

*Third
Annual
Health Equity
Award
For
Medi-Cal
Managed Care
Health Plans*

October 2020



2020

Award Winner

Anthem Blue Cross

**Anthem Doula Pilot Program: A Multi-sector Partnership
to Improve Birth Outcomes among African American
Women in Fresno County.**

And

SCAN

Insulin Advisors.

Runner Up

Partnership Health Plan

**Reducing Disparities in Members Recently Released
from Incarceration**

The Third Annual Health Equity Award, October 8, 2020

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 reviewed and scored the submissions based on the criteria described above in order to determine a winner(s) and runner up.

DHCS received sixteen nominations from twelve MCPs.

AWARD NOMINATION SUMMARIES

Anthem Blue Cross

1. Anthem Doula Pilot Program: A Multi-sector Partnership to Improve Birth Outcomes among African American Women in Fresno County, Dec 2019 – Ongoing

This intervention is a multi-sector partnership between Anthem, Black Infant Health (BIH) and a community-based doula organization aimed to improve the birth outcomes of Anthem members, targeting African Americans. In Fresno County, the preterm birth rate for African American women is 64.6 percent higher than White women according to the March of Dimes. Our intervention provides comprehensive doula services to address the needs of pregnant women and curtail the potential impact of systemic racism. Through ongoing engagement between the three entities, we knit a tightly woven care matrix where we effectively coordinate services for this vulnerable population. Participants of BIH, identified as Anthem Medi-Cal members, are offered doula services and childbirth education classes, covered by Anthem. Doula services include prenatal and postpartum visits and continuous labor support (in person and virtual). Doula services supplement the BIH program and fill support gaps where BIH leaves off. Together, we provide education, care coordination, case management, depression screening, referral to programs addressing other social needs, and family support. We ensure that participants have a personal advocate and learn self-advocacy skills to navigate through the complex medical system and beyond so that they can have a healthy pregnancy.

Multiple sources of quantitative data were used for the health disparity analysis. We looked at multiple clinical measures along the maternal birth outcomes continuum, including prenatal and postpartum Healthcare Effectiveness Data and Information Set (HEDIS) rates, caesarean section rates and preterm birth rates. Additionally, to further our understanding, year-end HEDIS data was used to compare prenatal and postpartum visits rates among different racial groups using the Department of Health Care Services' (DHCS) enrollment data. A chi-square test of independence was used to confirm the statistical significance of the disparity. In addition, other quantitative data included claims and encounter data which was used to understand inpatient utilization in relation to preterm labor and delivery. Public county data was also used to confirm county trends and rates. On a qualitative level, we conducted key informant interviews with local county health program staff from the BIH program, the March of Dimes and community-based organizations, and existing projects such as the University of California San Francisco (UCSF) Preterm Birth Initiative and the West Fresno Resource Center. We relied upon their footprint in the community and experience in working with this population to guide program development. On a statewide level, we have extensively invested in relationship building with doula organizations that serve communities of color and continuously rely upon ongoing dialogue and their guidance for mentorship, problem solving guidance and process improvement opportunities.

Utilizing a community-participatory approach towards addressing this disparity, the doula pilot was born from workgroup discussions between BIH and Anthem. Recognizing that the BIH program has over 30 years of experience with serving African American women, we leveraged their expertise in directing us on what the community needs were. Their recommendation was for Anthem to create access to doula services. To that, we prioritized the objective to create a new, sustainable payment model to contract with doulas. Through this contract, we elevated the importance of doulas as alternative providers and the integration of doulas into Anthem's provider network. Recognizing the historic role of birth workers within African American culture, our intention was to honor this tradition by providing respectful, culturally concordant care. We were intentional about contracting with a doula organization that was recommended by BIH. There is a growing

consensus that doulas play a vital role in supporting vulnerable communities of color and can have a positive impact in birth outcomes. Research suggests that doulas improve maternal health outcomes through multiple mechanisms, including offering continuity of care, as well as by helping pregnant women feel empowered to communicate their needs and concerns to their provider.

This intervention represents a new model of collaborative care between a county-level program, a community-based doula organization and a managed care organization. There are several layers of innovation. The first involves the creation of a doula provider contract to provide access to doula services. This unique contract represents the growing importance of contracting with alternative providers and their role in community-based care. The second layer is the relationship that contract enables between BIH and doulas to provide wraparound services to support members. Members benefit from a resulting “sandwich effect” where their needs are nurtured and cared for. While doulas in the community is not a new idea, the formation of the BIH-doula partnership now provides access and compensation for services that were not there before, that Anthem enabled. The third layer involves the successful integration of Anthem into the community framework as a working partner. At the core of the program are open communication channels and ongoing dialogue where we work as a collaborative team to support each member. As an iterative process, we continue to evolve the triadic relationship and fine-tune problem solving and issue resolution.

Anthem is part of a larger statewide effort to streamline and standardize data from doula pilots, in efforts to collectively impact policy change. The primary objectives of this intervention are to reduce the risk of preterm birth of participants and ensure that members attend their prenatal and postpartum visits. We are tracking the success of the program with a set of process and outcome measures, on a quantitative and qualitative level. These include and are not limited to: **Process:** (1) Number of visits or encounters (in person and telehealth), (2) Number of referrals to other services and programs (e.g. Case management, housing, food access, transportation); **Outcome Measures:** 1) The percentage of full term births (greater than 37 weeks), (2) The percentage of cesarean births, (3) The percentage of breastfeeding initiation, (4) Neonatal Intensive Care Unit (NICU) admissions; (5) Participant satisfaction with doula services. Reporting dashboards and reports have been created to reflect the program metrics, status and overall effectiveness. We are also collecting ongoing feedback from clinical providers to increase the acceptance of doula services into the traditional medical practice. In addition, Anthem will be partnering with a research company, HealthCore, to conduct a secondary evaluation from a quantitative perspective ensuring the program is meeting specific health equity objectives. Analysis results from both studies will be used to enhance the program.

The program has resulted in positive outcomes. Our goal is to recruit 50 members and to date, we have enrolled 20. Given the 2019 novel coronavirus (COVID-19), we had an interruption with recruitment but have resumed. Of the 20 members, 10 members delivered, with 100 percent of them at full term. Of those 10, four had a history of prior preterm birth or were high risk. Fifty percent of members had vaginal deliveries and 100 percent of members had successful breastfeeding initiation. We also measure success by care coordination touchpoints and referrals made to other programs. Two of our successful stories are: (1) A member contracted COVID-19 while living in a homeless shelter. Through the advocacy of BIH and her doula, the member was able to have a healthy birth and relocate to safe, temporary housing after the delivery. The family is now in permanent housing. Through Anthem’s meals and housing support program, she will receive meals and support for housing expenses. Without the wraparound support, this member may have not been able to navigate and access these services. (2) A participant, with a history of three prior preterm births, completed all services in the program. Through the knowledge she received from her doula and childbirth classes, she learned to manage her pregnancy and to self-advocate. She achieved her goal of having a healthy, full-term baby boy. Given the early success of

our program, we will expand to other identified counties where we can employ a similar model of collaborative care.

2. Watts Healthcare COVID Testing Pilot'

Anthem Blue Cross helped launch the 'Watts Healthcare COVID Testing Pilot'. First we identified one of the clinics of Watts Healthcare, a Federally Qualified Health Center, to host COVID-19 testing in South Los Angeles (LA) (Watts). The objective of this project is to improve health disparities in Black and Latinx communities by making COVID-19 testing more readily available in South Los Angeles. Black and Latinx Californians impacted by COVID-19 have higher mortality rates, especially in low-income communities. Data from the California Department of Public Health show that differences in working and living circumstances, as well as other conditions exacerbated by systemic racism, generally put low-income Black and Latinos at greater risk of exposure. As COVID-19 cases continue to increase, the Watts Healthcare COVID Testing Pilot was launched in June 2020 with the understanding that it is even more crucial to make testing readily available in these higher risk communities. It facilitated both drive-through and walk-through options, to minimize barriers. Watts Healthcare is currently expanding daily testing numbers and now plans to continue to operate this testing site as long as needed.

Anthem Blue Cross used various internal and external data sources to pinpoint health disparities and select a site for testing. We reviewed member-specific information on race and ethnicity and diagnoses from our encounter data and claims, in order to locate members with relevant underlying conditions. We also used geographic information to determine where there were less testing sites. We paired this information with other data gathered from the Centers for Disease Control and Prevention (CDC), the Los Angeles County Department of Public Health and the University of California Los Angeles. We discovered that the morbidity rate among Latinx and Black residents in California is twice as high as their White counterparts. South LA had some of the highest cases and death rates. While Latinos make up 39 percent of California's population, Latinos account for 59 percent of COVID-19 cases and 46 percent of fatalities. In April 2020, the LA County Health Director reported that of the county's initial 93 COVID fatalities where race was noted, Blacks were 17 percent of fatalities despite being nine percent of the population. As we acknowledged that community partnerships were key to success, Anthem and Watts Healthcare also worked very closely with the local Young Men Christian Association (YMCA) on a health disparity analysis for the COVID test pilot. The YMCA has been a trusted community partner in South Los Angeles since the 1950s, serving more than 30,000 low-income residents. We worked with their data to develop community outreach plans and coordination for the Watts testing site.

To increase accessibility to South LA residents, Watts Healthcare customized the logistics and workflow of the test site to ensure navigability, efficiency and safety. Phone appointments were scheduled and tracked. Patients being tested were directed to their drive-up or walk through site of four separated stations, by a Watts or YMCA representative. After the appropriate checks and triage, and once at the final station for testing, a nasopharyngeal or oropharyngeal test is performed. Test results are followed up with a call and information on proper protocols and quarantine measures. Anthem assisted Watts Healthcare in making sure their billing procedures were customized to ensure every patient is covered for COVID-19 testing. We made sure no patients would get billed. In addition, the testing site was structured to accommodate the testing of multiple individuals in the same car. The community promotion and engagement was customized with the YMCA to encourage cross-promotion with other community activities such as food drives and health education events.

Anthem ensured that the Watts COVID-19 Testing Pilot offered testing for community members with and without personal transportation, and covered all ages, so multi-generational households could all get tested. In addition, individuals were not excluded from testing due to a lack of active

symptoms, in order to best help these communities better manage the risk of asymptomatic community spread. Watts Healthcare also used a digital media approach to inform South LA residents, where they used a text campaign and virtual pop-up banner on their website that displayed testing site information. The model for this testing site served as an innovative collaboration to address a health disparity. Using trusted community partners has been key to success. The partnership between the clinic and community organization focused on leveraging communication and engagement strategies. The funds that Anthem provided for this project allowed the YMCA to support and promote the Watts COVID testing initiative. Banners, flyers and social media posts have also been used in addition to engagement with food drives. Staff from the YMCA made sure community members safely made it through the entire testing process.

