Sixth Annual Innovation Award for Medi-Cal Managed Care Health Plans

October 2020

California Department of Health Care Services

2020

Award Winners

Blue Shield of California (Promise Health Plan)

The Neighborhood Health Dashboard

And

Inland Empire Health Plan

Using Location Intelligence to Monitor IEHP Members, Providers, and Facilities During Wildfires or Power Outages

Runner-up

Gold Coast Health Plan

Care Management for New GCHP Members

Sixth Annual Innovation Award, October 8, 2020

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

The intent of the Innovation Award is to highlight the innovative interventions developed by our Medi-Cal Managed Care Health Plans (MCPs) that strive to improve the quality of health care for Medi-Cal members. By highlighting these interventions DHCS hopes to facilitate and encourage the sharing of promising practices.

MCPs were each allowed to submit two nominations for the Innovation Award. The nominations needed to include a description of the target population, the scope of the problem, a description of why the intervention was innovative, and any outcomes or results of the intervention if available.

MCQMD reviewed all of the submitted nominations and provided summaries of the nominations to MCPs for voting. MCPs were allowed to submit up to three votes, but were advised not to vote for their own MCP.

DHCS received twenty-four nominations from seventeen MCPs.

AWARD NOMINATION SUMMARIES

Anthem Blue Cross

1. On-demand interpretation services and embedded digital solutions kiosk program for safety net health centers

The rising number of mono and multi-lingual speakers in California has created significant communication barriers in healthcare settings, resulting in challenges for providers and worse health outcomes for patients. Effective communication between a clinician and patient is critical for safety and quality of care. It is through conversations that clinician's process patient information to determine appropriate diagnosis and treatment plans. When patients and clinicians cannot understand each other, the risk of misdiagnosis, under-diagnosis, duplicative testing, and inappropriate prescribing increases. Additionally, patients that experience language barriers are less likely to seek care, build trusting relationships with providers, or adhere to treatment programs.

The target population is multi-cultural populations that have Medi-Cal and are assigned to safety net health centers across the 29 counties Anthem Blue Cross (Anthem) serves. This initiative supports participating health centers' entire patient population, not just Anthem's.

To help health centers address language barriers and establish stronger relationships with multi-cultural patients to improve health equity, Anthem launched a transformative initiative to access certified interpreters on-demand through live video and audio interpretation services. Anthem deployed iPad tablets on secure rolling carts (kiosks) to support the initiative. The kiosks allow healthcare providers to access more than 240 languages, including American Sign Language (ASL). This eliminates the need to pre-schedule and coordinate costly in-person interpreter appointments or wait on hold with health plan call centers, both major challenges for practice workflows. The kiosks are also pre-configured for telehealth visits using multiple video conferencing platforms. This added value became especially important during the current 2019 novel coronavirus (COVID-19) health crisis. Additionally, the kiosks can be used to access patient information via health plan portals. Historically, healthcare providers worked directly with vendors to launch on-demand video interpretation services in their health centers, adding significant financial and administrative burdens for them. Anthem was able to address and overcome significant billing and claims reimbursement challenges to scale the service within the multi-payer health care delivery system. Anthem is the first health plan to participate in this multi-payer solution, which is already reducing costs and administrative burdens for many health centers.

Since January 2020, Anthem deployed over 320 kiosks inside 120 safety net clinics and directly reimbursed over 30,000 minutes of interpretation services. This has helped save health centers over $44,000 and is expected to save hundreds of thousands more as the initiative grows. The top 10 languages prioritized by most frequently used are: Spanish, Dari, Pashto, Farsi, Punjabi, Vietnamese, Cantonese, Arabic, ASL, and Mandarin. Anthem has made a significant investment to procure, configure, and embed hundreds more kiosks in health centers across the state and is actively partnering with other Managed Care Health Plans to collaboratively launch this transformative service. WellSpace Health is one of the first health systems to utilize Anthem's kiosks to improve services for their patients. "The Anthem Blue Cross digital solutions kiosks are a tremendous benefit for the people we serve," said Dr. Jonathan Porteus, CEO of WellSpace Health, a community health system that serves more than 100,000 people in Sacramento, Placer, and Amador counties.

2. Reducing Readmissions through Video Case Management

Anthem uses a face to face case management approach to build trust and rapport with members who are at high risk for inpatient readmissions. During face to face visits environmental and safety measures can be assessed through comprehensive health risk assessments. During the COVID-19 shelter in place orders, hospitals and travel restrictions prevented the Anthem team of Nurses, Social Workers, and Community Health Workers from meeting face to face with members. During this time, Anthem noted a decrease in member engagement rates.

The targeted population includes Seniors and Persons with Disabilities, and members with complex physical and behavioral health and social determinants needs who are recently discharged from an inpatient hospital setting and considered high risk for 30 day readmission.

Anthem's Case Management Team rapidly implemented a process involving the use of technology to provide care to members in an innovative and sensitive way. Anthem utilized Zoom, Face Time, and Doximity to allow the member choices in comfort and accessibility and provided step by step assistance to connect to their care team. This face to face technology helped Anthem to maintain social distancing requirements while improving care to members who are vulnerable to social isolation, in a convenient setting they choose. Video calls allowed Case Managers to increase their caseloads by avoiding long travel to patients in remote locations.

