. The nutritionist assisted families in scheduling telehealth visits where she coached families on how to calculate for BMI, administered a food insecurity survey to identify barriers to purchasing fresh produce, discussed unhealthy eating behaviors, and measured knowledge about healthy eating using a Likert scale survey. CenCal Health staff created educational cards in both English and Spanish designed to be used as an everyday kitchen tool. They fan out for a quick view of healthy suggestions for breakfast, lunch, dinner and snacks. The educational cards also use Quick Response codes that lead to additional educational resources on how to cook healthy recipes, how to store fresh produce, and the importance of physical activity. Using United States Postal Service when sending information about the pilot to each family, telehealth visits, and delivering fresh produce every week to family's doorsteps reduced the need for in-person interaction minimizing exposure to COVID-19. But most importantly, it helped reduce barriers to accessing healthy produce by making it readily available. Families now have the knowledge and resources for a healthier lifestyle in efforts to reduce obesity and minimize food insecurity.

The Food Rx pre and post surveys were designed to measure the member's BMI and families' food insecurity. Each member was asked to provide his or her age, weight and height to determine his or her BMI to identify if he or she was above the 90th percentile for obesity. Food insecurity data was collected by asking the member and their family a series of questions formatted on a Likert scale. For example, "How likely are you and your family to skip a meal or go to bed hungry because of financial status?" Each pre-test response will then be compared to the member's six month post-test. At the end of each survey, the member and their family will have the opportunity to provide anecdotal data and provide feedback on their experience during the six-month pilot. In addition, the Santa Barbara Food Bank and the Santa Barbara Public Health nutritionist has the opportunity to provide feedback through the duration of the pilot either through email, setting up meetings, or a phone conversation. Open communication with all parties involved helped to maintain program fidelity and effectiveness.

The structure and workflow of the pilot made it easy for program enrollment, implementation and collaboration between CenCal Health, Santa Barbara Food Bank and the Santa Barbara Public Health Department. The Food Rx pilot has surpassed the goal of enrolling at least 70 members, as there are 75 actively enrolled families while still maintaining program sustainability. Since the implementation in September 2020, we have had a number of participating members complete their six-month pilot and each family has been given a post survey to gather pre and post BMI change, behavioral knowledge learned, and a reduction in food insecurity. To date, 16 families have completed post-tests, and we hope to gather significant data by the end of 2021 to determine success and continuation for future implementation across the CenCal Health's service area. At this time, families who have provided feedback have described that the pilot allowed their families to be well fed during the financial challenges that the pandemic has brought upon them. Most families have shared that they are now learning how to implement fruits and vegetables into their meals and how they hope for this pilot to continue beyond the six month pilot period.

Health Net

1. Creating a System to Achieve Equitable Health Outcomes through an Asthma Pilot (January 1, 2021 – December 31, 2021).

Health Net partnered with Radys Children's Hospital of San Diego (RCHSD) on an Asthma Pilot program. RCHSD serves San Diego, Imperial, and Southern Riverside Counties. The Asthma Pilot's target population are children with Medi-Cal or undocumented insurance, who live in San Diego, Imperial, or Southern Riverside Counties and are seen in our Emergency Department (ED) for poorly controlled asthma. In the past 12 months, RCHSD has served 2,882 children identified as having moderate to severe or poorly controlled asthma with an insurance classification of Medi-Cal or Undocumented. Of this population 65 percent identify as Hispanic/Latino and 12 percent as African American. Many of the children live in neighborhoods commonly associated with inequalities related to poverty, poor air quality, and other socioeconomic and cultural factors. Cluster regions include: Logan Heights, City Heights, National City and Chula Vista.

This partnership would pilot efforts focusing on children with asthma, as it disproportionally impacts underserved populations. RCHSD has a strong infrastructure and multidisciplinary team in place in order to support and test interventions for this population of children. In 2019, RCHSD implemented a robust Call Back Pilot with their Respiratory Therapist (RT) Team to call patients recently seen in the ED and hospital for an asthma related visit. A Population Health Clinical Informaticist worked closely with cross-functional teams to create a dashboard that identifies eligible patients for the pilot and tracks related outcomes. RTs used this platform to interact with families on a more frequent and timely basis after a recent exacerbation to ensure that patients understood their condition, their prescribed medications, and were connected to appropriate services, including establishing care with their primary care physician. While results from the 2019 pilot were impressive and improvements were see in the asthma population as a whole, the Medi-Cal population ED return rate remained higher. The team recognizes that in order to achieve equitable outcomes for all children served we need to better understand the disparities faced by our population and develop interventions accordingly.

RCHSD has been a community leader as one of the first hospitals in the area to adopt and implement an Electronic Medical Record (EMR) system. With the support of robust EMR dashboard development and reporting, Health Net had the ability to perform continual analysis of resource utilization, trends, cost, and outcomes to identify needed interventions and track outcome improvements. Registries, clinical guidelines, and Smart Sets were also available to guide our work. Additionally, although our work has been robust we must apply a health equity lens to our interventions, metrics, and outcomes. Health Net was awarded a grant, which offered an opportunity to work with a skilled Population Health Clinical Informaticist to build a health equity index to identify, track, and prioritize care gaps and develop appropriate interventions.