Anthem is taking the initiative to evaluate the effectiveness of the COVID testing pilot through joint weekly operation meetings with the YMCA and Watts Healthcare. Anthem assisted Watts Healthcare in becoming a county-recognized test site to gain additional access to testing supplies and Personal Protective Equipment. Anthem has also assisted in securing lab vendor capacity to ensure better test result turnaround times. Anthem is following these additional metrics of success: building community support, data management, and number of tests completed. Watts Healthcare now receives over 300 calls each day from individuals requesting testing appointments, highlighting community need for COVID testing. They are now expanded to complete 40-50 tests per day. Watts Healthcare data metrics include date of birth, race and ethnicity, address, symptoms, date of symptom onset, date of testing, test results, and hospitalizations. Anthem is working with Watts Healthcare to pass this information to the County to help with contact tracing for positive cases.

Watts Healthcare and Anthem have worked jointly to ensure that the project helps encourage residents in South Los Angeles to know their status, and the project has proven to be a low-barrier test site allowing testing for anyone who needs it. After each test is administered, Watts Healthcare provides resources for individuals on how to successfully quarantine and how to successfully maintain social distance. Watts Healthcare has also made testing more accessible and open to the whole community by streamlining billing. We have met a need for a community disproportionately affected by this pandemic, through a unique model that helped build community trust and encourage community uptake. Plans to expand are pending.

Blue Shield of California Promise Health Plan

South Los Angeles Community Resilience: Pledge Awards and Community Trauma Advisory Committee (August 2019 – Ongoing)

Blue Shield of California Promise Health Plan's (Blue Shield Promise) target population was Medi-Cal members in South Los Angeles (L.A.), also known as Service Planning Area six (SPA 6). The intervention aimed to reduce the mental health inequities in South Los Angeles by financially supporting existing trauma-informed services and creating resiliency-based training for community-based organizations that serve communities of color. Blue Shield Promise donated one point one million dollars to community-based organizations throughout Los Angeles County in 2019. Of this contribution, \$500,000 went to organizations supporting health equity work as it relates to trauma in the populations they serve. Their services ranged from providing mental health first aid training, holding powerful healing circles, and conducting art therapy sessions for youth. Knowing that the funding was only set to take place for a year-long term, Blue Shield Promise stepped up in wanting to take a more active community role by fighting inequities that plagued our members. A significant portion of our Medi-Cal members live and work in South L.A., and our commitment to improving the quality of life for these members led us to ask the question "How do we help, and what need is most urgent here?" The answers we received through quantitative and qualitative analyses led us to develop a resiliency-based training and support for a community advisory committee.

SPA 6 is home to approximately 278,000 Black residents and 673,000 Latinx residents¹, yet this area remains underfunded and underserved. This intervention sought to develop channels to engage with local community partners to inform relevant and resonant strategies to reduce mental health inequities in South L.A. According to the L.A. Department of Public Health, 16.8 percent of SPA 6's adult populations are at risk for major depression, the highest risk in the county². With this information in mind, qualitative interviews were done with each of our awardees in order to create a snapshot of the existing resources available in the community. These interviews provided an outlet for the organizations to let us know what areas of mental health specifically needed more support. The consensus among these organizations was that addressing trauma should take priority when developing an intervention and that any intervention should be co-designed with trusted community players. They also highlighted inequities in resources to address present and historical trauma. Communities of color are disproportionately burdened by past and present trauma which decreases life expectancy, quality of life, and increased chronic disease prevalence.

After community activist and rapper Ermias "Nipsey Hussle" Asghedom was murdered in March 2019, the Boys & Girls Club of Metro L.A. held a summer series of art therapy forums for youth sponsored by Blue Shield Promise. The series was a success and urged us to identify additional opportunities to support work across Los Angeles County. We decided to fix our focus on building community resilience and using an equity lens to enhance initiatives with a specific focus on serving communities of color. We proceeded with a community forum that amplified the voices of community members who would be most impacted. The result of the forum was a community advisory committee that would create a trauma-informed intervention in South L.A. This committee – which includes representatives from Stop the Violence, Increase the Peace Foundation, Southside Coalition, Boys & Girls Club of Metro L.A., Wellnest L.A., Jenesse Center, and Take Charge Inc. – has a deep understanding of the individual and collective trauma along with the assets that can be further supported to build more resilience. The attendance and interest to continue and scale these initiatives started by the awardees advanced the agenda to a robust, holistic effort. Voices of the committee were heard and the work to move towards healing and equity was seen as a key to the city's future – so much so that Council member Marqueece Harris-Dawson launched a one million dollar community safety initiative to fund healing circles in South L.A.

The forum covered a variety of topics and areas of concern regarding health and social determinants of health in this area. Through this open-discussion forum, the stakeholders came to an agreement that we should invest in creating a resiliency-based training for community-based organizations (CBOs). The CBOs would then utilize these learnings at their respective locations and would continue to build upon their knowledge using the resources from the training. The resulting curriculum was designed entirely by our trusted community advisory committee and will begin implementation on Aug. 26, 2020. At this training, it is expected that topics surrounding the effects of violence in and out of the home and the trauma induced by systemic racism will be covered. Outreach to approximately 10 organizations including, but not limited to, Martin Luther King Community Hospital and Community Coalition was completed with an explicit focus on organizations serving communities of color. The training and the continuing work of the committee will serve as a resource for CBOs in the region. With the disproportionate impact of COVID-19 on

¹ 2018 California Health Interview Survey, UCLA Center for Health Policy Research

² Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology. Key Indicators of Health by Service Planning Area; January 2017.)

communities of color and the recent killing of George Floyd and the related unrest, these trainings are seen as critical to supporting the needs of people who are experiencing current trauma and/or are triggered from past events.

Clear goals and strategies were put into place early in the process of soliciting and integrating the perspectives of those closest to the problem to lift their voices in naming and prioritizing what they are facing and offering solutions. It included identifying ways to build on the existing strengths and values that are important to the community. The training needed to be a resource that could be constantly updated and improved upon as it is implemented in this community. These are the standards by which the training will be evaluated on a continuous and iterative basis: Goals (1) Build a resilient and trauma-responsive community that shares intergenerational trauma knowledge, understanding, language, practices, values, commitments, and culture. (2) Increase compassion and accountability to improve community health and effectiveness. (3) Build community resilience to vicarious and secondary trauma while supporting front line workers – our greatest resource - to implement structures for safety, self-care, and emotional wellness. (4) Build and mobilize community from information to action. (5) Build a culture of excellence through state-of-the-art trainings and a leadership development program. (6) Build a committed planning team that provides the leadership to engage the range of public, non-profit, and private stakeholders in a resilience-building process, i.e. teachers, business owners, pastors, police, legislators, health and mental health providers, etc.

The following organizations were given a total of \$500,000 in order to support their health equity work as it relates to trauma: Boys and Girls Club of Metro L.A., the Center for the Pacific Asian Family, Community Coalition, The Guidance Center, Southside Coalition, Special Needs Network, and the Stop the Violence, Increase the Peace Foundation. Nearly 300,000 lives were impacted by their work in community resiliency. Organizations submitted monthly reports in which they reported outcomes such as an increase in resource referrals and utilizations for children and their families, the creation of safe spaces in areas where they previously did not exist, and active engagement for violence prevention all with a focus on supporting communities of color. Outcome results are not yet available from the resiliency-based trainings. However, we have identified mechanisms and indicators through our internal teams and partner organizations that we will utilize upon the completion of the pilot phase of this intervention. These indicators will measure overall reception of the training, level of community cohesiveness as a result of the training, and general stress levels among the population receiving services. Each of these programs will be continuously monitored by our Blue Shield Promise team in collaboration with our Blue Shield of California health equity committee to ensure that we are promoting just and equitable spaces in all lines of work.

California Health and Wellness

COVID-19 Outreach to Communities of Color Project. (April 2020 – August 2020)

The COVID-19 pandemic has caused many disruptions in members being able to access health care. California Health and Wellness (CHW) developed a rapid response with the collaboration effort across the California market including clinical teams, community relations, care coordinators, and health education specialists, to perform member outreach to members who were determined to be at high risk. The purpose of the COVID-19 Outreach to Communities of Color project was to address access to care issues, provide community based resources, education, and care coordination. Members identified as testing COVID-19 positive were provided education from a clinician on self-care, effective quarantine procedures, and medication adherence, if applicable. Members were provided the opportunity to ask any questions they had and received answers and support.

Data from the CDC helped drive us to a stratification model. Initially, the population was stratified by acuity, age 56 and above, and those with certain health conditions. As the pandemic evolved, and county specific information became available, we found an opportunity to reach out to other populations. For example, there was an increase of COVID-19 cases specifically within the Hmong and Spanish speaking membership so we organized focused outreach. We leveraged certified language talent within our organization to reach out to members and speak in their preferred spoken language. Understanding different cultures and adapting to those cultures was pivotal in effectively sharing information, connecting members to the care and services needed. We also included California Children's Services eligible members within our stratification. Connecting with the various counties to determine level of support, we were able to understand which counties needed additional support for outreach due to constraints on their resources.

While outreaching to members, the CHW team identified needs outside of health care. In these cases, associates connected members to our internal member services department, telehealth, and community resources to fill gaps in care. Using Aunt Bertha, we connected members to free and low cost programs available in their area. These programs included food, utility assistance, and housing assistance. Additionally, to quickly support member needs, an internal document with local support programs was created. As new information became available, the resource document was updated. Some of the populations at high risk for COVID-19 were the Hmong and Spanish-speaking members. CHW organized a team to specifically outreach to these vulnerable communities and provide support. The project brought in associates who were certified bilingual to perform the project outreach, thus ensuring that health plan language specific support was available. By associates utilizing their language talent, it allowed us to connect with the member, decrease language barriers, and bring awareness to cultural differences.

The state mandate of social distancing and isolation presented CHW with the opportunity to leverage a virtual platform. Because of the sudden changes, many members were not knowledgeable on how to access their telehealth options. CHW reacted swiftly and was able to successfully help members gain access to telehealth options. During care coordination, our associates found that many other clinics around the state were providing their own forms of telehealth. Utilizing that information, our associates coordinated members' virtual appointments. Through our agile culture and process, we are able to quickly adjust to changes in the community, allowing us to better serve our members. For example, initially we identified a certain population that was at risk for COVID-19. However, this information was changing on an almost daily basis. CHW was able to pivot and rapidly reach out to new demographics.

The COVID-19 Outreach to Communities of Color project was a collaboration with various departments with the goal of addressing member needs. For example, our clinical teams worked with a member who needed medication support and education. By identifying a gap in care, the team provided education to the member that would positively influence their medication compliance. The member stated they were appreciative of the call and it was nice knowing they were not going through this alone. Based on interactions we were able to track and trend member's ability to connect to telehealth, transportation, access to food, and housing assistance. CHW received stories of appreciation, success, and other positive feedback. Members were overall appreciative of their health plan reaching out to them to ensure they still had access to care and other necessities were being met.