One of our best indicators of success comes from a member's success story. After two phone call attempts and mailing a letter, we were unable to reach a 25 year old male with substance use disorder and suicidal ideation. The member was eventually admitted to the hospital and was receptive to the Case Manager's outreach. The Case Manager offered a face time call which provided an opportunity for reflective listening and empathetic responses. Although this member had refused social work services, and substance use disorder treatment in the past, through building trust and rapport with the Case Manager, the member verbalized a willingness to begin treatment. The Case Manager continued to follow up with member and provided additional community resources and support. The member's withdrawal symptoms have resolved and he has expressed motivation to continue with his sobriety. He credits the face time call with Anthem's Case Manager and hospital team as his turning point. Anthem offers FaceTime, Zoom, and Doximity to every member in the Readmissions Program. Since April 2020, 450 members have been offered this technology, 114 members have accepted its use. During the 114 face to face calls via technology, medication reconciliation, health education, stronger relationships/rapport, family conferences, home environment and health risk assessments, have been accomplished. Anthem has seen a 22 percent reduction in the readmission rate for the members served through Video Case Management.

Blue Shield of California (Promise Health Plan)

The Neighborhood Health Dashboard

Blue Shield of California partnered with mySidewalk, a data intelligence platform, to equip users with information on communities. The Neighborhood Health Dashboard allows all Californians to create health reports on community strengths and needs.

To be truly data-driven, it is essential to tell a story about progress in communities. Establishing a baseline lays the groundwork for tracking and reporting but often requires resources. This data is often publicly available yet costly to align with other data sets. Even for those that have established infrastructure, it takes time to produce a single report or a community health needs assessment. We need to standardize this process to communicate the value proposition of public health. With access to these indicators, resources can be spent on ensuring community input is paving the way. By democratizing the data, the Neighborhood Health Dashboard has the ability to defragment the needs assessments – ensuring funding goes where it is needed and makes progress towards health equity.

Blue Shield of California envisions community leaders, health departments, hospitals, students, and advocates will be equipped with powerful information that will shine light on our communities. Blue Shield of California Promise Health Plan Community Health Advocates use mySidewalk to identify needs in Antelope Valley and Los Angeles County, highlighting areas for improvement in those regions for the Medi-Cal population. By identifying and understanding social determinants of health in that community, anyone can better serve their population with increased knowledge that provides context to the community's story. The Neighborhood Health Dashboard allows the data to be accessible to everyone and can highlight health inequities in every neighborhood to create lasting change in communities across California.

mySidewalk makes powerful geospatial analytics simple and user friendly, which is why Blue Shield is using it to track, analyze, and communicate progress on their goals and performance

measures. Here are key features that makes mySidewalk innovative: (1) Dashboard is simple to update and requires no graphic information system mapping graphic design, web design, or data analysis software expertise. Most users are making customized reports within one hour of training. (2) 2,300 plus pre-loaded datasets from Bureau of Labor Statistics, United States Department of Agriculture, Environmental Protection Agency, Housing and Urban Development, Centers for Disease Control and Prevention, and the Census, provide instant access to the most up-to-date data and save staff precious time. (3) mySidewalks' web-based platform, mobile-first design and shareable graphics make it easy to highlight progress and make comparisons within and across regions. This identifies best practices and opportunities for investment. (4) mySidewalk centralizes the data needs of every stakeholder to one convenient space. The platform not only enables its users to share data in a timely manner but also allows them to communicate the value of their work in their respective communities. (5) It is estimated that 80 percent of data for needs assessments can be found in the dashboard saving time, money and allowing the community to build solutions.

Blue Shield's Neighborhood Health Dashboard provides community data to organizations and individuals. This data is being used to better understand the demographics of communities – down to zip code – and what may be impacting individuals' health. The Blue Shield Promise Community Health Advocates (CHAs) who used the dashboard to identify needs in Antelope Valley and Los Angeles County built the reports with just two hours of training. The reports highlight key needs in the region for the Medi-Cal population (food deserts, transportation, and housing were the top needs). The data also highlights high gun ownership and suicides which is key information for the CHAs and providers who do home visits and provide social needs support. This information is used to build the UniteUs social needs referral network to ensure that resources are aligned to support our members. This tool will be used in our Community Resource Centers in collaboration with L.A. Care. The data will determine social needs referral resources as well as initiatives inside the centers. Blue Shield is building the Neighborhood Health Dashboard in collaboration with the California Primary Care Association and guidance from the California Public Hospitals Association. As Blue Shield engages provider partners and communities across the state, the mySidewalk platform will make previously inaccessible and complex data available to all and enable alignment of opportunities to promote and create health across sectors.

California Health and Wellness

1. Mobile Devices for Telehealth/Virtual Care

The rural counties have provider shortages in certain areas and the COVID-19 pandemic has also limited members from being able to access care. California Health and Wellness (CHW) intended for this project to target community members at large.

Samsung mobile devices are to support the ability for patients to avail themselves of Telehealth Apps which provide Virtual Care capabilities like talking, texting, chatting, and participating in videoconferencing sessions with doctors, scheduling prescription delivery, and enabling access to patient education materials etc. The MCP will pay for a three gigabyte (3GB) rate plan for a period of three months for the consumer.

Our results will improve access to care and patient compliance with keeping their doctors' appointments.