The outcomes of the Asthma Pilot demonstrates how Health Net was able to reduce this health disparity. First, a health equity index development that captures 90 percent of children with asthma was used by RCHSD ED for 12 months. Results showed all patients seen in ED or inpatient setting captured on equity index that details: location (geo-mapping created), race and ethnicity, gender, language, patient age, payor, prior ED visits. Second, there was a reduction in ED return rates by 10 percent for patients in targeted zip codes identified with geo-mapping technology. These results are still in progress. Third, the social determinants screening for transportation, food insecurity, homelessness, and smoking exposure in 80 percent of children seen for an asthma exacerbation in our ED is still in progress. Fourth, we are attempting to connect with highest risk asthma patients recently seen in the ED (about 30 a week) and successfully connect 30-50 percent of families to social and community services to address transportation, food insecurity, and homelessness by December 31, 2021. As of today, 100% of families in need of resources that consent to assistance

are referred to available programs by the patient care coordinator with one on one support navigating resources such as food banks and referrals to 2-1-1 San Diego.

2. **Breast Cancer Screening for Russian Members in Sacramento County (October 23, 2020 – December 31, 2022)**

The narrow focus for the Health Net Community Solutions (HNCS) Breast Cancer Screening (BSC) health equity Process Improvement Plan is on members identified as Russian by Race/Ethnicity and/or Language in Sacramento County. Russian-speaking members have a lower rate of BCS than any other language in Sacramento County. The intervention is to offer care coordination to Russian-speaking members to assist members in scheduling a mammogram, arranging transportation and interpreter services, and explaining the importance of mammography and breast cancer early detection. HNCS is also exploring the possibility of a radio campaign in the Russian language using Russian-speaking providers.

HNCS has performed below the minimum performance level (MPL) of the 50th percentile in BCS for the last two years. HNCS used the Healthcare Effectiveness Data and Information Set (HEDIS) barrier analysis tool developed by the HNCS Health Equity Team and the Quality Improvement Research Analysts using medical claims, encounters, supplemental data, and membership demographics to identify a statistically significant disparity between Russian-speaking members and Vietnamese-speaking members in Sacramento County. The Russian-speaking population has a 45.55 percent BCS rate compared to the Vietnamese-speaking population BCS rate of 81.31 percent. The HNCS Quality Improvement Biostatistician used the rolling 12-month data from the HEDIS department that uses medical claims, encounters, supplemental data, membership demographics, membership enrollment history and provider assignment to calculate the BCS baseline rate for Russian-speaking population of 38.46 percent and the goal rate of 50.13 percent. The data consisted of members who were 52-74 years of age as of September 30, 2020 and eligible for the BCS HEDIS measure. This is the latest 12-month rolling file produced by our HEDIS department and looks back an additional three months for claims completeness.

The first step HNCS took was to have the breast cancer health education material translated into Russian. HNCS has ordered printed copies of the material which explains the importance of mammography to deliver to the high volume providers serving the Russian population in Sacramento County. HNCS is also developing a care coordination model through the Participating Provider Groups (PPGs) that will target the Russian-speaking non-compliant members with Russian-speaking staff. The care coordination model will have the PPGs use Russian-speaking staff to contact non-compliant members by phone, provide education, schedule appointments, and arrange transportation and interpreter services. Outreach to the Russian-speaking population with a Russian speaker is important for building trust. It is important that the Russian speaker address any misconceptions that they may have about mammography. Since members may not know the process, the Russian speaker can explain the process and ensure privacy and respect. Language barriers and transportation were often cited as barriers to mammography. This led to the process of arranging transportation and interpreter services, rather than just referring members to resources.

HNCS will train staff on the intervention, the process, roles, responsibilities and documentation. In addition, the Health Equity department is contacting the Slavic Assistance Center to provide cultural competency training to the PPGs, the Imaging Centers, and staff**.**

Care Coordination is not often offered to members of disparate racial/ethnic groups or languages. Offering care coordination to the Russian-speaking population for BCS meets the needs of the Russian-speaking population and may lead to improved health equity for the BCS measure for the Russian-speaking population.

Another intervention that HNCS is currently exploring is doing a radio campaign with Russian-speaking health care providers who can talk about different health care topics, such as the importance of annual well-care exams with one's provider and the components of a well-care exam, The importance of cancer screening, especially breast cancer screening and cervical cancer screening, and COVID-19 vaccination and other vaccinations. The Slavic Assistance Center operates Russian radio programs in the Sacramento area. HNCS has a relationship with the Slavic Assistance Center and has worked on radio programming with them targeting infant and childhood vaccines. HNCS is currently outreaching to Russian-speaking providers to do 20-30 minute segments/interviews on the radio that can be taped and replayed. HNCS is also in contact with the Slavic Assistance Center to do some radio programming. This type of intervention would fill the need to increase community awareness of the importance of BCS and well-care exams in the Russian language.

Outcome results are not yet available. Care Coordination has not yet begun as of 8/26/2021. Care Coordination is anticipated to start in September or October 2021 and run through December 2022.

The radio programming with the Slavic Assistance Center is still in negotiations.