The purpose of the COVID-19 Outreach to Communities of Color project was to outreach to the most vulnerable populations and ensure they had access to care and that their needs were met. Due to the pandemic, many members wanted to avoid going into their clinic to avoid exposure. Data collected shows CHW connected members to the Nurse Advice line, Teladoc, or to the Babylon Health Application. By outreaching to members and having the opportunity to provide

education, we identified members that were not familiar nor had used their transportation benefits. We took this opportunity to support and assist the member with gaining transportation services to ensure they were able to access the care and services needed, like picking up medication or getting it delivered at no cost to the member. Overall, 78 percent of our targeted population had access to food. The team connected families needing food resources to community programs such as food delivery, state programs, and food pantries. Connecting with our members has allowed us to empower members and allowed them to make the best choices for their care. They have the knowledge of what services and supports are available to them. They are empowered to make the best decision on how to access care and not delay it. They have access to the resources in the event that their circumstances change and they need support. Moreover, they have the knowledge that their insurance carrier is there to support them at any time.

Health Net

1. COVID-19 Outreach to Communities of Color. April 2020 – August 2020.

The COVID-19 pandemic has caused many disruptions in members being able to access health care. Health Net developed a rapid response with the collaboration effort across the California market including clinical teams, community relations, care coordinators, and health education specialists to perform member outreach to members who were determined to be at high risk. The purpose of COVID-19 Outreach to Communities of Color project was to address access to care issues, provide community based resources, education, and care coordination. Members identified as testing COVID-19 positive were provided education from a clinician on self-care, effective quarantine procedures, and medication adherence, if applicable. Members were provided the opportunity to ask any questions they had and received answers and support.

Data from the CDC helped drive us to a stratification model. Initially, the population was stratified by acuity, age 56 and above, and those with certain health conditions. As the pandemic evolved, and county specific information became available, we found an opportunity to reach out to other populations. For example, there was an increase of COVID-19 cases specifically within the Hmong and Spanish speaking membership so we organized focused outreach. We leveraged certified language talent within our organization to reach out to members and speak in their preferred spoken language. Understanding different cultures and adapting to those cultures was pivotal in effectively sharing information, connecting members to the care, and services needed. We also included California Children's Services eligible members within our stratification. Connecting with the various counties to determine level of support, we were able to understand which counties needed additional support for outreach due to constraints on their resources.

During outreach, the Health Net team identified needs outside of health care. In these cases, associates connected members to our internal member services department, telehealth, and community resources to fill gaps in care. Using Aunt Bertha, we connected members to free and low cost programs available in their area. These programs included food, utility assistance, and housing assistance. Additionally, to quickly support member needs, an internal document with local support programs was created. As new information became available, the resource document was updated. Some of the populations at high risk for COVID-19 were the Hmong and Spanish speaking members. Health Net organized a team to specifically outreach to these vulnerable communities and provide support. The project brought in associates who were certified bilingual to perform the project outreach, thus ensuring that health plan language specific support was available. By associates utilizing their language talent, it allowed us to connect with the member, decrease language barriers, and bring awareness to cultural differences.

The state mandate of social distancing and isolation presented Health Net with the opportunity to leverage a virtual platform. Because of the sudden changes, many members were not

knowledgeable on how to access their telehealth options. Health Net reacted swiftly and were able to successfully help members gain access to telehealth options. During care coordination, our associates found that many other clinics around the state were providing their own forms of telehealth. Utilizing that information, our associates coordinated members' virtual appointments. Through our agile culture and process, we were able to quickly adjust to changes in the community, allowing us to better serve our members. For example, initially we identified a certain population that was at risk for COVID-19. However, this information was changing on an almost daily basis. Health Net was able to pivot and rapidly reach out to new demographics.

The COVID-19 Outreach to Communities of Color project was a collaboration with various departments with the goal of addressing member needs. For example, our clinical teams worked with a member who needed medication support and education. By identifying a gap in care, the team provided education to the member that would positively influence their medication compliance. The member stated they were appreciative of the call and it was nice knowing they were not going through this alone. Based on interactions, we were able to track and trend member's ability to connect to telehealth, transportation, access to food, and housing assistance. Health Net received stories of appreciation, success, and other positive feedback. Members were overall appreciative of their health plan reaching out to them to ensure they still had access to care and other necessities were being met.

The purpose of the COVID-19 Outreach to Communities of Color project was to outreach to the most vulnerable populations and ensure they had access to care and that their needs were met. Due to the pandemic, many members wanted to avoid going into their clinic to avoid exposure. Data collected shows Health Net connected over 4,000 members to the Nurse Advice line, Teladoc, or to the Babylon Health Application. By outreaching to members and having the opportunity to provide education, we identified members that were not familiar nor had used their transportation benefits. We took this opportunity to support and assist the member with gaining transportation services to ensure they were able to access the care and services needed, like picking up medication or getting it delivered at no cost to the member. Overall, 70% of our targeted population had access to food. The team connected families needing food resources to community programs such as food delivery, state programs, and food pantries. Connecting with our members has allowed us to empower members and allowed them to make the best choices for their care. They have the knowledge of what services and supports are available to them. They are empowered to make the best decision on how to access care and not delay it. They have access to the resources in the event that their circumstances change and they need support. Moreover, they have the knowledge that their insurance carrier is there to support them at any time.

2. Cherished Futures for Black Moms & Babies (January 2019 – Ongoing)

Cherished Futures for Black Moms & Babies, a Health Net partnership with the Hospital Association of Southern California and Public Health Alliance of Southern California, is a collaborative effort to reduce infant mortality and improve maternal patient experiences and safety among Black moms and babies in Los Angeles County. Health Net launched Cherished Futures as a collective impact model-based systems approach to addressing African American/Black infant and maternal disparities through partnerships with local hospital leadership, public health officials, health plans, and advocates in select pilot sites to jointly identify and implement interventions collectively. This initiative unites decision-makers from all sectors, including Black birthing people, to co-design systems-change interventions at three levels: clinical, institutional, and community. Interventions developed and implemented included the completion of an organizational equity assessment, engagement of advisory members for each hospital team from the local community representing thought leaders in Black infant and maternal health, implicit bias training for hospital partners and health care providers, data analysis and intervention by race/ethnicity, and convening

of Black women-centered listening sister circles to identify additional interventions for hospital implementation.

We used qualitative data from both external and public county data, and internal data from Health Net's claims and encounter data. Analysis was conducted by race and ethnicity for multiple pregnancy and newborn care measures, including complications during pregnancy, gestational diabetes, preeclampsia, maternal outcomes, postpartum mood disorder, neonatal outcomes, birth injury, pre-term delivery, stillbirth, and cesarean section births. Additional analysis was conducted for each hospital in Health Net's Los Angeles County network on these same measures to stratify hospitals by zip code of residence of the mother. We targeted hospitals with the highest rates of adverse measures for Black infant and maternal outcomes. The goal of the data stratification is to identify the greatest potential impact on adverse birth outcomes and hospital care.

Interventions from inception to implementation have been fully guided by our African American/Black community partners representing the full diversity of Service Planning Areas (SPAs) within Los Angeles County. A lead representative from each African American Infant and Maternal Mortality (AAIMM) community advisory group by targeted SPA actively participated in each Cherished Futures convening and intervention planning to provide the target population-centered voice and real-life stories with Health Net, Hospital Association of Southern California, Public Health Alliance for Southern California, LA County health department, participating hospital partners, and other community and health care stakeholders. In actuality, the real-life stories of Black birthing people and their families have been an intervention in itself that have been further integrated into additional interventions, such as the implicit bias training wherein the stories of their unjust treatment at the hospital and poor birth outcomes have made the most impact with the training participants. Due to the COVID-19 pandemic and gathering safety measures in LA County, the framework for the collaborative timeline was adjusted and moved to virtual platform and engagement.

This health equity intervention utilizes a Collective Impact Model that applies a systems level approach to addressing African American/Black infant and maternal disparities. The collective impact model requires a commitment of key stakeholders from different sectors to a common agenda (Black infant and maternal disparities) for solving a specific social problem. Our group, Cherished Futures for Black Moms and Babies, works towards the same outcome, looks at the same data, aligns strategies, and continuously improves practices over time. Our collective impact intervention continues as we continue to engage our hospital partners for deeper levels of interventions now that they are on board, understand the data, and are committed to our collective goal.

Intervention effectiveness for this collective impact model has been measured primarily with qualitative measures and through assessing the level of engagement by our hospital and community partners. Over eighteen months of intervention involving community engagement, capacity building and hospital engagement, each stakeholder has become more engaged in doing their part in this collective intervention approach.

As a collective impact intervention, progress is a continuous building up of interventions, leading to the ultimate goal of reducing Black infant and maternal disparities. Progress includes the following qualitative outcomes: (1) Secured participation from five hospitals and conducted two organizational equity assessments; (2) Launched learning collaboratives; (3) Due to the COVID-19 pandemic, in-person workshops and training were moved to a virtual platform; hosted the following 90-minute web based workshops: Group Technical Assistance Call; Exploring Root Causes, Best Practices, and the Role of Data Collaborative; Utilizing Data to Establish the Need for Equity-Based QI: Introducing the CMQCC Maternal Data Center Equity Dashboard; Assessing Community Conditions & Group Mapping Activity; Cherished Futures Collaborative Midpoint Workshop:

Creating a Regional Oasis of Care; Hospitals implemented their first Data Intervention Selection and progress made to-date, including health disparities analysis on perinatal indicators; Hosted a Community Advisor pre-launch informational webinar to provide a foundation of the community advisors' role in partnering and amplifying the community perspective; A community advisor scope of work and confidentiality agreement form was developed for each advisor to serve on a hospital team; Implicit bias and cultural humility awareness incorporated in all the virtual workshops.

Inland Empire Health Plan

1. Behavioral Health Integration and Multidisciplinary Medication Assisted Treatment (BHI MMAT) grant-funded pilot program (September 2018 – May 2020)

Inland Empire Health Plan's Practice Transformation Department implemented the Behavioral Health Integration and Multidisciplinary Medication Assisted Treatment (BHI MMAT) grant-funded pilot program to ensure health equity amongst its Members by increasing access to needed services. This program offered grant funding to selected practice sites to assist providers with expanding treatment options for Members with both mild-to-moderate behavioral health needs and Opioid Use Disorder (OUD) in the Inland Empire. The program commenced in September 2018 and concluded in May 2020. BHI MMAT Target Population are IEHP Members with mild to moderate behavioral health diagnoses and/or OUD. BHI MMAT Target Population (Provider sites): Primary Care Providers (PCPs) identified as: submitting high numbers of referrals for behavioral health services; or frequent prescribers of psychotropic medications, or frequent prescribers of opioids defined as greater than 10 paneled patients who were identified as having an average of a morphine milligram equivalent (MME) greater than or equal to 120 for three consecutive months. In addition, the practice sites met the following criteria: (1) the project expanded the number of patients receiving behavioral health services; (2) the project expanded the scope of behavioral health services by offering new and needed services to patients; (3) the project aimed to significantly improve the quality of behavioral health services; and (4) the project aimed to significantly intervene on health inequity within the patient population.