2. Promote Utilization of Babylon Telehealth Services to Meet Members' Health Care Needs During the COVID-19 Pandemic

The COVID-19 pandemic disrupted our health care system. Many providers closed their office or drastically reduced medical appointments resulting in cancellation or postponement of routine preventive services and treatment for illnesses and chronic health conditions. Members could not get new medications or refills. Members felt anxious and stressed not knowing who to call or how to seek medical care. We need to develop a new communication channel that can quickly educate our diverse membership about COVID-19 information and available telehealth services. Traditional mode of communication of mailing information to members is not cost effective, takes a long time to produce and cannot show direct impact. Email could not be used because we have limited email addresses for members.

We deployed a text message campaign to quickly communicate information about COVID-19 safety and Babylon telehealth services to members. Following federal and company text messaging guidelines, we limited the target audience to adult members 18 years old and older. However, the telehealth service is available to members of all ages. To avoid communicating to multiple adults living in the same household or sharing the same cell phone number, we scrubbed the membership list to limit outreach to only one adult member per address or phone number. We sent English or Spanish texts matching members' preferred written language. Non-Spanish speaking members received the English texts with information on how to access interpreter services.

There are two innovations: 1) use short messaging system (SMS) to quickly communicate and track engagement; and 2) promote Babylon telehealth services to meet members' health care needs. SMS campaign is cost effective and quick to develop and launch. It provides engagement data to measure impact and subsequent texts can easily be modified to adapt to members' response. We designed, programmed and launched a brand new SMS campaign within two weeks, much faster than producing a print campaign. The SMS campaign only cost $0.14 per member. We tested the effectiveness of five different messages (COVID-19 symptom check, COVID-19 advice, telehealth, mental health, and general illness) by sending two different messages to two different cohorts at the same time. We reversed the messages for these cohorts in the next round of texts. This allowed us to compare the effectiveness of each message to ensure validity. We also evaluated the engagement rate for each message by language (English vs Spanish), geography (urban vs rural) and its direct impact on member registration with Babylon.

We sent two point nine million text messages to 57,000 California Health & Wellness (CHW) members. SMS had higher click through rates (CTRs) than email campaign at one point two percent. Messages about telehealth, COVID-19 advice, and feeling stressed saw statistically significant higher CTR compared to other messages. CTR by message type gave insights into members' states of mind. The top two most engaged messages were about telehealth and COVID-19. CHW SMS campaign started early when there was less COVID-19 cases. With this finding, we repeated the most effective messages in subsequent weeks. SMS impacted new Babylon registration. Registration peaked on days messages were sent (17-23 percent) and continued on subsequent days (11-16 percent). Babylon received 3,732 new registrations with 537 members seeking 935 medical and behavioral health consults and 751 prescriptions. Registration was highest among women (two point twenty four times more than men) and members ages 31 to 45. Members 56 years of age and older had nine percent of the total registration. Telehealth is a viable option for all ages.

CalOptima

1. Orange County Nursing Home COVID-19 Infection Prevention Program

It is widely accepted that nursing home residents are at high risk of infection from the novel coronavirus due to comorbid conditions and close living conditions. Nationwide, approximately 41 percent of all COVID-19 deaths are tied to nursing homes. From March through August 11, 933 of CalOptima's 2,569 reported COVID-19 cases (36 percent) have been among nursing home residents. Given the disproportionate impact, CalOptima's medical leadership identified an urgent need to improve conditions and performance among our nursing home partners. Last May, CalOptima's Board of Directors committed more than $629,000 as a grant for the Orange County Nursing Home COVID-19 Infection Prevention Program to improve infection control training in anticipation of a second wave of COVID-19 cases.

The target population of the COVID-19 infection prevention training program is CalOptima's 67 Orange County contracted nursing homes that currently care for approximately 3,400 members. The age distribution of the residents is as follows: Age 1–49, 13 percent; Age 50–59, 11 percent; Age 60–69, 19 percent; Age 70–79, 20 percent; Age 80–89, 23 percent; and Age 90 and older, 14 percent. Female residents represent 58 percent of the population compared with male residents at 42 percent. Early experience with COVID-19 has shown that the risk of death from infection increases with age, so the urgent need to protect and support this target population with special staff training is clearly evident.

The Orange County Nursing Home COVID-19 Infection Prevention Program is innovative because it aims to elevate the quality of care among CalOptima's contracted nursing homes across the county, which will provide a lasting cultural shift toward improved convalescent care. While there are regulatory requirements for individual nursing homes in response to the pandemic, there are no other comprehensive, coordinated training programs that direct the focus of Orange County health care staff on infection prevention best practices to significantly impact Skilled Nursing Facility (SNF) residents. Because user acceptance is critical, the program invites participation in multiple formats, including intensive in-person training, feedback via cameras placed in common areas or an online toolkit with resources and videos. The program is a response to the critical, pragmatic needs of SNFs with practical observations and recommendations that reflect the resources and challenges of the environment. The program is also unique because CalOptima draws on the expertise of two collaborative partners: UC Irvine and the Orange County Health Care Agency. Having the combined force of three well-respected organizations in Orange County ensures that nursing home administrators and caregivers commit to the challenge of quality improvement.