Inland Empire Health Plan

1. Jaime Camil campaign

Inland Empire Health Plan (IEHP), in partnership with L.A. Care Health Plan, started our Jaime Camil campaign on 8-17-21 with an Instagram Live session featuring actor Jaime Camil and a physician from L.A. Care. During the 40-minute conversation, more than 500 people viewed the live event and many more will see the video replayed via social media posts. The campaign, a first-of-its-kind partnership with two health plans in neighboring counties utilizing celebrity talent, was created from conversations with our physician partners on the front lines as well as County and state data showing that Hispanic and Latino families were dying at disproportionate rates from COVID-19. The overall plan includes the following: 1. Two Instagram Live conversations with Jaime Camil and a physician from L.A. Care and IEHP 2. Public Service Announcements about the importance of (A) Getting the COVID-19 vaccine and (B) Going to your doctor for preventive health visits. These PSAs will be featured on television and radio for 30 days and social media for up to six (6) months in San Bernardino, Riverside and L.A. Counties. These PSAs are in both English and Spanish. (C). Billboards will be placed alongside designated freeways in San Bernardino and Riverside Counties (on behalf of IEHP) and in L.A. County (on behalf of L.A. Care) (D). Promotional material featuring Jaime and these messages will be sent to all 1.4 million IEHP members via newsletters in October of 2021.

Both qualitative and quantitative data were used to guide this project. First, qualitative data was gathered by speaking with physicians on the front lines at Social Action Community (SAC) Health System and Loma Linda University Health. These physicians spoke to the dire need to address the racial inequities they saw during their experience dealing with COVID patients in the hospital. They noticed the majority of families suffering from COVID were from Hispanic or African American households. Reading numerous articles about the pandemic and this issue of racial disparities, one theme rang true: there was a high degree of mistrust in the vaccine when the messages came from political or governmental authorities. Instead, it was imperative to find trusted leaders who resonated with the community: pastors, physicians of color, or other trusted community leaders and/or celebrities. Because Jaime was so well-known and well-respected in this community, we decided to try something new to get our message out to save lives.

This intervention was customized to the target population based on community partner feedback and collaborations with IEHP and L.A. Care leadership who represented the community we were targeting.

The campaign is the most innovative approach that any health plan has tackled during the COVID-19 pandemic. During a recent call with LHPC (Local Health Plans of California), IEHP and L.A. Care presented the Jaime Camil project, and the health plans in attendance marveled at the creative, collaborative and innovative means we were utilizing to break away from the clutter and try something new. We have received feedback from this population that he is the "perfect" spokesperson because he is a father, husband and trusted entity in the Hispanic community. Kids, mothers, fathers, grandfathers and grandmothers all love him.

We are currently in the beginning stages of the campaign and can provide more detailed analytics at the end of September. The chat engagement from the first Instagram Live showed many questions asked and answered that we hope will create a snowball effect in the community. The more people who are informed and can talk to their loved ones about getting vaccinated, the better.

2. COVID-19 Mass Vaccination Site: A partnership with Inland Empire Health Plan and San Bernardino County (February 2021 – Present)

San Bernardino County is home to 2.1 million residents. Of the 2.1 million residents, 1.0 million are eligible for the COVID-19 vaccine. Our goal was to increase vaccination rates among San Bernardino County residents and IEHP members through a COVID-19 Mass Vaccination Clinic. IEHP partnered with San Bernardino County to address COVID-19 vaccine distribution disparity and expand access to the vaccine to residents in the region. IEHP and San Bernardino County focused on COVID-19 vaccine eligible residents in San Bernardino County (Ages 12+). IEHP is the first and only health plan in the state to host a vaccine clinic in its corporate headquarter building. Early analysis suggested COVID-19 vaccines were inaccessible to vulnerable populations and IEHP members in this region. Concerted efforts were made to coordinate with County, local communities and public officials to create a vaccine clinic that would reach these vulnerable and underserved populations, and increase equity and access. Percentage of eligible residents in San Bernardino County who are partially or fully vaccinated is 58.7 percent.

To identify the health disparity, a qualitative and quantitative analysis of external focus groups, social determinants of health data, demographic data and public health data was studied. The information suggested a lack of access to the COVID-19 vaccines. As a result, in February 2021, IEHP and San Bernardino County partnered to become one of the first indoor mass COVID-19 vaccination sites in the Inland Region. By pooling our resources, we could answer the call and bring much needed vaccines to the region. The collaboration brings together experts to address all aspects of vaccine delivery. The work required logistical engineers, medical directors, informaticists, clinical and nonclinical staffing and scheduling experts, emergency medical services professionals, infection-prevention officers, and communications specialists.

Although the speed of development of COVID-19 vaccines exceeded expectations, the initial deployment of these vaccines lagged. According to the Center for Disease Control and Prevention, by January 11, 2021, the United States had distributed 22.1 million doses but administered only 6.7 million vaccinations. In San Bernardino County, similar struggles existed with the speed of vaccine delivery. That's where IEHP stepped in. The intervention was customized based on target population feedback. Data suggested that sole use of conventional hospitals and health care sites to administer the vaccine was not sufficient to achieve rapid enough vaccination. The slow-paced distribution of the COVID-19 vaccine prompted the need for an innovative and unconventional approach: a mass vaccine clinic in the heart of the community.

As the COVID-19 vaccine became increasingly available, and the race to quickly and equitably inoculate our communities became crucial in achieving herd immunity, we used an innovative approach, developing one of the first indoor mass COVID-19 vaccination sites in the Inland Region. This intervention offered the target population a chance to receive life-saving vaccines in an equitable, accessible and safe environment. IEHP is uniquely positioned to partner with the County and galvanize resources in a timely and intentional manner and continues to innovate by conceptualizing processes, building bridges and always putting our members first.