During the pilot planning phase, IEHP analyzed multiple data sources to obtain a clear understanding of the impacts of both the underutilization of the behavioral health benefit, and the lack of OUD treatment options in the Inland Empire. The data sources that informed decisions regarding the BHI MMAT pilot included: (1) Emergency Department utilization data; (2) claims data; (3) geo-mapping data; (4) Member demographic data; and (5) pharmacy data.

National prevalence data indicates approximately 500,000 IEHP Members suffer from behavioral health conditions. Given the significantly fragmented and siloed physical and behavioral health care landscapes in California and the disjointed care transitions between county behavioral health, physical health and community agencies, IEHP has aimed to develop an integrated model within its network. This includes expanding access to behavioral health providers by strategically placing them at more frequently accessed primary care sites, and to increase the number of IEHP Members utilizing the behavioral health benefit based on ease of access alone. Furthermore, OUD and its consequences, including early death, have increased dramatically in the last 20 years. The Urban Institute estimates there are 13,000 IEHP Members with OUD. Historically, only one in ten people with OUD can access treatment; the number is lower for people of color. Access to needed treatment is limited and often delayed, resulting in untreated disease, increased hospital and Emergency Department utilization and poor outcomes, including potential overdose and death. Part of IEHP's strategic response is to ensure a robust network of BHI MMAT Providers who are positioned to treat OUD and its underlying behavioral health conditions timely and effectively. This program provides the foundation and footprint for creating and expanding this benefit within IEHP's service area.

The BHI MMAT pilot furthers IEHP's strategic efforts to implement creative models of care aimed at improving population health overall. The model introduced by the BHI MMAT pilot incorporates the treatment of mild and moderate behavioral health conditions and opioid use disorders in a primary care setting, reducing the need for referrals, decreasing delays in care, and improving patient health outcomes overall. IEHP provided technical assistance related to BHI and MAT for the selected practice sites and facilitated relationship building between local Emergency Department (ED) and the BHI MMAT sites. Members who received MAT medications in the ED were immediately referred to one of the six IEHP BHI MMAT sites for continuing MAT treatment without experiencing barriers to their care or unnecessary waiting periods, which contribute to relapse rates. IEHP developed an incentive for the MAT services provision within the primary care setting by providing participating PCPs an additional fee-for-service payment over and above any capitation received for providing MAT services to both assigned and unassigned Members. IEHP generally uses an authorization-based system for specialty services; however, considering the barriers that OUD patients experience when attempting to access treatment, it was determined that the authorization itself would create confusion and delays for a necessary and life-saving service. Thus, IEHP does not require an authorization for a Member to access MAT Providers.

Program evaluation for BHI MMAT included the following metrics as compared to baseline: (1) The number of IEHP Members receiving MAT; (2) The number of active IEHP X-waivered Providers; (3) The number of active IEHP behavioral health clinicians; and (4) The number of IEHP Members receiving behavioral health services.

It is important to note that the COVID-19 pandemic struck as these sites neared their goals. While the data is still trending in the positive, it has likely been impacted by the changing landscape of the provider-patient interactions and protocols due to COVID-19. BHI MMAT Data Results: the total number of unique Members who obtained MMAT services was 168, just shy of the 180 goal; a total of 17 additional X-waivered Providers were added to the IEHP network, far exceeding the pilot goal of six; each pilot site increased the number of behavioral health clinicians by at least one full-time Provider, for a total of six additional behavioral health clinicians; five hundred and thirty-eight unique Members received behavioral health services for the first time.

2. The Doula Access Pilot Program (January 1, 2020 – Ongoing)

The Doula Access Pilot Program, supported by Inland Empire Health Plan (IEHP) and administered by the Riverside Community Health Foundation (RCHF), began on January 1, 2020, and will continue until December 31, 2021. During this time, up to four hundred eligible enrolled IEHP Members will receive doula services for the entirety of their pregnancy, including three prenatal visits, labor and birth support, and three postpartum visits. IEHP designed and implemented the Doula Access Pilot Program to address disparities in birth outcomes and perinatal care usage. Studies suggest that doula birth supports can help decrease cesarean birth rates, improve patient experience, improve rates of nursing, and optimize the use of outpatient perinatal care. Even more importantly, these studies demonstrate improvements specifically in those populations disproportionately affected by birth complications: birthing persons identifying as Black or Hispanic, those with lower income, and those with limited English proficiency.

Despite high health care expenditures, the United States trails all industrialized nations when it comes to quality maternal health, including higher than average pregnancy complications and adverse birth outcomes. This poor performance is mainly driven by health disparities or systemic differences in health complications and outcomes based on social factors. IEHP is the payer for approximately half of all births in Riverside and San Bernardino counties. Stratified analyses of health plan claims/encounter data and quality metrics were performed to guide project development. These analyses demonstrate the pregnancies and birth outcomes of IEHP Members are characterized by clearly marked disparities: older women, Black women, and women living in

remote geographic regions have higher rates of complications during pregnancy and at birth. With respect to sociodemographic characteristics, IEHP's maternal health disparities are consistent with statewide and national data trends. Validating the presence of disparities among IEHP Members built a strong case for creation and implementation of the Doula Access Pilot Program.

The Doula Access Pilot Program was developed with community partnerships in mind. The Inland Empire is served largely by independent doulas as this region lacks the birth worker "infrastructure" seen on the coast. Thus, project development launched in 2019 with a "listening session" hosted by IEHP to welcome all regional doulas interested in providing care to Medi-Cal-insured birthing persons. The doulas, presented with data on the perinatal and birth disparities experienced by IEHP Members, worked collaboratively with health plan leadership to design the intervention, including details for doula coverage in remote regions and reimbursement rates. IEHP was fortunate to learn that RCHF leadership had extensive knowledge of doula services; RCHF became the program's administrator. Because IEHP and RCHF wanted the Doula Access Pilot Program to be responsive to the needs of the Inland Empire birthing community, key community partners collaborated to inform the program's structure and content. These partners include county public health (Black Infant Health programs), perinatal behavioral health providers, and local experts in antiracism. IEHP and RCHF also partnered with network birthing facilities for provider education regarding doula care. The voluntary community-partnership approach has driven the success of the Doula Access Pilot Program to date and will help ensure its sustainability going forward.

Early research findings suggest that some etiologies of maternal health disparities may be modifiable via interventions within health care delivery systems. The literature has described several classes of interventions thought to decrease disparities in birth outcomes. Doula care may be one such intervention. Doulas are trained birth support professionals who offer emotional, informational, and psycho-social support during pregnancy, childbirth, and the postpartum period. While doula services have been available to pregnant women for some time, it is only recently that these services have been evaluated for their effects on birth outcomes in disadvantaged populations. Doula services are underutilized by low-income women and women of color. Observational studies of doula support in the pregnancies of low-income women have resulted in decreases in preterm birth, low birth weight, and cesarean birth. A randomized trial of doula support in labor for nulliparous women resulted in significantly decreased rates of cesarean birth and epidural use. Doula services have been associated with additional health benefits, including breastfeeding initiation and delayed introduction of solid food. Despite this evidence, doula services are not typically health plan benefits. This innovative pilot sought to demonstrate the feasibility and impact of Medi-Cal coverage for doula care.

Once completed, the Doula Access Pilot Program will be evaluated based on performance metrics in the following areas of interest: infant gestational age at birth, mode of birth, use of pain medications during labor, postpartum visit completion, postpartum mood, lactation initiation/continuation, and Member satisfaction with doula care. The evaluation plan was developed collaboratively between IEHP and RCHF. The health plan will provide administrative and cost data to support the evaluation; in contrast, RCHF will leverage its relationship with participants and doulas to gather survey and qualitative data to understand program impact.

The Doula Access Pilot Program launched in January 2020 and 72 births have been supported by the program to date. A 12-month evaluation will be initiated in the first quarter of 2021 to allow for the lag in claims and follow-up participant survey data required for analysis.

Kern Family Health Care

Baby Steps Program (October 2018 – Ongoing)

All pregnant & postpartum members were targeted with the exception of members assigned to Kaiser. Emphasis on targeted subgroups was also identified and consisted of members who identified as Black or African American, members residing in the 93305 and 93308 zip codes, teen pregnancies, and deliveries via Cesarean section. Outreach efforts and partnerships in the community were expanded in an attempt to reach the targeted groups. Information on pregnancy benefits, services and resources were shared with local pregnancy centers, hair and nail salons, parks and recreation centers, local colleges, and retail stores with emphasis on the targeted zip codes. The HealthyWe pilot was founded with the local Public Health Nursing (PHN) department to perform outreach and education to all members identified by Kern Family Health Care (KFHC) as being Black or African American or residing in the targeted zip codes to encourage timely access to care and assist with appointment scheduling, transportation and other social service resources. A file of members is shared monthly with the PHNs along with monthly meetings to provide updates and share challenges. Member and provider surveys gained further insight on the challenges to accessing care and identified a baseline on member behavior patterns and thoughts on accessing care. Member report cards were created to provide customized information on each member's gaps in care, benefits, and resources. Plan-wide reporting for early identification and prenatal care activity was also streamlined.

Reporting Year (RY) 2018 Healthcare Effectiveness Data and Information Set (HEDIS) and RY 2020 Managed Care Accountability Set (MCAS) data was used to determine percentage point differences between intervention years. Demographic data for RY 2018 identified the 93305 and 93308 zip codes and Black and African American members as the focus for encouraging routine prenatal and postpartum care. Claims data was used to identify plan-wide compliance and non-compliance with prenatal care, interrupted prenatal care, Neonatal Intensive Care Unit (NICU) admissions and premature deliveries. Claims data, fax notifications of KFHC members with positive pregnancy tests from the local colleges and public health department, member self-reported data, Fiscal Intermediary Access to Medi-Cal Eligibility file and lab data were used to develop the pregnancy registry report that is shared with KFHC departmental stakeholders each month as an internal means of early identification of pregnant members. Data from pregnancy surveys was also used to obtain information on member's satisfaction with their care, awareness of member rewards and benefits, and communication preferences. State data findings such as the California Health Care Foundation's Listening to Mothers in California report was also used.

Given that KFHC's RY 2018 HEDIS data identified higher non-compliance with the prenatal and postpartum care measures among Black and African American members and members residing in the 93305 and 93308 zip codes, we focused our outreach efforts among stores and services in these areas. We partnered with our local Black Infant Health Program and PHNs to help extend our direct outreach to these groups to provide education on the importance of accessing care and offered assistance with scheduling appointments. The age group (18-35 years) helped us determine which sites to target which led us to connect with the Planned Parenthood, Bakersfield Pregnancy Center, student health centers at the local colleges, hair and nail salons, and retail stores in the targeted zip codes. Expanding our efforts to target parks and family resource centers and perform telephone outreach with an emphasis on promoting our pregnancy member rewards and benefits was due to survey data we received from members where we learned that most of these members were unaware of our pregnancy rewards and benefits, the majority already had at least one other child and did not currently work or attend school.