Since launching on June 1, the program adoption has been strong. Intensive intervention is available for a maximum of 12 SNFs, and 11 have signed on. This group is receiving weekly in-person visits with leaders and training sessions with staff to review toolkit materials and video feedback. The training is divided into three sections that align with the toolkit: 1) Information about how COVID-19 is spread and best practices for self-protection; 2) Proper personal protective equipment usage and best practices for caring for residents; and 3) Correct methods of environmental cleanliness. Individual consultative sessions are available to all other SNFs, and many are participating. More than 70 nursing home leaders attended a CalOptima-hosted webinar on July 9 to debut the toolkit (www.ucihealth.org/stopcovid), which is ahead of schedule. Seven of the 12 sections are complete, with more than 30 documents and 20 videos. The impact of the coaching has been immediate, as participating facilities report staff enthusiasm and adherence to proper infection protocols because personal safety, in addition to patient safety, is emphasized. SNFs are grateful for direct assistance at a difficult time in a complex setting. The goal is to hardwire prevention techniques in staff, which will be invaluable in the expected fall viral resurgence. UCI Infectious Diseases professor Susan Huang, M.D., and her team developed the material and conduct the visits and trainings in conjunction with CalOptima communications and webinar support.

2. Post-Acute Infection Prevention Quality Initiative (PIPQI)

Each year, two point eight million people contract an antibiotic-resistant infection, and more than 35,000 people die, according to the CDC. In particular, infection control in nursing homes is a major problem due to close quarters and shared surfaces. Even before the pandemic, a range of "superbugs" threatened residents, especially methicillin-resistant Staphylococcus aureus (MRSA), vancomycin-resistant Enterococcus (VRE) and carbapenem-resistant Enterobacteriaceae (CRE). An early study in 16 Orange County nursing homes showed that an average of 64 percent of residents were colonized with a multidrug-resistant organism (MDRO) on the skin, which can lead to many deadly infections. The pressing need to protect vulnerable institutionalized people with a simple solution was the foundation of CalOptima's PIPQI.

The target population of the PIPQI program is CalOptima's 67 Orange County nursing homes that currently care for approximately 3,400 members. The age distribution of the residents is as follows: Age 1–49, 13 percent; Age 50–59, 11percent; Age 60–69, 19 percent; Age 70–79, 20 percent; Age 80–89, 23 percent; and Age 90 and older, 14 percent. Female residents represent 58 percent of the population compared with male residents at 42 percent. Thus far, 26 nursing homes are participating in PIPQI, and there is room for further adoption of the program.

PIPQI protects nursing home residents from dangerous infections using a new, clinically proven bathing regimen. Bathing residents with Chlorhexidine (CHG) antiseptic soap, instead of standard liquid soap, along with using Iodophor nasal swabs every other week significantly reduces the colonization of multidrug-resistant organisms, according to a two-year study by the University of California Irvine (UCI), which is the basis for CalOptima's PIPQI. The program includes outreach and engagement, establishment of protocols, facility staff training, adherence monitoring and

quality testing. UCI Professor of Infectious Diseases Susan Huang, M.D., developed the program in collaboration with CalOptima, and it is strongly supported by the CDC. Not only is the bathing regimen innovative, but so is the partnership that drove its adoption. CalOptima has dedicated $5.7 million to cover costs and award incentive dollars to nursing homes that maintain the program and report the outcomes. To our knowledge, this is the only countywide project in the country that strengthens infection control in nursing homes using CHG and Iodophor.

In July 2017, UCI's Dr. Huang tested the CHG bathing protocol in 16 CalOptima-contracted nursing homes. The study was completed in July 2019, and the results showed a significant 25 percent decrease in colonization of MDROs on the skin of patients bathed using the CHG protocol. CalOptima also demonstrated a 61 percent reduction in inpatient hospital costs due to infection, according to CalOptima Deputy CMO Emily Fonda, M.D. Among the study group, inpatient costs due to infection in the six quarters before the CHG protocol was introduced were $1.2 million, compared with $468,000 in the six quarters after use. Given the potential to reduce infections and save costs, CalOptima formalized the program and initiated training in October 2019. Currently, 26 nursing homes are harnessing PIPQI power to fight superbugs. Interestingly, the killing effects of CHG are active against coronaviruses, so PIPQI is operating alongside a COVID-19 infection control training effort (described in a separate entry). The PIPQI project continues during the pandemic, with special challenges in training updates and compliance due to a high rate of staff turnover. Outcomes in the first four months prior to the COVID-19 pandemic have shown promise. Additionally, PIPQI has generated national interest that included CDC encouragement and funding for the initial trainer. Dr. Fonda considers the bathing protocol "a cutting-edge best practice on the national radar." Dr. Huang plans to publish results in an academic journal.

Central California Alliance for Health

Adapting to a Novel Virus: Using Claims Data to Measure Risk and Design Member Outreach for COVID-19

The COVID-19 (COVID) pandemic was well established in California by March of 2020. Leadership determined that there were many risks posed by both the emerging pandemic and the related community conditions. Health Services staff worked together to devise a plan for live outreach phone calls to the highest risk of our membership. A risk score was determined for each member using available literature about the disease. Members were weighted by age, gender, disability status, and diagnoses, and an overall score was calculated and then they were ranked by the highest score. Using these methods staff completed two waves of outreach to 7,802 unique members between April and July 2020.

In March of 2020, the Morbidity and Mortality Weekly Report (MMWR) reported out on initial surveillance of cases and their predisposing health issues. This and other publications allowed the health care community to monitor expanding evidence and apply the information to their practice. To understand which members were at the greatest risk, staff created a relative risk system for each known risk factor and used the values to calculate an overall score. A Medical Director scored the relative risk factors for all known or suspected risks and the Quality and Population Health manager created risk scores for greater than 65,000 members across Merced, Monterey, and Santa Cruz Counties.