The intervention, which started February 2021 and is still running, began with a maximum of 500 daily appointments but due to expanded eligibility and increased demand, was quickly ramped up to over 800 maximum daily appointments. To date, more than 36,000 COVID-19 vaccines have been administered at the IEHP/San Bernardino County vaccination clinic. 50 percent of San Bernardino County residents have received the COVID-19 vaccines.

Monthly IEHP Vaccination Clinic Data: February 21' - 2258, March 21' - 7920, April 21' - 16568, May 21' - 7835, June 21' - 1130, July 21' - 472, August as of 8/17 - 362 for a total of 36,545 vaccinated at the IEHP/SB Clinic.

Kern Health Systems

On October 30, 2020, Kern Health System (KHS) organized a mobile mammogram event in the rural, underserved, town of Taft. The event involved coordination with a local health care clinic and one of KHS' contracted mobile health care providers. KHS kicked off this project on September 21, 2020 by conducting outreach to non-compliant members in that rural area for the Breast Cancer Screening (BCS) measure. Outreach was completed by October 23, 2020. The outreach efforts were focused on connecting with female members 50 years and older, living in the Taft area. There was a strong focus on the Hispanic population due to Hispanics accounting for 69.62 percent of our membership.

Taft and its surrounding area are in the foothills of the extreme southwestern edge of the San Joaquin Valley. It is one of the few remaining towns in the United States that exists exclusively because of nearby oil reserves and without the resources one would find in a more populous community. There were 312 members of the Taft area who were non-compliant with their mammograms, and with no radiology provider in town to offer this service. Of the 312 non-compliant members, KHS identified that 78 members had listed Hispanic as their ethnicity. Of those 78 members contacted, 56 members listed Spanish as their primary language. KHS utilized one of our Quality Improvement (QI) non-clinical support staff to perform the member outreach. This individual is fluent in Spanish and has a background in health care. All 312 non-compliant members were outreached to by our QI non-clinical support staff. A total of 60 members were reached, 59 appointments were scheduled, and a total of 47 mammograms were successfully completed, which gave us a completion rate of 71 percent.

Due to the Taft area not having a clinic where our female population can get a mammogram screening, KHS brought a clinic to them. KHS partnered with a local clinic and mobile health care provider to complete mammograms for the non-compliant members in the area. Some of the members who were contacted understood the importance of getting a mammogram, while some did not know the purpose of a mammogram. Our QI Assistant shared with each member she contacted the inherent advantages and benefits that come with taking responsibility for one's health by completing preventive screenings, such as a mammogram. She was able to convey this information to each member in English or Spanish, based on their preferred language. The interventions created with this effort in providing services to this population include partnering with the local health care clinic and the mobile mammography provider, telephonic outreach to non-compliant members, and setting up a three-way call with the member and the clinic to book the

appointment for the mammogram. One challenge we encountered was an FQHC not affiliated with the local clinic who did not want their member getting a mammogram from the mobile provider. Their concern was potentially losing their patient to another provider. We mitigated this by having our Provider Network Management Representative reset the priority of member care. That member was able to complete their mammogram with the mobile provider.

Health care services that are provided within this small community are scarce. Some members must travel as many as 50 miles to see a specialist in Bakersfield. By bringing the mobile clinic to Taft, it resolved the issue of the service being unavailable there. The KHS QI Assistant directly outreached to all non-compliant members living in the Taft area. This staff person was also able to meet the needs of this population with her fluency in Spanish. This approach provided a more personal connection with the members, which led to successfully filling all available appointments. In addition, this effort was so successful that the clinic and mobile provider set up additional hours to offer mammograms. Another innovative aspect leading to successful outcomes was setting up a three-way call to have members schedule and set up the appointment while on the phone. One member was elated she had received a phone call from KHS. She was over 50 years old and had never had a mammogram. Another member was relieved that KHS was bringing a mobile clinic to their area because it was hard for her to travel. Another member received the call with excitement to know that a mobile clinic was coming to town. She knew of its importance and wanted to have this test done. Before hanging up, she expressed her sincere gratitude to our team with a tender-hearted “thank you”.

KHS generated a list of non-compliant members for the Taft area. There was a total of 312 members who needed a mammogram before the end of the year. A call log was created to capture outreach attempts, as well as the outcomes for the attempted calls. The QI Assistant utilized the call log to track the progress of the outreach efforts. By scheduling the appointments while the member was on the phone with the QI Assistant, we were able to track the number of appointments that were successfully scheduled. The collaboration and partnership with the local health care clinic allowed us to validate which members kept their mammogram appointment. One of the outcome measures was the feedback from the members. Utilizing direct calls with the member in lieu of robocalls, allowed us to engage with the members and obtain their input and feedback.

KHS identified an area in Kern County where a radiology provider was non-existent. By bringing a mobile radiology facility to the Taft area, we were able to increase the rate of compliance with mammograms in this area for 47 members. Also, by tracking our outreach efforts, we were able to identify the volume of members we reached and how many of those members completed a mammogram. By partnering with a mobile mammography provider and using a log to track efforts, we were able to effectively measure how many members scheduled and completed appointments. Of the members reached, we were able to schedule appointments for 98 percent of the members. Of the members scheduled, 80 percent kept their appointments. This initiative led to a one point sixty-seven percent improvement in KHS’ overall compliance with the BCS measure, comparing October 2020 through December 2020. This level of tracking allowed us to identify the success of this initiative. The direct interaction with members allowed us to obtain anecdotal feedback on the services offered and their ability to make informed decisions.