KFHC's innovative approach was to connect with community partners that we had not engaged with in the past for pregnancy outreach. The hair and nail salons and retail stores that we approached in the targeted zip codes allowed us to leave copies of our educational brochures and member reward postcards for customers to read and take with them. We anticipated that the age

group that we were targeting could be college age students which led us to partner with the local college student health centers where we would receive fax notifications of positive pregnancy tests for KFHC members and were allowed to leave copies of our educational material and member rewards postcards for students to read and take. Strengthening our partnership with the public health department (PHD) allowed us to display a rolling digital message in their lobby promoting pregnancy care and we were able to establish a process where the PHD would send us weekly fax notifications of KFHC members who tested positive so that we could outreach and assist with coordinating services. The local pregnancy centers agreed to provide copies of our educational brochures and postcards to KFHC members who came in for services as well.

Monthly trending reports on compliance with prenatal care, NICU admissions, and premature deliveries were developed along with a final rate for each year that encompassed claims lag. KFHC compared 2019 monthly and annual rates for each of these aforementioned metrics with the 2018 monthly and annual rates to determine whether the outreach interventions had any impact on improving routine prenatal care each month and overall for the year. HEDIS and MCAS data was used to evaluate the effectiveness of targeting outreach efforts in the 93305, 93308 zip codes and among Black and African American members through KFHC's partnership with the PHN HealthyWe pilot and regular contacts with hair and nail salons, retail stores, parks and pregnancy centers and college campuses.

Although KFHC did not see a decrease in its premature delivery and NICU admission rates between 2018 and 2019, a significant improvement was demonstrated in member compliance with routine prenatal care visits. In 2019, there was a zero point seven percentage point decrease in members identified as non-compliant with routine prenatal care, a two point nineteen percentage point decrease in interrupted care and a two point eight six percentage point increase in members completing 13 or more scheduled visits. KFHC's July 2020 trending rate for compliance with routine prenatal care increased to 27.44 percent from 18.48 percent in July 2018 and the rate of premature deliveries decreased from eight point seventy nine percent (July 2018) to six point forty four percent (July 2020). MY 2019 MCAS rates also demonstrated a two point ninety one percentage point increase in prenatal care visits (PPC-Pre) and a 13.58 percentage point increase in postpartum care visits (PPC-Post) in comparison to MY 2018. PPC-Post also exceeded the high performance level (HPL) during MY 2019 by six point sixty six percentage points when compared to missing the HPL by six point thirty three percentage points in MY 2018. Comparison of RY 2018 and RY 2020 rates for PPC-Pre by zip code revealed a 14.45 percentage point decrease in non-compliant members residing in the 93305 zip code, a 12.14 percentage point decrease in the 93308 zip code and a 12.21 percentage point decrease in Black and African American members. For PPC-Post, a 13.90 percentage point decrease in non-compliant members was found in the 93305 zip code, an 11.06 percentage point decrease in the 93308 zip code and an 18.31 percentage point decrease in Black and African American members.

Los Angeles Care Health Plan

COVID-19 Disparities Response Project (April 2020)

L.A. Care Health Plan launched its ongoing "COVID-19 Disparities Response Project" ("Project") in April 2020. The Project is a multi-pronged, strategic response to the COVID-19 pandemic that is disproportionately impacting Black, Indigenous and People of Color (BIPOC) communities. Specifically, L.A. Care focused its efforts on the African American/Black (AAB), Hispanic/Latinx, American Indian/Alaska Native (AIAN) and Native Hawaiian/Pacific Islander (NHPI) populations. Increased testing access and improved data accuracy shows that COVID-19 data trends mirror other health disparities, with BIPOC communities showing the highest rates of morbidity and mortality. L.A. Care proactively launched a response to help ameliorate and address COVID-19

disparities. L.A. Care's Project includes: (1) telephone outreach to the high- and low-risk member populations most impacted; (2) geo-targeted social media campaign posts and radio public service announcements (PSAs); (3) a COVID-19 Disparities Leadership Summit series to discuss with community partners the disproportionately high rates and current and future actions to curb negative outcomes; and (4) grants to community agencies assisting with food and housing resources, and a one million dollar Equity and Resilience initiative which supports organizations led by and serving BIPOC communities to mitigate health and social inequities.

L.A. Care used external and internal data to inform its approach. Los Angeles County Department of Public Health (DPH) data and COVID-19 geographic heat maps created from DPH data by the Advancement Project were used. As of August 11, 2020, DPH identified 211,808 COVID-19 positive cases and 5,507 deaths. BIPOCs lead in the number of cases and deaths. Of COVID-19 deaths, Hispanic/Latinx individuals make up 49 percent, AAB make up 10 percent and less than one percent are NHPI individuals. Although AIAN percentages are low, they are a historically marginalized population with rampant health disparities. Initial data showed the AAB population with the highest rate of COVID-19 deaths in comparison to its county population. However, recent data is now showing increased mortality rates among the Hispanic/Latinx population. Internal administrative data was used to identify cases and deaths among L.A. Care members, broken down by race, ethnicity, gender, age and other demographics. L.A. Care data mirrors county data trends; specifically, that AAB and Hispanic/Latinx COVID-19 deaths are at a younger age distribution than White and Asian member populations. Member zip code data was used for the high-risk, targeted member populations. Member feedback from internal outreach call campaigns informed the Project's efforts on their urgent needs for housing and food assistance.

L.A. Care worked closely with DPH and The California Endowment (TCE) to identify topics to emphasize in the Project's tailored COVID-19 messaging. Population specific topics included: testing locations, cost concerns for COVID-19 testing and procedures, food security resources and mental health stigma. For example, California's statewide stay-at-home orders resulted in burgeoning mental health issues due to increased isolation and anxiety. Mental health needs continue to be stigmatized in many of these targeted communities. L.A. Care's outreach call script asked if members wanted social isolation resources. Members who said "yes" were provided with resources and referred to L.A. Care's Social Service Department for follow-up. The Project's social media campaign also includes mental health resources. L.A. Care also used population specific messaging from DPH for the radio PSAs. Radio ads were curated for the BIPOC community, informing Angelenos that although the virus does not discriminate, data showed BIPOC communities are the most impacted. The radio ads were recorded by DJs from the community, relaying the urgency of the message, and were played on Los Angeles's number 1 urban radio station and the number 2 radio station in the all-listeners market. Feedback from members and local partners revealed BIPOC residents in particular were struggling financially, urgently needing assistance. This informed L.A. Care's COVID-19 grant dollars provided to housing, food and BIPOC non-profit agencies.

L.A. Care used a multi-pronged approach to address the needs of the Project's target populations. L.A. Care's Customer Solution Center (CSC) and Community Resource Center staff made live phone calls to our most impacted, high-volume member populations, specifically AAB and Hispanic/Latinx populations. Pre-recorded phone calls with the opportunity to connect to a live CSC agent were used to reach the smaller NHPI and AIAN populations. The calls allowed staff to educate members on COVID-19, and address social isolation, social needs or other concerns. In an era where everything is impersonal and automated, live calls demonstrated a level of personalized attention to members to which they are not accustomed. A paid social media campaign targeting the most impacted L.A. zip codes was also deployed. Social media posts

reinforced CSC phone call messaging, ensuring the highest risk communities had COVID-19 safety information and related health and social resources. L.A. Care was also proactive in engaging its health care partners, community-based organizations (CBOs) and philanthropic partners to discuss the disparities ravaging BIPOC communities. L.A. Care partnered with TCE and DPH to host a virtual COVID-19 Disparities Leadership Summit to discuss how to mitigate and control COVID-19 spread in disproportionality impacted populations. The Project's grants were targeted to address the community's most pressing social needs and were deployed immediately. Grants allow for flexibility during emergencies.

The effectiveness of the Project's live outreach calls was evaluated by the number of live connects and the responses received from a post-call member survey. The Project's social media campaign effectiveness will be evaluated using analytics available through Facebook and Instagram platforms. Facebook and Instagram metrics include post reach, impressions, views and engagements; engagements include post likes, comments, shares, and clicks, which are indicators of more meaningful message penetration. Should the social media analytics show high engagement, L.A. Care will conduct further internal analysis, like reviewing increases in member utilization of mail-in pharmacy benefits, a service highlighted in the campaign. A post-summit survey to collect qualitative and quantitative data on attendees' opinions was used to evaluate the effectiveness of the Project's COVID-19 Disparities Leadership Summit. The survey consisted of Likert scale ratings and open-ended feedback questions. In the survey, summit attendees were asked to rate the summit, indicate the most valuable information learned, describe ideas for next steps and provide additional feedback. Survey responses indicated that participants found the summit to be informative, valuable, and necessary. L.A. Care's Equity and Resilience grantees have measurable objectives in their Scopes of Work and will report on their progress every six months.

The Project's phone call outreach was a success. L.A. Care live connected with 11,000 AAB members, representing a 36 percent completion rate. Of those AAB members who completed the survey, 84 percent stated the information provided was useful. For Hispanic/Latinx members, 59,000 calls were live connected representing a 78 percent completion rate, and 99 percent of members that took the survey stated the information was useful. Of member calls requesting further help, food assistance was the greatest need with 91 percent of AAB and 95 percent of Hispanic/Latinx members requesting information. Many members conveyed that they "felt L.A. Care really cared about them." Data for the Project's social media campaign is not yet available. The COVID-19 Disparities Leadership Summit was also a success, allowing for an important conversation about a global pandemic that has disproportionately ravaged communities of color. Fifty-four unique organizations and 180 individuals attended the Summit. The Summit was rated as Excellent or Very Good by 87 percent of respondents. Respondents stated the most valuable aspects of the event were the data presented and the sense of collaboration among the organizations. Respondents asked for another summit, and other health plans expressed interest in collaborating with L.A. Care on future summits. Food and housing security are ongoing issues. Targeted financial assistance to community partners to protect under resourced communities has continued with a recent \$750 thousand dollar grant to help fight evictions.

Partnership Health Plan

Reducing Disparities in Members Recently Released from Incarceration (2016 – Ongoing)

The target population for this project were beneficiaries released from a California correctional facility with a chronic health condition or older than 50 years of age. Partnership Health Plan's intervention focused on providing start-up funding for PCPs to each start a Transitions Clinic.

California counties and the California Department of Corrections do not currently share names of those released from jails or prisons with MCPs. Therefore the MCPs are not able to use their own data to identify this population as one with health care disparities. Instead, we rely on published studies, which indicate that the population of those recently released have high rates of death, exacerbation of illness, use of emergency rooms instead of primary care, and hospitalizations (see below for several references). In key informant interviews with our primary care network as part of broader initiatives to address social determinants of health and opioid overuse, the post-incarceration population was identified as one in need of specialized intervention, because of delays in getting established with primary care, high rates of post release mortality, and the need for specialized case management support. According to the Prison Policy Initiative, 28.5 percent of the California prison population is Black and 41 percent are Latinx, both higher than expected for their proportion of the state population³.