This outreach project was innovative because it was rapid, fine-tuned, and member centered, and was implemented in the setting of a novel virus pandemic. In addition, this response was unique to our highest risk individuals. Staff quickly designed an algorithm to identify our most vulnerable members using existing resources. Health conditions were identified through diagnoses listed on claims data in the prior 12 months to identify any members with diagnoses for asthma, cancer treatment, chronic obstructive pulmonary disease (COPD), diabetes, heart disease, immunocompromised states including human immunodeficiency virus (HIV), liver disease, organ transplant recipient, pregnancy, obesity, steroid treatment, and tobacco use. Furthermore, pharmacy data queries were completed to ensure a complete picture was available for each member's current health status. During April, the first month, staff contacted 4,194 members speaking directly with at least 2,000 members, leaving messages for others. This is a reasonable

success given the documented challenges in reaching Medicaid members by phone. Response rates to outreach calls have climbed since April, peaking in June with staff speaking directly to half of members. The most requested resources were details about how to access care, food, and the 'other' category which includes transportation assistance.

Gold Coast Health Plan

1. Proactive Care Management for New GCHP members

Gold Coast Health Plan (GCHP) identified a new group of members as a population within our membership that present a health disparity due to increased utilization, high incidence of unmanaged chronic conditions and use of the emergency room for primary care. We identified this population utilizing our membership data along with the Health Information Form / Member Evaluation Tool (HIF/MET) data from returned surveys as well as utilization data identifying this population's utilization of emergency room services as well as inpatient days.

Interventions were customized based on the data we received from our HIF/MET program. We recognized that primary barriers to our member's getting care needs met were a need for education around members' specific health conditions, help navigating the health plan and guidance on engaging as active participants in their care. Interventions directed towards meeting these needs included interaction with our Care Management and Health Education Teams using a tailored approach based on members' stated needs. These included engaging members in following care guidelines, health and wellness activities, guidance on talking to members' healthcare providers, and support in identifying and accessing community resources to help meet social determinants of health needs.

GCHP Care Management receives all returned HIF/MET surveys and reviews each to determine need for support from Health Education, Care Coordinators and/or Nurse or Social Work Care Management. Each survey returned is reviewed and any positive responses will trigger a referral for outreach from one of the Care Management staff in order to offer services and, if accepted, perform a further needs survey to identify level of support needed. This survey covers additional 'red flag' areas such as high-risk medication conditions, health literacy, inappropriate utilization history, medication adherence, mental health concerns and social determinants of health. Depending on survey results, members are engaged with written information on their specific condition(s), connection to GCHP resources such as transportation, Care Coordination for members who may need assistance with non-complex needs, or Complex Care Management focused on those members who may have multiple comorbidities, significant social determinants of health needs and/or low health literacy preventing them from engaging fully in their health care.

Review of our data showed that approximately 21 percent of HIF/METs sent were returned. Of those, 76 percent resulted in a program referral for further evaluation. Following this outreach, we found that 19 percent opted out of the program or were unable to be reached, 12 percent received a health education referral, 39 percent accessed Care Coordination services, and 30 percent were entered into our Complex Care Management program. We found that members engaged in Care Management services had 26 percent fewer Emergency Department (ED) visits than those members who did not return their HIF/MET, and 18 percent fewer ED visits as compared to our overall population. 71 percent of members engaged in Care Management had no ED utilization. Additionally, members engaged in Care Management had seven percent fewer inpatient days as compared to our new members who did not return their surveys. This showed that proactive Care Management focused on internal and community resource connection, education on condition, and tailored support and empowerment for these members to become self-advocates significantly impacted their engagement, health literacy, and confidence in their ability to communicate their needs to their providers.

2. Utilize all clinical encounters to screen and immunize children

An analysis of the clinic's performance on the Childhood Immunization Status – Combination three (CIS-3) measure and their workflow for assessing each child's immunization status revealed two primary barriers that this intervention addressed. Barrier one: missed opportunities to immunize children before their second birthday. A review of the clinic's performance showed that a high

percentage of children had completed all required CIS--3 immunizations, but one third had not received all immunizations on or before their second birthday. Barrier two: no outreach to schedule well-care exams. The clinic assessed a child's immunization status only during well-care exams, but since there was no proactive outreach to schedule well-care exams, the clinic was missing opportunities to administer immunizations on/before the child's second birthday.

The target population was GCHP members, less than two years of age who had any type of clinic encounter (e.g. scheduled, non-schedule, sick visit, etc.) with one pediatrician at Mandalay Bay Women's and Children's Medical Group.

Since the clinic was successful with administering all the required immunizations during well-care exams, but unsuccessful with administering them timely due to missed opportunities, we evaluated what existing workflows could be expanded and enhanced to improve immunization assessments at all clinic encounters. For the intervention study, a medical assistant prepared a California Immunization Registry (CAIR) status report for each child (younger than age two) who had any type of scheduled or unscheduled clinic encounter. During the appointment, the pediatrician used the report to assess each child's immunization status and determine any immunizations needed. To evaluate the effectiveness of the intervention, the clinic documented the outcome of each child's immunization assessment which included tracking the type of encounter, immunizations administered, and reasons if no immunizations were administered. The intervention was innovative for evaluating existing clinic workflows that could be expanded and enhanced (assessing immunizations during well-care exams) to compensate for barriers to care (no outreach to schedule well-care exams or immunization appointments and missed opportunities during clinic encounters). The intervention was achievable, sustainable, and proved to be very effective with improving clinic workflows to improve the assessing and administering of immunizations for all children (younger than two years of age) who had an encounter with a pediatrician at the clinic.