Los Angeles Care Health Plan

COVID-19 Disparities Response Project (April 2020)

In collaboration with the Los Angeles (L.A) County Dept. of Public Health and the University of Southern California (USC) School of Pharmacy, the L.A. Care Community Pharmacy Value-Based Program – California Right Meds Collaborative (CRMC) expands access to healthcare for our most vulnerable high-risk patient populations. Community pharmacists are one of the most accessible

health care providers in patients' neighborhoods, especially in underserved areas. Our goal is to develop a network of highly trained and experienced CRMC community pharmacists to manage chronic diseases and ease the burden on our strained primary care system. The program launched in January 2020 and is ongoing with no set end date. L.A. Care data demonstrated disparities in the Black or African American and Latinx or Hispanic populations residing in specific geographic regions (Antelope Valley and South Los Angeles). L.A. Care pharmacy technicians/clerks outreach to those in this target population. After enrollment into the program, our CRMC pharmacists serving these high-risk populations provide comprehensive medication management (CMM), which is an in-person/telehealth appointment service in collaboration with the patient's primary care provider, involving thorough review of clinical information (progress notes, labs, vitals, etc.) and consistent follow-up monitoring to reach treatment goals.

From internal L.A. Care health disparity analysis, the Black/African American population is the lowest performing group in the Comprehensive Diabetes Care HEDIS measure, specifically in terms of poor control of glycated hemoglobin (A1c) at greater than nine percent. This result is statistically significant compared to the highest performing group (Asians), over the three year averages (HEDIS 2018 to HEDIS 2020). The Latinx or Hispanic population is also disproportionally affected by uncontrolled diabetes. According to the Centers for Disease Control and Prevention (CDC), Hispanic/Latinx Americans are one point seven times more likely to have diagnosed diabetes for adults aged 18 years and older than non-Hispanic white counterparts. Furthermore, the Hispanic population is also two point six times more likely to develop complications, such as end stage renal disease (ESRD) related to diabetes, and one point three times more likely to die from diabetes when compared to their non-Hispanic white counterparts. Historical data has shown that L.A. Care's Regional Consumer Advisory Committee (RCAC) 1 region (Antelope Valley) and RCAC six (Compton, Inglewood, Watts, Gardena, and Hawthorne) also have the highest rates of uncontrolled diabetes.

L.A. Care partnered with the USC School of Pharmacy to implement CRMC as they have a prevalent and trusted presence in the communities where disparities are demonstrated. L.A. Care and USC also collaborated with Federally Qualified Health Centers (FQHCs) like Watts HealthCare, Center for Community Health (JWCH Institute), ParkTree Community Health Center, KHEIR Clinic, and Arroyo Vista Family Health Center to enroll mutual members of highest need for closer monitoring and disease management. L.A. Care's enrollment and outreach process involves risk stratification involving both health and socioeconomic-related factors. A greater risk is assigned to members of Black/African American race, Hispanic/Latinx ethnicity, or living in RCAC region one or six. Members with a higher risk score will have a higher prioritization status for outreach and enrollment. A post-enrollment survey was developed to gain feedback from L.A. Care members, and responses will be used to make changes to the program.

CRMC is an innovative program to use our existing community pharmacy network to help manage members with uncontrolled diabetes along with other comorbid conditions. Enrollment in this program begins with the L.A. Care Pharmacy Department outreaching to the member or the primary care physician who serves at a clinic or FQHC referring high-risk members. L.A. Care's internal data teams will identify members who have uncontrolled A1c greater than nine percent or A1c greater than 11 percent. L.A. Care Pharmacy technicians/clerks will outreach to the eligible members. If the member expresses interest in the program, they are referred to one of the partnered community pharmacies who will schedule the initial appointment and follow-up appointments. Our CRMC pharmacies are local leaders who are familiar with cultural, linguistic, and health literacy differences in their communities, primed to deliver care to patients of different backgrounds. Specially-trained pharmacists in the management of diabetes and other chronic conditions will conduct in-person or telehealth appointments to provide CMM, which includes

developing a plan to overcome barriers to disease control (i.e.: lifestyle changes, medication adherence, medication or medical equipment counseling, and disease state education) and recommending medication changes to the provider. Member will be considered at goal if A1c less than or equal to eight percent and blood pressure is less than 140/90 millimeters of mercury (mmHg) and on statin therapy, if clinically appropriate.

Another innovative component of this intervention is the value-based payment model used to compensate participating pharmacies providing CMM services. While pharmacies are paid per CMM visit, a larger bonus payment is only paid upon achievement of all three clinical goals (A1c less than or equal to eight percent, blood pressure less than140/90 mmHg and on a statin), thus incentivizing pharmacies to ensure their interventions are effective towards reaching these goals. Then an internal data analysis was conducted by the L.A. Care Pharmacy Department to evaluate the A1c, blood pressure, and statin use trends among the L.A. Care members enrolled in the program compared to a matching cohort of L.A. Care members who were not enrolled in the program. This data analysis was then stratified by race, ethnicity, and RCAC region. The data used for this analysis was pulled directly from provider chart notes and internal L.A. Care data systems. Furthermore, a critical success factor for CRMC is a stringent continuous quality improvement (CQI) process managed by L.A. Care. Each visit between a CRMC pharmacy and an L.A. Care member is scored against a systematic quality assurance rubric to assess if the recommendations and interventions made were comprehensive and clinically appropriate to ensure effectiveness of the program as a whole. L.A. Care also facilitates the collaboration between CRMC pharmacies and partnering FQHCs to streamline patient care and monitor progress towards reaching clinical goals.