Our MCP collaborated with a program started at the University of California San Francisco (UCSF) to implement the model at three of our Federally Qualified Health Center (FQHC) primary care providers. The Transitions Clinic program originated at UCSF to facilitate transitions of care for individuals released from incarceration. The model has spread throughout the country into the Transitions Clinic Network (TCN). TCN provides primary care to anyone released from a correctional facility with a chronic health condition or who is older than 50 years of age. The Transitions Clinic model is likely to eventually be covered under the Department of Health Care Services proposed California Advancing and Innovating Medi-Cal (CalAIM) Enhanced Care Management (ECM) program. Over the past several years, our MCP provided start-up funding for the establishment of Transitions Clinics in three FQHCs in the PHC region, located in cities with a higher density of post-release members.

Although many individuals released from jail or prison have Medi-Cal on the day of release, there are delays in assignment to MCPs and then assignment to a PCP. Prisoners are given only 30 days of medication upon release, and the early release time is associated with the highest risk of adverse outcomes, so a system is needed to connect released prisoners with PCPs immediately upon release, before the MCP is financially responsible for their care, and before they are assigned to a PCP. The TCN facilitates video communication between prisoners before release and their future primary care providers, ensures a first primary care visit is set up, and establishes interdisciplinary teams to care after release. A central important part of these care teams are community health workers (CHWs) with personal histories of incarceration. CHWs interact with patients in and out of the clinic to address re-entry-related social determinants of health, such as housing, food access or employment, and link patients with community agencies. They use their personal experience of incarceration to educate the healthcare team about patients' challenges, facilitate patient-provider communication, and help patients navigate and build trust in the medical system. Behavioral health needs are assessed at each visit and appropriate referrals to substance abuse and mental health treatment are made. CHWs advocate on patients' behalf in interactions with the criminal justice system when appropriate.

The MCP asked each Transitions Clinic that was awarded start-up funding to submit a narrative of their experience and outcomes at the end of the year. Metrics reported included the number of

³ Reentry Health Policy Project: Meeting the Serious Health and Behavioral Needs of Prison and Jail Inmates Returning to the Community." California Health Policy Strategies report to CHCF: June 2018. "Mortality after prison release: opioid overdose and other causes of death, risk factors, and time trends from 1999 to 2009." Annals of Internal Medicine. (2013).

enrollees, time between release to appointment with PCP and the CHW, retention rate, and achieving goals on chronic disease and preventive measures. A narrative summary of non-numerical challenges and successes as well as lessons learned was also submitted by each TCN program funded by the MCP. In terms of financial and utilization outcomes, the MCP lacks a control group to make meaningful conclusions. TCN is working with the California Department of Corrections for release information of other prisoners not in the program who are MCP members, so a control group can be created for analysis against TCN enrolled members. TCN programs around the country are created and monitored for relatively high fidelity to their model of care, so outcomes outside California may be reasonably extrapolated to the TCN programs sponsored by the MCP.

More than 290 individuals have been served. Among participants, 75 percent had an appointment within four business days of leaving the jail, either with their new PCP, with the CHW or both. Retention rate in three months was 70 percent, all were screened for social and economic needs and referred to community resources as appropriate. As noted above, we rely on outside studies to show that high-fidelity TCN programs reduce societal and health care costs. A peer-reviewed open access article published in the British Medical Journal in March 2019 titled, "Propensity-matched study of enhanced primary care on contact with the criminal justice system among individuals recently released from prison to New Haven," showed a decrease in re-incarceration (Odds Ratio of point thirty eight; 95 percent Confidence Interval point sixteen to point ninety three), and another published in the American Journal of Public Health in 2012 titled "Engaging Individuals Recently Released from Prison into Primary Care: A Randomized Trial," found a 35 percent decrease in ED utilization compared to controls (P=.04).

Rady Children's Healthcare

Health Equity and Continuity of Care During COVID-19 Crisis (March 2019 – Ongoing)

California Kids Care (CKC) is a provider-based Population Specific Plan (PSP) pilot that since 2018 has provided patient-centered, comprehensive, coordinated care to children with the following California Children Services' eligible conditions: Acute Lymphoid Leukemia, Cystic Fibrosis, Diabetes, Hemophilia and Sickle Cell Disease. The program serves a high percentage of Hispanic and Latino (53.3 percent) and African American (16.1 percent) members. CKC members face serious challenges including health status, socioeconomic level and access. Given the complex nature of these conditions and the health disparities seen in Medi-Cal members, CKC offers innovative care navigation so that providers can better assess, monitor, and meet member needs to close care gaps. The goal of the interventions is to avoid adverse impact on this vulnerable population with increased support to ensure continuity of disease management. During COVID-19, this focused work was more important than ever. Our team rapidly convened to establish a plan to proactively prevent adverse outcomes. A brief description of interventions follows: (1) Care coordination and outreach (2) Emergency 90-day supply of pharmaceuticals (3) Emergency preparedness education (4) COVID-19 education, disease specific and general education (5) Assess and track new stressors (6) Family empowerment (7) Vaccine and well child exam reminders.

Demographic data was pulled from our Population Needs Assessment (PNA), a compilation of data from two surveys (Consumer Assessment of Healthcare Providers and Systems (CAHPS) and a Member Survey). The PNA is a comprehensive report that is intended to provide a meaningful understanding of the needs of CKC members, identify gaps between which needs are being met and not being met, and serve as a foundation for setting priorities. CKC members are tracked through our Electronic Medical Record (EMR) system, Epic, to identify trends and monitor progress towards goals such as outreach efforts. Data regarding appointment completion rate was sourced

from our EMR system for CKC members and comparison groups. Additionally, quarterly CKC Family Advisory Council (FAC) meetings are held in which participating families share their valuable insights related to program initiatives. Since the pandemic stay-at-home orders were put into place in March, two virtual FAC meetings have been completed. Family feedback regarding support services, such as vaccine and well child birthday reminders, new stressors, and accessing services, have been key topics addressed since March 2020 that have contributed to determining and reducing health disparities for the larger CKC member population.

To meet the unique needs of our population and customize interventions, the CKC team has continued to meet with its FAC. These meetings have been particularly helpful during the COVID-19 crisis and have offered valuable insights into our approach and services. An example of customized feedback received from the FAC is the newly identified preference for mailed reminders as families are now inundated with emails from schools and organizations. As COVID-19 continues, the CKC team had additional concerns regarding access. Many providers, Mental and Behavioral Health Services, Medi-Cal offices and schools have implemented online and telehealth services not accessible to members without computers or with limited technology skills. The entire CKC population is at higher risk of access issues during the pandemic as a result of pre-existing social determinants that are now exacerbated, in addition to complex disease management challenges. As one of our overarching goals is to help the Medi-Cal population with complex diseases complicated by social determinants, we targeted all members to receive additional interventions and services during the crisis. Our existing partnerships with the specialists, pharmacists and primary care providers that serve our members have strengthened our efforts. Through direct lines of communication with providers caring for our members, including regularly scheduled meetings, we have been able to immediately and better respond to member needs.

Interventions put in place to immediately support and help families through COVID-19: (1) Member and family care coordination outreach for receiving regular medical care and how to navigate new modes of care (e.g. telehealth, urgent care) and potential barriers, information for the Rady Children's Health San Diego (RCHSD) dedicated COVID-19 nurse line. Assess transition/transfer to adult services on a case by case basis and ensure continuity of insurance coverage after 21st birthday. (2) Ensure access to an emergency supply of pharmaceuticals and supplies. In collaboration with MedImpact, provided up to a 90 day supply of all prescription drugs. Coordinate with Homecare companies for supply delivery. (3) Continue to link CKC website to the RCHSD COVID-19 website which contains RCHSD hospital and specialty clinic COVID-19 services, procedures to access care, patient education and family-friendly resources. (4) Continue to provide resources to members and families as they become available. Includes updated emergency check lists specific to chronic medical conditions, as well as health and wellbeing resources. (5) Assess and track new stressors (i.e. loss of employment, food insecurity, financial); refer to 211 or social work as appropriate. (6) Family engagement and empowerment through our FAC to identify effective interventions and better support members. (7) Vaccine and Well Child Exam birthday postcard reminders, and call campaigns to encourage medical home connection and compliance with vaccine schedules.

Various interventions have been deployed to provide members with necessary support. Care coordination outreach is done by the member's assigned Registered Nurse Care Navigator and Patient Care Coordinator and completeness captured in our EMR system. Access to an emergency supply of pharmaceuticals was applied to all and the 90-day supply re-examined and extended as the pandemic continues. The CKC doctor of pharmacy (PharmD) regularly monitors member medication possession ratio to measure medication adherence and shares information with the care team to identify trends and member needs. Ensuring educational content is up-to-date and readily available to members is ongoing and evaluated by our Quality and Education Director and

Coordinator. The FAC reviews and provides feedback on educational content and modes of delivery. To ensure continued family engagement and empowerment we have successfully managed to maintain FAC meetings in a virtual capacity. Our shared EMR system, Epic, allows the CKC care team to assess, track and review new stressors to be further evaluated by the team. Lastly, regular review of an existing appointment completion rate report allows for real time monitoring of CKC members compared to other payer populations at Rady Children's Hospital. This report, as well as existing reports to track ED and hospitalization rates, has allowed us to evaluate the impact of the interventions and proved that extensive outreach is reducing disparities during a time when they are widening for many.

A reduction in health disparities for our Medi-Cal population of children with complex conditions was demonstrated through increased Completed Visit rate for CKC members compared to RCHSD Medi-Cal and California Children's Services (CCS) patients. The data demonstrates the impact of customized interventions and outreach on continuity of care for a population that faces many additional challenges on a daily basis. When the stay-at-home orders were put into place in March 2020, CKC immediately contacted members to offer the aforementioned interventions to ensure access was intact. While the No-Show and Same Day Cancellation rate for specialty clinic visits spiked for all payer populations in our organization, CKC members experienced a five percent lower no-show and same day cancellation rate compared to the general Medi-Cal and CCS population. This is directly attributed to the immediate and routine check-ins by our highly skilled Care Navigation team. COVID-19 outreach efforts and interventions are ongoing as the crisis continues and we have immediately seen the impact of our efforts. For fiscal year 2020 year end (July 2019 – June 2020), specialty appointment completion rate for CKC was 83 percent compared to a 76 percent completion rate for the general RCHSD Medi-Cal population, 78 percent for CCS, and 88 percent for the commercial population. Efforts to close gaps and maintain continuity will continue throughout the crisis as continuity of care is critical in promoting better health outcomes and satisfaction.