The intervention increased the administration of immunizations. During the study period, the percentage of children who received immunizations during all clinic encounters with a pediatrician (scheduled and unscheduled) increased seven and a half percentage points, and the percentage of children who received immunizations during a well-child exam increased significantly from 30.43 percent to 83.33 percent. The intervention also improved the clinic's assessment of each child's immunization status and scheduling follow-up well-care exams for children who were not administered vaccines. Tracking documentation showed that 45 percent of the children assessed received immunizations during the encounters; 45 percent were up to date; nine percent did not receive immunizations due to an illness; and one percent did not receive immunizations due to parental/guardian refusal. For the children who could not receive immunizations due to an illness, the clinic attempted to schedule follow-up appointments. Overall, the intervention was very successful with enhancing to the clinic's workflow for evaluating immunization status during all clinic encounters, improving coordination of care, and providing an opportunity for the clinic to schedule follow-up immunization appointments and well-child exams before the parent/guardian left the clinic.

Health Net

1. Frontline Doulas - Centering the Community

Los Angeles County Maternal and Infant Mortality rates for African American women far exceed the rates from other racial backgrounds. African-American women make up nine point two percent of all women in LA County, but 31.8 percent of all maternal deaths. Rates of African-American premature birth, infant mortality, and low birth weight are two and a half times higher than for Caucasian infants. One of the needs expressed by the African American community was to have more healthcare providers from the same cultural background. This cultural concordance and trust between the client and doula provider contribute to the success of the partnership. Evidence shows that increased access to doula care, especially in under-resourced communities, can improve a range of health outcomes for mothers and babies.

The target population includes African American pregnant people in Los Angeles County who have Medi-Cal insurance. Descriptive and Geospatial mapping was conducted on the member and

provider data from Healthcare Effectiveness Data and Information Set (HEDIS) results. Project targets and regions were specified within Los Angeles County that have a high volume of numerator negative members for HEDIS prenatal and postpartum care guidelines. Service Planning Areas one and six in Los Angeles County have the highest rate of preterm births, both at 11 percent, compared to nine point one percent countywide. We specifically targeted pregnant people in Antelope Valley as the disparity in outcomes that exists in that region is greatest due to a limited number of providers as well as other social determinants of health factors.

This is the first program of its kind where a Medicaid payer has funded doula care to reduce disparities. Doula care is not routinely covered by health insurance. Health Net is the first Medicaid contracted health plan in California to offer free doula services to its Medi-Cal members. This innovative approach supports both African American doulas as well as African American mothers. The Frontline Doula Program establishes a consistent pay rate or reimbursement for doulas as well as providing needed support for Health Net members. It also engages our Health Net members, the community and providers in a unique partnership to work together to improve birth outcomes for African American women. This program laid the foundation for other programs that are now underway at other Medi-Cal MCPs. The Los Angeles County Department of Public Health used this program to successfully apply for $2 million in Medicaid draw-down funds for their own doula program which has successfully launched.

The Community Doula Program officially began enrolling members in June 2019. The program is still collecting data and we anticipate that the complete data will be available (taking into account claims lag) in the first quarter of 2021. The second iteration of this project under The Frontline doulas are tracking Cesarean sections, postpartum visits, and low birthweights. The doulas will collect and track prenatal and postpartum appointments and complete the African American Maternal Stress Scale with enrolled members. We have completed enrollment for the project and will have had a total of 82 clients enrolled by the end of the program. At this time, 37 clients have delivered and 45 are still pregnant. The outcomes evaluation will be conducted in full upon conclusion of the program. Health Net has analyzed the data for the members who have completed the program with initial results available on the first 30 members. Using HEDIS data from prior years for comparison, Cesarean sections decreased by 40 percent in the intervention group. Postpartum care increased by 27 percent in the intervention group. Prenatal care attendance increased by 19 percent in the intervention group. Client satisfaction was measured and found to be high. A qualitative analysis was done about the doulas' experiences and a publication is forthcoming which describes that the racism experienced by the pregnant people is reflected in the racism experienced by the doulas themselves.

2. San Diego Neighborhood Networks

Social Determinants of Health (SDoH) contribute to approximately 50 to 60 percent of mortality and healthcare costs in an underserved population. Health plans' success in managing the underserved Medi-Cal population is measured by both quality indicators (HEDIS) and utilization metrics. The underlying difficulties in caring for the underserved population are often attributed to the "non-compliant" patient. However, when one factors in SDoHs and the uphill battle that underserved populations face, we realize that the problem is a "non-compliant" system. It is challenging for members to prioritize needed screenings and medical appointments when feeding their family or affording housing is a daily struggle. Understanding the problem is the first step in identifying a solution.