To date, there are seven pharmacies participating in this program that have assisted 287 members, including 262 direct L.A. Care Medi-Cal (MCLA) members and 25 Cal MediConnect (CMC) members. Demographic data shows the majority of members participating in this intervention are Black or African American (n=81) as well as Hispanic or Latinx (n=157). A one point five percent in A1c reduction was seen in Black/African American members enrolled in the program compared to a point six percent increase for members in the matching cohort. In the Hispanic and Latinx population we also saw an A1c reduction of one point five percent compared to an increase of point five percent for the matching cohort. Members who had five or more visits with a CRMC pharmacist had an average decrease in A1c of two point seven percent, which was statistically significant compared to our matching cohort, p-value less than 0.001. Overall, 75 percent of the enrolled member population is currently taking a statin, compared to 46 percent in our matching cohort. All data points comparing our CRMC population to our matching cohort were statistically significant. A positive trend is seen with number of visits that the member has had with the clinical pharmacist and change in blood pressure, i.e., the more visits the member has had with a CRMC pharmacist, the greater the observed drop in blood pressure. Overall, 68 percent of the CRMC member population have a blood pressure less than 140/90 mmHg.

Positive Healthcare (AHF)

1. Increasing Access to Colon Cancer Preventive Screenings among Medicare and Medicaid Populations (May 1, 2021 – Present)

The target population consists of all AIDS Health Foundation (AHF)/Positive Healthcare (PHC) members aged 50 years and older (recently reduced to 45). The intervention included a monetary incentive for completing either a colonoscopy or a ColoGuard kit. The ColoGuard kit is similar to the Hemoccult immunochemical fecal occult blood test (iFOBT) lab test, however, the kit is sent from the vendor with all the items needed to complete the test at home and sent back for lab analysis. The test consists of obtaining a small stool sample and inserting the sample into a provided test

tube. While the iFOBT must be done annually, the ColoGuard Test is different and allows for a three year interval between tests. The ColoGuard kits were introduced to combat the COVID-19 pandemic barriers such as limited appointment availability of colonoscopy, flexible sigmoidoscopy, and CT colonography. While at-home testing does not eliminate all barriers associated with colon cancer screenings, it does offer a non-prep, non-invasive, and convenient option for eligible patients. The implementation of primary care physicians ordering the test also eliminated any concern of ineligible patients receiving a kit, and Registered Nurse Care Team Managers were readily available to patients that required additional guidance throughout the process.

Literature reviews show colorectal cancer is the third leading cause of cancer-related deaths and is expected to cause 52,980 deaths in 2021. Although the annual percentage rate of deaths continuously decreases by one percent, the disparities in incidence, mortality, age, socioeconomic status (SES), and screening remain. African Americans (AA) have the highest incidence (20 percent more likely) and mortality (40 percent more likely) rates than any other racial/ethnic group, and are most likely to be diagnosed with colorectal cancer (CRC) at a younger age. Ratio comparisons of educational status among CRC link low educational status to an increased mortality rate in all racial/ethnic groups. AAs with less than 12 years of education have a death rate of 16.7 per 100,000 persons, compared to a rate of 10.4 with 13-15 years, and nine point two with more than 16 years. AAs are also least likely to share their positive diagnosis of CRC with their family and have the lowest likelihood of CRC screening based on familial history. Hispanics are reported to have the lowest CRC screening rates (47 percent) compared to AA (56 percent) and non-Hispanic White (62 percent). All members are adults (21 years and older) with a diagnosis of AIDS. A review of member demographic information showed that: most members are over the age of 50 (70 percent) or between the ages of 40-49 (17 percent). Race and ethnicity information show that most in the plan are White/non-Hispanic (13 percent), Latinx/Hispanic (16 percent), or Black/African American (17 percent).

AHF partnered with ColoGuard, which has a nationwide range and targets patients eligible for colonoscopies through TV, radio, email, and SMS-text message. We provided the company with our target population's contact information and they used their multiple methods of outreach to contact members. Once a member received a kit via physician order, ColoGuard followed for 60 days with reminder calls, emails, and/or text messages. Members have one year to complete the test.

With the COVID pandemic and barriers to colonoscopy, at-home testing is a method to reach several members. The intervention included a monetary incentive for completed tests and returned lab reports. Staff members were also incentivized with company Above and Beyond points that accumulate and can be exchanged for gifts on a company website. The ColoGuard cancer screenings kits not only allowed patients to conduct at-home screenings but also increased coded claims data creating a more efficient process when retrieving test results.

To validate the intervention's effectiveness a log and survey were created and monitored. As patients returned their incentive form, results were validated and analyses of utilization among the colon cancer screening options was composed. The survey was sent to members upon receiving their gift cards. The mixed-method data collection allowed for a qualitative and quantitative analysis of the intervention's effectiveness.

The target population totaled 1,056 members eligible for a CRC screening as of February 2021. To date, we received 107 returned patient incentive forms, 32.7 percent (35 of 107) of patients conducted a colon cancer screening test, and 54.2 percent (19 of 35) of patients utilized the at-home screening kit option. The survey demonstrated that patients were very satisfied with the overall experience of the program.