San Francisco Health Plan

Promote utilization of 12-month supply of hormonal contraceptives (December 1, 2019 - Ongoing)

According to the CDC, unintended pregnancy and abortion rates are declining over the past few years but reproductive health disparities continue to exist. Women of color with lower socioeconomic status continue to have the highest rates of unintended pregnancies. San Francisco Health Plan (SFHP) covers a wide range of contraceptives and up to a 12-month supply. Research demonstrated that dispensing 12 months at one time versus one or three months at a time improves reproductive outcomes. This project aimed to increase use and promote awareness of the 12-month supply benefit targeting females ages 15 to 44 years old. Interventions included: (1) implementation of a pharmacy incentive payment strategy focused on correcting financial disincentives and (2) a comprehensive educational campaign focused on benefit awareness. The pharmacy incentive payment strategy was implemented on December 19, 2019. An incentive fee was applied for contraceptive claims with a 12-month supply in addition to dispensing fee and drug cost. SFHP designed a women's health poster that highlighted the 12-month supply benefit and other women's health recommendations as part of the educational campaign. The poster was translated to Chinese, Vietnamese, and Spanish, and over 600 posters and flyers were distributed to pharmacies, medical offices, clinics, youth centers, and Planned Parenthood throughout San Francisco.

Quantitative data from internal sources was utilized in preliminary and primary outcome analysis. SFHP pharmacy claims from 2018 indicated that less than one percent of contraceptive

users received a 12-month supply of self-administered hormonal contraceptives and that the 12-month supply benefit was being underutilized. Pharmacy claims data was utilized throughout the project to determine the rate of 12-month supply dispensing pre- and post-implementation of the interventions. Qualitative data will be analyzed for the secondary outcome analysis after the program has been implemented for one year, which will evaluate ethnicity and age of members that received a 12-month supply.

SFHP collaborated with San Francisco Department of Public Health (SFDPH) physicians and focus groups who provided feedback on the women's health poster to ensure we had the most up-to-date and relevant clinical information. Health screening recommendations presented on the poster were referenced from the U.S. Preventative Service Task Force (USPSTF) and the Advisory Committee on Immunization Practice (ACIP). Additionally, SFHP worked with the Lesbian, Gay, Bisexual, Transgender, and Queer or Questioning (LGBTQ) community and SFHP's transgender workgroup and incorporated feedback to make the poster more inclusive to people of marginalized genders. The poster was revised to include updated images and inclusive language, which was crucial for the overall success of the poster because of the large proportion of San Francisco residents that identify as LGBTQ.

SFHP used an innovative approach by teaming up with Walgreens corporate in San Francisco to develop additional member materials. Walgreens and other chain pharmacies were not authorized to display or distribute third party materials. This presented a barrier for the project because approximately 80 percent of contraceptives were filled at chain pharmacies. Although Walgreens was unable to display the poster, they supported the cause and developed a Walgreens-branded health resource panel (HRP) that mirrored the same message as the poster. The HRP listed SFHP's customer service phone number and was coded to print at Walgreens pharmacies specifically for SFHP female members age 15 to 44 years old who filled prescriptions at Walgreens. Furthermore, the educational campaign was incorporated in the agenda at the Joint Association Meetings (JAM) with SFHP's largest medical groups. Physicians and administrators at the JAM were able to request copies of the women's health poster for distribution to their affiliated clinics and medical offices. They were also encouraged to educate and promote use of the 12-month supply contraceptive option to eligible patients, which would benefit their patients from less frequent visits to the pharmacy during the COVID-19 shelter-in-place order.

The effectiveness of the interventions was evaluated by analyzing pharmacy utilization reports on a monthly basis. The primary endpoint was to evaluate the rate of 12-month supply of hormonal contraceptives dispensed at one time. After implementation of the interventions, pharmacy claims were analyzed each month to measure the number of members that received a 12-month supply. The monthly rate post-implementation was compared to the baseline rate and displayed on a graph to capture an overall trend.

In the first eight months post-implementation, the rate of 12-month supply dispensing increased compared to baseline. Baseline rate had an average of three point three prescriptions per month. From December 1, 2019 to July 31, 2020, there were 39 prescription claims with a 12-month supply, which averages to four point nine prescriptions per month. This is an ongoing initiative and utilization data will continue to be analyzed up to 12 months post-implementation. A long-term anticipated outcome will be a reduction in unintended pregnancies and abortions by reducing access barriers and improving medication adherence.

SCAN Health Plan

1. Housing and Homelessness Care Management Initiative (July 2019 – Ongoing)

The target population focused on SCAN members living in Los Angeles county who are experiencing or at risk of homelessness. Our intervention focused on sustainable case management provided by a Social Worker and a Community Health Worker to provide in-person, personalized support in navigating the housing and healthcare systems. The goal of the program is to help members create long term, sustainable solutions to meet their living and health care needs by collaborating with all stakeholders who play a role in maintaining the well-being of the individual. Interventions include in person visits to assess their current health status and health risks and other social determinants of health, in person triage with community based partners and organizations (including housing organizations, legal assistance providers, landlords, local housing authority, court hearings, etc.), accompaniment to primary care physician or specialist visits, and support in addressing other social and health needs that stem from homelessness or housing insecurity. This is a long-term case management program, in order to accommodate the length of time it takes to become housing secure and manage a population with very difficult and complex needs.

SCAN Data and Community Partners were leveraged for this project. SCAN data was used to identify members at risk of or experiencing homelessness: (a) Health Risk Assessment (HRA) – SCAN’s goal is to assess the entire SCAN membership as a global initiative. Two housing security questions from the HRA were leveraged for this project: “Are you experiencing homelessness?” and “Are you worried about losing your housing?” (b) Diagnosis Codes – sourced from members’ encounter and claim data that contain the diagnosis code for homelessness or inadequate housing. (c) Internally developed triggers that assume homelessness or housing insecure status. This was determined if members’ address matches a shelter address and/or member has changed address more than once in a half year period. (d) Identification of at risk or homeless members by provider groups and community based partners. Community Partners participated in a SCAN Community Based Organization Advisory Committee on the topic of Housing and Homelessness in July 2019, whereby nine representatives from six organizations working in the homelessness space from across Southern California came to SCAN’s headquarters to provide insights into their experiences working with seniors and give feedback/suggestions on SCAN’s Housing and Homelessness program. Through this Advisory Committee, many changes were made to the program design, and a formal referral process was developed to coordinate efforts with SCAN’s community partners.

Community partners were heavily involved in the planning and program design process. Prior to the Housing and Homeless Advisory Committee, in person visits were made to over 20 organizations working in the homelessness space. The goal was to understand existing services, programs, and resources in Los Angeles, Orange, and Riverside Counties, and the needs of the senior clients who they serve. In doing so, SCAN was able to establish 13 core partners, and gain clarity on what gaps in services SCAN could fulfill. Through the initial outreach and the Advisory Committee meeting, the following feedback was received and incorporated: (1) Program and interventions design should focus on navigating the existing coordinated entry system and processes that exist with the housing authority; and SCAN should create a program that integrates itself into the existing system; (2) The interventions should also prioritize member wishes—whether the member wishes to remain housed, obtain housing, or remain homeless—and assist members in improving their health, well-being, and access to essential services/goods regardless of their housing preferences; (3) The team should work with community partners to best leverage resources and coordinate on overlapping cases; and (4) The program should include development of a referral network that consists of internal member-facing staff, provider groups and community partners, in order to identify members in need of SCAN’s assistance.

SCAN’s approach to addressing homelessness is to teach members the skills necessary to be self-sufficient, in order to create a sustainable living solution as well as managing their health and health risks. Our strategy is focused on two concepts: (1) Personalized support –the Housing and

Homeless team meets with members in person to understand their backgrounds, lifestyles, health and health risks, and goals—meetings can last up to seven hours. The goal of an initial meeting is to ensure that SCAN truly understands the member's situation and earn the member's trust. The team meets members where they are, anywhere from personal boats to local McDonalds. (2) Long-term orientation—the team walks members through evictions, attending court hearings, housing applications, coordination with housing authorities and more, acting as an advocate and literally standing next to the member through every step. Handholding is used to teach members how to navigate the housing process themselves and give them confidence in self-advocacy. If a member is successfully housed, connected to their healthcare, and/or equipped with other social supports, members are taught how to maintain their newly established resources. The team has become expert in the low-income housing process. SCAN's approach not only promotes sustainability in the lives of our members, but also in SCAN's ability to provide long-term support to those who need it.

Intervention effectiveness was evaluated by: (1) Number of members housed in permanent or temporary housing; (2) Number of members who became homeless after SCAN assisted member in obtaining housing; (3) Retention rate of members enrolled in program; and (4) Number of closed loop referrals or coordinated efforts with community partners. Member-level analysis will be conducted using qualitative and quantitative measures, including: (1) Were the goals that the member set for themselves met? (2) Was the member able to retain lessons learned and become more self-sufficient in navigating their social, health and/or housing needs? (3) Was the member satisfied with the interventions? (4) Was the member more engaged with their care or SCAN after the program? This includes review of members' use of benefits, primary or specialty care visits, ER visits, and perceived quality of provider/patient relationship.

To date, 97 members have been referred to the program internally, through a provider partner, or through a community partner. In total, 44 members have been enrolled in the program. Of the 44 members, 19 members have been placed in permanent housing and nine members have been placed in temporary housing. All members enrolled received other supports from the program. The most prominent interventions were: establishing care with the care team, providing assistance with food or helping the member enroll in Cal Fresh, applying or reinstating the member in Medi-Cal, connecting the member to transportation resources, and assisting the member in obtaining Supplemental Security Income (SSI) support. In addition to supporting the member's needs for housing, SCAN's ultimate goal is to also support members' health care needs which often takes a back seat to their living situation. Over 60 percent of those identified for the program have diabetes, and 44 percent have chronic obstructive lung disease as well as other serious health conditions. A total of 71 percent in the program report that "pain" interfered in their life, and 29 percent reported incontinence. The program team works diligently to ensure good coordination with members' primary doctor, and help to establish follow up care with the members' care team for 51 percent of those in the program. SCAN continues to enroll new members into the program and track the progress of existing enrollees.

2. Insulin Advisors (July 2019 – Ongoing)

The target population were Spanish-speaking SCAN members with poorly-controlled diabetes who reside in the greater Long Beach, California area. Intervention: A bi-lingual community health worker (CHW) provides intensive support to Spanish-speaking members with poorly-controlled diabetes. The CHW meets with members in the home and at the doctor's office, and also supports members telephonically. The CHW works closely with the member to identify goals, assesses and removes barriers to goal achievement, provides disease education as well as motivation and support to make lifestyle changes. The CHW helps improve the member's connection to the healthcare team, and also to community resources when needed. The goals of the program are to

lower A1c scores, reduce acute hospital and ER utilization, improve treatment plan adherence and close care gaps.