The program target population are Medi-Cal members residing in San Diego County, with an identified HEDIS care gap for breast cancer screening, cervical cancer screening, and/or prenatal and postpartum care. In San Diego County, the plan's membership mostly consists of White, Hispanic, Filipino and Vietnamese members. The plan's Cultural and Linguistic Department provided geo-mapping by zip code to identify member hotspots with care gaps. Particular attention was given to members with multiple clinical quality care gaps. As a result, Chula Vista was selected as the program target area. Due to the impact of the pandemic on community outreach and provider office visits, the project scope was expanded to include children's health measures, including well care visits and immunizations.

The plan contracted with the San Diego Healthcare Quality Collaborative (SDHQC), a non-profit organization to implement Neighborhood Networks (the program). The program is an innovative service designed to address health-related social needs of healthcare members, utilizing a network of curated, linked and organized community-based solutions to improve member health outcomes. The program model is to establish a community HUB, which links members to community resources by utilizing health workers called Neighborhood Navigators. The Navigators support members with referrals to resources and health services such as cancer screenings, pre/post-natal care visits, housing support and other social services. The program is a pilot and first of its kind for the plan. The program goal is to determine the benefits and cost-effectiveness of providing community based interventions (CBIs) as a mechanism for closing care gaps and improving health outcomes. The purpose of the program includes: 1) To demonstrate that the CBIs will improve specified health outcomes for individuals assisted through the program; 2) To demonstrate the value of these services as an investment by the healthcare organization; 3) To link together organizations that provide CBIs, in order to leverage and promote efficient use of community assets; 4) To promote the sharing of data that helps identify unmet health and social needs in order to promote collaborative, community-based solutions.

Program data is collected on various metrics such as member outreach and enrollment; race, ethnicity and language; social determinants of health barriers identified; numbers of members enrolled in a Pathway (screenings and referral services); and number of care gaps initiated and closed. COVID-19 has greatly affected program implementation. Navigators are unable to do in person interviews and home visits. Medical providers prioritize urgent needs and postpone some screenings and preventative appointments. In order to increase the program reach due to impact of COVID-19, the Adolescent Well-Care (AWC) HEDIS measure was included to the program care gap list. Navigators made call to parents to assist with scheduling AWC appointments. As of July 2020, there are currently 10 members enrolled in the program. Enrolled members are engaged in various Pathways such as medical referrals, education and social services. A member completing a Well-Care Check Up closed one care gap.

Health Plan of San Joaquin

Point of Care Gift Card Distribution Clinics

Western Stanislaus county had a large number of members in need of preventative services. A particular clinic in this county struggles with member no shows and wanted to partner with our plan to decrease the member no show rate and increase preventative services. In addition, the provider partnership group was in need of more members to be seen at their location to ensure their group of interns could see the volume of patients needed during the family medicine rotations.

The target group for this project were members located in Stanislaus county who were due for preventative services such as: Hemoglobin A1c testing, cervical cancer screening, breast cancer screening, eye exams, and annual visits.

Members were contacted and scheduled based on gaps in care. Members with multiple care gaps had the ability to earn multiple gift cards during one visit and gift cards were distributed on the day of the appointment. This partnership allowed the plan, members, and the providers to meet established goals.

The clinic was scheduled for every Thursday from May 2019 through December 2019. The plan was able to close 635 care gaps.

Health Plan of San Mateo

Dear Neighbor: Keeping people connected, healthy and safe during the COVID-19 crisis

As stay-at-home orders continue in many cities and social distancing becomes the new norm for interacting, the prevalence of social isolation and loneliness is increasing. According to the National Institutes of Health, these conditions have been linked to higher risks for a variety of physical and mental health problems, including high blood pressure, heart disease, obesity, anxiety, depression, Alzheimer's, and more. The same people most susceptible to life-threatening COVID-19 infections are also at high risk for social isolation. Older adults and people with disabling

conditions living alone reported higher rates of loneliness than the general population long before COVID-19. With the response to the pandemic, Health Plan of San Mateo (HPSM) focused on developing innovative solutions to combat the harmful effects of these risk factors.

Out of concern that people may fail to receive needed medical care, HPSM staff continually evaluate if high risk members need services, such as medication delivery or telemedicine. The pandemic has also led to many non-medical needs, so HPSM assesses members' holistic needs, such as meals and grocery delivery. HPSM partners with several organizations to reach out to older members and those with disabling conditions to assess health risks, perform COVID-19 risk screening, provide advice about medications, answer health-related questions, and arrange for home-based care. HPSM is also contacting other high-risk members – such as those with asthma, pregnant women, and new moms – providing them with education and linking them to medical care and resources.

Providing access to medical services and local resources is essential – but it is not enough. Now more than ever, people need human connection and social support. HPSM found this support by leveraging the strength of its community. Employees throughout HPSM as well as HPSM partner organizations are calling members to check-in and provide social support. One of HPSM's partners also organizes older adult members to call each other, so that isolated members receive periodic "buddy calls" from their peers. We hope these personal connections help members feel less alone during this challenging time. Additionally, HPSM designed and printed a series of postcards with space for handwritten personal notes. With the help of San Mateo County, HPSM recruited volunteers to write brief positive messages to members to help lift their spirits. The postcard also reminds members through graphics and secondary messaging to "Stay home. Stay strong. Stay connected!" This highlights the importance of maintaining social connections, while also assuring members that HPSM is still here working for them.