2. Improving Retinal Eye Exams among our Medicare and Medicaid Populations (March 1, 2021 – Present)

The target population consists of all Human Immunodeficiency Virus (HIV) - positive patients with a diabetes diagnosis seen at 10 of AHF's healthcare centers. The digital retinal eye exam cameras were introduced in 10 of our healthcare centers to reduce further complications of diabetes and provide early detection of vision abnormalities. The staff were trained on camera usage and offered non-monetary incentives to encourage participation amongst staff. PHP members were offered a monetary incentive to complete a Diabetic Retinopathy (DR) screening at one of the 10 healthcare centers. The exams were combined with previously scheduled appointments to reduce the number of in-person patient visits during the COVID-19 public health emergency. All patients were offered the traditional option of receiving the exam from visiting an ophthalmologist. However, diabetic retinopathy screenings at the healthcare center were encouraged to identify patients who need an in-person ophthalmologist visit. The process consisted of scheduling retinal eye exams with existing appointments, allowing a patient's eyes to naturally dilate in a dark room, taking optical pictures, and uploading the images to the devices portal. Once images were uploaded a specialist reviewed and diagnosed the patient with DR severities, no DR, or other eye conditions.

External data from literature reviews were used to inform our health disparity analysis. The literature reviews show approximately 34.2 million individuals in the United States are diagnosed with diabetes (roughly 1 in 10 individuals), and nearly one in three individuals are diagnosed with prediabetes. Those who suffer from diabetes may develop other complications such as DR, which is the number one cause of non-traumatic blindness in working adults. The 2019 Medicare claims data exhibits a national annual crude prevalence rate of 11.5 percent in patients 65 years or older with diabetic eye diseases. California and Florida showed some of the highest national prevalence rates. California was above the national average reflecting an 11.6 percent prevalence rate. Early detection of DR is known to reduce up to 94% of severe vision loss. The 2018 IRIS Registry data also revealed age and race disparities amongst those who suffer from diabetic retinopathy (DR). Within the 40-64 age range, North American Native Americans (13.34 percent), Hispanics (12.10 percent), and Other (12.57 percent) race/ethnicities show leading numbers in DR. All members of our health plan are adults (21 years and older) with a diagnosis of Acquired Immunodeficiency Syndrome (AIDS). A review of member demographic information showed that: most members are over the age of 50 (70 percent) or between the ages of 40-49 (17 percent); the majority are male, 81 percent. Race and ethnicity information show that most in the plan are White/non-Hispanic (13%), Latinx/Hispanic (16 percent), or Black/African American (17 percent).

AHF purchased RetinaVue eye exam cameras and utilized them to conduct retinal eye exams at our healthcare clinics. Diabetic patients were identified by their medical records and eye stickers were placed on their chart as a staff reminder to perform a retinal eye exam. The collaboration of AHF with RetinaVue allowed real-time access to patient results and narrowed the number of patients that needed in-person ophthalmologist visits.

The introduction of RetinaVue cameras for retinal eye exams served as an innovative approach to decrease the barriers patients reported during the previous year. These barriers included transportation, unwillingness to have medicated dilation, and fear of additional COVID risk if an appointment was available. In-house retinal eye exams limited COVID-19 exposure risk, removed the barrier of additional transportation needs, and eliminated the need for medicated dilation.

The intervention's effectiveness was evaluated using a spreadsheet exported from the RetinaVue portal and a survey sent to patients. The spreadsheet provided quantitative data collection methods such as the number of exams performed, billed, and results of each exam.

Patients on the log were further stratified by their health insurance, while the survey provided qualitative data to demonstrate the plan's effectiveness.

Our 10 healthcare centers screened a total of 418 patients. Of the 418 patients screened, 345 (83 percent) exams contained readable images for both eyes, and 105 (30.4 percent) of those patients are enrolled in the PHP Medicare plan, while nine (two point six percent) are enrolled in the PHC Medicaid plan. The other 231 (67 percent) patients are registered in other health plans (68 percent). Thirty four exams had referable pathology (eight point thirteen percent). Fifteen exams had non-referable pathology (three point fifty nine percent), and 364 exams had no identified pathology. A detailed look into the referable pathologies differentiates between each notable pathology: Non-proliferative Diabetic Retinopathy Moderate (NPDR) accounted for nine point forty three percent; Non-proliferative Diabetic Retinopathy Severe (NPDR) accounted for one point eight nine percent; Non-proliferative Diabetic Retinopathy Mild with clinically significant macular edema, accounted for one point eight-nine percent; Proliferative Diabetic Retinopathy accounted for 33.96 percent; Age-related Macular degeneration (AMD) accounted for nine point forty-three percent; Glaucoma, accounted for five point sixty-six percent; and Other accounted for 37.74 percent. The survey resulted in maximum satisfaction with the program amongst the information provided, comfortability with the exam, value pertaining of health maintenance, and overall experience. In conclusion, the DR intervention resulted in early detection, reduction of societal/economic cost of blindness, and excessive specialist referrals.