To identify the disparity in diabetes management we used SCAN data to compare Hemoglobin A1c (HbA1c) scores for English versus Spanish-speaking members. Looking at the CMS Star Rating A1c Poor Control measure we identified a statistically significant difference between the two groups based on a chi-square test. Additionally, in designing the intervention we reviewed data for findings from a similar SCAN program that utilized a team of a social worker and a CHW. Although in that program there was no specific goal related to diabetes, analysis revealed a statistically significant reduction in A1c scores, particularly among those with A1c greater than nine.

The intervention was based on a similar SCAN program originally launched nearly five years ago. During this program we partnered with several SCAN provider groups to deliver intensive, individualized care management to highly complex patients through a social worker and a CHW. This program was launched in multiple geographies and provided SCAN experience working with Hispanic and Armenian populations. During the program evaluation we were able to collect feedback from physicians and other healthcare providers, members, and caregivers. This feedback guided further program development, and also showed us that our ability to work closely with our members in a culturally sensitive way can improve the management of diabetes and other chronic conditions. Insulin Advisors was customized to meet the needs of Spanish-speaking members by first hiring a CHW that was not simply bi-lingual, but who is Hispanic and therefore possesses an understanding of cultural influences on beliefs, motivation and self-efficacy. Understanding these cultural influences is critical to promoting behavior change that leads to improved health outcomes. The CHW's awareness leads to improved understanding of the needs of the population, and to the ability to individualize the plan of care for the member. Further, educational resources and communication tools were adapted to meet the specific goals and needs of each participant, and were both linguistically and culturally appropriate.

SCAN's approach to working with this population is to meet the member where he or she is in terms of managing health. The key is to provide individualized, personalized support. After obtaining consent for a home visit, the CHW meets with members in the home to assess and understand their backgrounds, lifestyles and goals. The objectives of these initial meetings are to assess the members' knowledge and status, understand their situations, ascertain the strengths or weaknesses of the support system, address urgent issues, and start to earn the members' trust. As soon as possible the CHW will attend a doctor visit with the member. CHW observations are brought to the attention of the physician so that specific questions and issues can be addressed timely, whether it is simplifying a medication regimen or addressing symptoms or other needs. If there is an urgent issue the CHW contacts the doctor right away, often during the initial home visit. Goals are achieved by diligently, respectfully and thoroughly identifying and resolving the barriers faced by each member. Changes are rarely immediate. Modifying behaviors built over years of poor access to care and/or not being heard or understood is not an easy task. Modeling and teaching healthy behaviors, implementing new tools, and developing skills to self-advocate takes time and perseverance. Once member goals are met, the support system is strong and the connection to the primary care team is solid, then the case is closed.

Intervention effectiveness was evaluated by examining HbA1c scores, acute hospital and emergency room (ER) utilization pre- and post-intervention, and by reviewing CMS Star Ratings gaps in care metrics such as diabetes-related tests, cancer screenings and flu vaccines. To evaluate change in HbA1c scores, members were required to have a minimum of two lab values on record, one on or close to the enrollment period, and a second one at least three months after program enrollment. The hospital and ER utilization metrics were evaluated by calculating "Before" and "After" periods individually for each member. February 29, 2020 was used as the cutoff date to

be included in this analysis. This ensured inclusion of members enrolled in the program for at least three months, and avoided potential confounding of results by the COVID-19 pandemic. The number of days between the member's start date and the cutoff date was defined as the "After" period. The same number of days as the "After" period was used to define the "Before" period for that member. We then examined Hospital and ER claims and encounter data for each member during "Before" and "After" periods. To evaluate the closing of gaps in care, only members enrolled at least 3 months were included in the analysis. For each member we identified if the gap existed at the time of enrollment by reviewing claims, encounter, pharmacy, and lab data. We then identified if the gap was closed after program enrollment.

Between July 2019 and May 2020 a total of 35 members were enrolled in the program. All were Spanish-speaking and half were women. The youngest person enrolled was 57, the oldest was 93 and the mean age was 72. There were 20 members with sufficient lab data to evaluate HbA1c scores. Prior to the intervention 14 (50 percent) had poor control (A1c greater than 9); this was reduced to seven members after (50 percent reduction). Thirteen of the 20 (65 percent) had a reduction in average HbA1c value after the intervention. Lastly, the overall mean HbA1c score of the eligible members before intervention was nine point seven. This was reduced to eight point eight after the intervention, a nine point three percent reduction. In evaluating utilization, 28 members were enrolled prior to the cut-off date of February 2, 2020. The data showed that eight members (28.6 percent) had a total of 10 acute admissions before enrolling, while five members (17.9 percent) had a total of 6 acute admissions after enrolling. Regarding ER use, four members (14.3 percent) had an ER visit before enrolling, resulting in a total of five visits, compared with only one member (three point six percent) and one visit after enrolling. Several care measures were reviewed to evaluate the closing of care gaps. For flu vaccine, eight members had not received a flu shot at the time of enrollment. Of those, six members (75 percent) obtained a flu shot after enrolling. For other gaps, nine of 23 (39 percent) identified care gaps were closed, including 50 percent of diabetic eye exams and 43 percent of kidney disease lab tests.

United Health Care

Baby Blocks Program

The Baby Blocks Program is an online, interactive incentive program designed to help pregnant women and new mothers with prenatal, postpartum, and well-baby care. The program was developed in response to low HEDIS® rates among English and Spanish speaking members. The Baby Blocks Program aims to improve perinatal care, well-baby care, member engagement, and close gaps in care for specific HEDIS® measures. A program mailer is sent to all eligible members and newly identified pregnant members encouraging them to enroll in the program. The program rewards women for completing "Blocks" or visiting the doctor and reporting the information online during their pregnancy and their baby's first 15 months of life. Each enrolled member can complete up to 26 "Blocks" of perinatal and infant care. Once women sign up for Baby Blocks, they can access an interactive board that shows their prenatal visits, along with opportunities to earn rewards for prenatal visits. Using a game-like interface, members can track appointments and receive appointment reminders. Members are offered up to eight incentives with a total maximum value of \$100 for completing "Blocks" throughout their pregnancy and the first 15 months of baby's life. What made this program novel was the creative approach to providing on trend content, relatable images, and digital delivery. For example, members can customize notification preferences and can access the Baby Blocks interactive web-based program via a mobile device.

Multiple sources were assessed to identify health disparities and opportunities for improvement over year to year. The Plan initially utilized HEDIS® data to assess disparities among members with gaps in care for a select set of measures (Frequency of ongoing Prenatal Care - FPC, Prenatal

and Post-Partum Care - PPC, Lead Screening in Children - LSC, Well Child Visits in the first 15 months of life -W15). Rates for these measures for calendar year 2017 were below Minimum Performance Level. Prior to program launch, the Plan also analyzed demographic data such as age, language, and zip code. Specific disparities were observed in members who spoke English and Spanish with minimal disparities among members who spoke other languages such as Arabic, Chinese, or Vietnamese. These findings lent to program development targeting the majority population for English and Spanish speaking members, although the program would be offered to all eligible members. The program was implemented first in 2017 and the Plan assessed and evaluated program implementation in the years after. For example, the Plan surveyed members to assess how or where they heard about the program. The results indicated that 65 percent of the eligible members heard about the program through direct member outreach such as mail, email, and telephone call. Based on this finding, the Plan enhanced efforts to verify correct mailing address, email address, and telephone number to maximize enrollment.

The Plan hosted a focus group with an engaged provider practice to field test materials and assess recommendations for optimal implementation. Feedback included recommendations to provide materials to providers so they can market the program; translate materials into multiple languages, specifically Spanish; and ensure telephone calls are available in the member's preferred language. Based on this feedback, the Plan printed and distributed marketing materials in multiple languages to provider offices. Monitoring reports were developed to allow for continuous reporting of these metrics. The Plan incorporated this feedback and enhanced evaluation metrics to include assessing the impact of health outcomes for the mother and child. The Plan also identified opportunities for improvement the year prior to better promote the program and increase participation rates. As a result, the Plan enhanced program promotion and partnered with providers and their staff to encourage enrollment into the Baby Blocks Program. Additionally, marketing materials promoting the program were also provided during the Plan's Marketing outreach events throughout the reporting year to increase program participation. The Plan hosted monthly Quality Department meetings with provider practices and provided updates regarding the program. Those meetings served as a forum for additional feedback and recommendations. Feedback was incorporated to continuously enhance program development.

The Plan observed differences among the pregnancy and postpartum populations. Overall, the populations were young and predominantly English-speaking Hispanic or Latino members. The following cultural considerations and barriers were identified among this population, including: this may be a young working class that expect more of an expedited process for accessing care for themselves and for their children; considering a more digital approach for delivery of clinical programs since it is no longer common to have a land line telephone number and many have only a mobile cellphone; consideration of other social determinants of health and competing priorities such as housing, education, and employment that are all barriers to access to care that may impede these populations to seek care and go to their doctor. Based on these observations and considerations, the Plan developed program content to address social determinants of health. Content included referral information to food support services such as Women, Infants, and Children (WIC). Transportation was offered as a means of supporting and encouraging access to medical visits. Telephone scripts and email content were designed to address cultural and social norms and sought to creatively engage members to (1) enroll in the program and (2) encourage perinatal health, routine prenatal care, and timely well child visits.

The Plan assessed qualitative and quantitative data during program implementation. Comprehensive monitoring reports were generated per month and reviewed by the Quality Management Committee. The Plan continuously reviewed program participation rates, enrollment rate, total pregnancies completed, average number of "Blocks" completed, postpartum visits

completed, and HEDIS® rates for the PPC, W15, and LSC measures. The Plan also assessed any grievances that might have been received and zero were reported. Member satisfaction was assessed throughout the program and members could unsubscribe from the program at any time.

Baby Blocks program participation rate increased from 32.26 percent in 2018 to 73.2 percent in 2019, an increase of 40.94 percent. On average, enrolled members completed an average of five point seven “Blocks”. In assessing HEDIS® rates, the Plan observed a significant increase in the following measures: Prenatal and Postpartum Care - specifically, the Timeliness of Prenatal Care measure increased by 14 percent with 75 percent reported in 2018 compared to 89 percent in 2019. The Postpartum measure increased by 19 percent with a reported 56 percent in 2018 and 75 percent in 2019. Postpartum completion rates were 17 percent higher for members enrolled in the Baby Blocks program. When specifically looking at the perinatal Spanish-speaking population, the Plan observed significant improvements for members enrolled in the Baby Blocks program. The overall rate of Timeliness of Prenatal Care for all eligible members was 74.07 percent. Members whose preferred language was Spanish had a Timeliness of Prenatal Care rate of 85.71 percent. Furthermore, the overall rate of Postpartum care for all eligible members was 56 percent compared to a rate of 71 percent for members who preferred language was Spanish. A positive correlation was observed between Baby Blocks participation and the prenatal and postpartum care HEDIS® rates, specifically for the Spanish-speaking population thus confirming the Baby Blocks program met the needs of Spanish-speaking members. There were no further disparities identified for any languages other than Spanish.