SCAN Health Plan

Organization wide strategy to reduce disparities in COVID-19 vaccination rates among vulnerable older adult population (February 2021 – July 2021)

During COVID-19, SCAN Health Plan built upon existing health equity efforts to develop a comprehensive organization wide COVID vaccine strategy. Core areas of the strategy focused on ensuring equitable access to vaccinations by: 1) building confidence and trust in the safety and efficacy of the vaccine, 2) providing information regarding locations and accessibility, 3) assisting members with scheduling appointments and 4) bringing vaccines into homes of vulnerable homebound members. All COVID related interventions were kicked off in February 2021. The majority of the interventions were completed by end of July and the remaining efforts will continue until end of October 2021. SCAN identified target populations based on community needs index (CNI), social vulnerability index (SVI), homebound indicators, number of chronic conditions, difficulties performing activities of daily living, race, and language. This information helped to identify appropriate interventions and provide outreach to address gaps in inequities. Interventions ranged from launching a dedicated COVID vaccine hotline, having a dedicated team to conduct outreaches to Black, Latinx and Asian members, forming a "Provider Task Force", to launching California's first in home vaccination program for the homebound, just to name a few.

SCAN used multiple quantitative and qualitative methods to conduct the health disparity analysis. This included creating a COVID-19 vaccine dashboard using administrative data to track total vaccine doses administered, members vaccinated, and vaccination rate by age, race, language, gender, county, and income-status. SCAN continually reviewed this information to identify areas requiring improvement. Information on members that received vaccines were also obtained directly through Medicare Administrative Contractors (MACs), California Immunization Registry (CAIR) and direct feedback received from members as part of various outreach efforts. Online surveys were created to understand members' and caregivers' views on receiving the vaccine, as well as to strategize vaccine communication and education to members. Pre and post intervention data was analyzed to determine the gaps between homebound to non-homebound members, English to Spanish speakers, vaccination rate gap between Whites, Blacks and Latinx

members, low income members to others, etc. Additional research data from Centers for Disease Control and Prevention was obtained to understand the cost of COVID related hospitalization in older adults across the country. This was used to calculate gains from avoiding COVID related hospitalizations. Member satisfaction surveys were conducted at the end of each intervention to report on qualitative outcomes.

In line with core areas of corporate vaccine strategy, SCAN developed targeted approaches for our members, providers, employees and community at large. For members, SCAN conducted onsite vaccination clinics, launched the first of its kind homebound vaccination effort using Emergency Medical Technicians (EMTs), launched a COVID vaccine hotline with bi-lingual staff dedicated to helping members with questions as well as navigating the process of registering and receiving vaccines. An equity focused outreach team was also formed in an effort to minimize disparities in vaccination specifically among Black, Latinx and Asian members. For providers, we established a “Provider Integration Task Force” to share data specific to chronic conditions and member demographics, homebound and income statuses to promote and collaborate on equitable vaccine distribution efforts. For the community at large, SCAN allocated more than $5 million in emergency funding to support COVID-19 relief for seniors throughout California, and partnered with the State to vaccinate homeless individuals.

SCAN used a Person-Centered Care (PCC) approach to understand what mattered to members with respect to their health and the pandemic, and applied those findings to design a multi-prong persuasive strategy to inspire change. This helped SCAN to look beyond basic demographic data and implement interventions based on members’ COVID specific needs. At a time when guidelines related to COVID vaccinations were changing rapidly, SCAN created a dedicated hotline with bi-lingual staff to provide assistance to members. COVID vaccine related inquiries were directed to this phone line for action or escalation to appropriate care management teams. In parallel to the COVID Vaccine hotline, SCAN formed an equity based outreach team comprised of bi-lingual staff that focused on reaching out to Black, Latinx or Asian members as well as members that met the criteria to be “High Need” seniors. The purpose of these outbound calls was to build vaccine confidence and offer assistance in scheduling vaccine appointments. SCAN then launched the first in-home COVID vaccination program in California to homebound members, their caregivers and household, leveraging a mobile logistical geo-mapping platform and EMTs. SCAN hosted COVID-19 TeleTalks (telephone education sessions) in English and Spanish for over 30,000 members with leaders from each respective community, that addressed concerns and answered questions related to COVID vaccines.

At the beginning of the pandemic SCAN set up an organizational goal to vaccinate 70 percent of the members by July 2021, in order to ensure “herd immunity” is reached within the membership. SCAN achieved this goal by having 71.3 percent of the members vaccinated at the end of July 2021. SCAN analyzed the effectiveness of the overall vaccine strategy by using various quantitative and qualitative methods. These included: 1) comparing number of vaccinated members at the beginning of the data collection period to end of the data collection period, 2) comparing vaccination rate gaps by ethnicity, spoken language, homebound status and income status, 3) factoring cost savings related to preventable COVID related hospitalizations and 4) feedback received though member satisfaction surveys.

SCAN launched various COVID vaccine interventions at the beginning of February 2021. Since then the vaccination gap between minority populations to White members diminished significantly. As of August 2021 the vaccination rate gap between Whites and Blacks dropped from 17 percent to four percent, and the vaccination gap between Whites and Latinx dropped from 11 percent to four percent. Disparities among English and Spanish speakers reduced from 14 percent to nine percent at the end of July. SCAN also noticed the disparity gap among low-income to middle-and high

income members lessen as time progressed. The vaccination rate difference between the low income members to others dropped from 15 percent to eight percent by mid-August. SCAN used zip codes as another indicator of wealth and the potential prevalence of social determinants of health barriers. The measured disparities between members of various zip codes were based on each area's CNI. A higher CNI indicated a higher prevalence of social determinants of health. Vaccination rates among members that have a high CNI score was reduced from 15 percent to eight percent at the end of the data collection period. Vaccination rate among homebound members rose from 35 percent at the beginning of the data collection period to 73 percent at the end of July. SCAN is proud of many of our successfully executed health equity efforts for older adults during COVID-19, which we will continue even after the pandemic is over.