From the beginning of April to mid-August, 99.4 percent of members identified as high risk have received a social call, a welfare check, assessment or both. Because outreach to high risk members was achieved, HPSM expanded its social outreach efforts to include lower risk populations. As of the end of July, 19.7 percent of HPSM's membership received a social call, a welfare check, assessment or both. Over 4,600 handwritten notes were mailed to HPSM members from over 550 volunteers as of mid-August. Many of the postcards sent were adorned with vibrant drawings in addition to positive messages in Spanish, Chinese, Tagalog, Russian, and English. Like the social outreach campaigns, members on the mailing lists for receiving postcards are identified as seniors and/or persons with disabilities. As HPSM continues to receive volunteers from throughout San Mateo County and the Bay Area, the list of postcard recipients will be expanded to members identified as lower risk. HPSM is still evaluating the impacts on utilization as result of the social outreach efforts. Staff continue to monitor access to medical services as well as information gathered through the various outreach channels to identify additional member needs and initiate activities to connect members to supportive resources and services in the community.

Inland Empire Health Plan

1. Using Location Intelligence to Monitor IEHP Members, Providers, and Facilities During Wildfires or Power Outages

Riverside and San Bernardino counties experience several fast-moving wildfires on an annual basis. The counties are also periodically subjected to controlled power outages by Southern California Edison (SCE) in an effort to avoid new wildfires. Either of these situations have the potential to disrupt the delivery of vital health care services throughout the communities Inland Empire Health Plan (IEHP) serves. For a member who relies on Durable Medical Equipment (DME) or a provider whose practice falls within a wildfire evacuation area, the effects of these experiences can be broad and vary in magnitude. IEHP needed a way to quickly identify members and providers who may potentially need assistance during these types of events.

IEHP is concerned for all members and providers who fall within a power outage or wildfire (or other natural disaster) area and need assistance. During an event like this, focus is initially directed to members who utilize DME. Electricity is vital for this population who is especially vulnerable and

adversely affected if power is unavailable or if evacuation is required. The population of IEHP's providers and the team members at IEHP facilities are also a priority during these events. If provider practices or IEHP facilities are affected, IEHP members everywhere could suffer if vital health services are delayed or interrupted. The ability to quickly and accurately identify areas of need is essential for IEHP to establish communication and ensure continuity of care for all members.

IEHP implemented an Esri Enterprise Geographic Information System (GIS) platform to manage and visualize the data within a GIS data repository. Data contained within the repository helps create web applications used throughout IEHP. A daily GIS Extract Transform Load (ETL) has been designed to incorporate multiple sources to simultaneously process data within an automated environment. This alleviates the burden of manual processing and reduces the resources required to keep the data updated. It also decreases errors by bypassing the need for manual updates. In addition, by adding a geographic component to the data, location allocation is possible. IEHP uses Esri's mapping and spatial analytics to intelligently identify members who rely on DME and may be impacted during an event. By overlaying data from local utilities, emergency response authorities, and IEHP member records, a straightforward, easy-to-use web application was built and implemented that allows team members to quickly identify vulnerable members, providers, and facilities in the perimeter of a wildfire/natural disaster or in proximity of a power shutoff. The ease of use and fast performance of the application allows IEHP to identify within minutes the members, providers and facilities affected by the event. This allows for prompt deployment of interventions and outreach.

Since the introduction of the IEHP Emergency Preparedness web application, San Bernardino and Riverside counties have experienced 13 SCE Public Safety Power Shut Offs and eight wildfires. In each of these events, areas were quickly evaluated to determine if members or providers were impacted. The application allowed IEHP's Provider, Care and Utilization Management teams to rapidly deploy an outreach or intervention, when required. Contact with members and providers was made, and essential information was distributed that helped to ensure the health and safety for all those affected. In some instances, arrangements were made to transport members to a safe, alternate facility. The application has been very effective in increasing efficiency and reducing response time during an event. It is important to note that daily reporting to state agencies is required during these events. The application was created with an automated reporting process within the daily GIS ETL. Results can be quickly exported from the application and easily formatted to the appropriate submission requirements for each agency, so daily deadlines, clear communication and reporting are achieved. Due to its ease of use and effectiveness in identifying affected members and providers, the IEHP Emergency Preparedness web application has been included as an essential tool in the IEHP Emergency Preparedness plan of action.

2. IEHP's COVID-19 Response Strategy

In late December 2019, the novel coronavirus emerged which resulted in a global pandemic in the first half of 2020. The primary mode of transmission of COVID-19 was thought to be respiratory droplets spread from person to person. Economic shutdowns and strategies for sheltering in place began globally, in the United States, statewide, and then locally in the Inland Empire. As of August 10, California has 528 thousand cases, and the Inland Empire has 80.6 thousand cases. It is important to note that San Bernardino and Riverside counties, IEHP's service area, have had higher percentages of positive COVID-19 cases than the state average.

The target population for IEHP's All Hands on Deck: Managing COVID-19 project is every soul in the Inland Empire, more specifically all of IEHP's 1.25 million members, all of our providers, health care workers, community partners, and more than 2,200 team members and their families. Our focus, however, is our most vulnerable populations and those directly impacted by COVID-19, as communities in the Inland Empire have a large at-risk population and people with health disparities, including: all members admitted to inpatient acute care; all members transitioned to a lower level of care – post-acute and long-term care; all members in hospice, palliative, transplant

and end stage renal disease programs; all members in the community settings impacted by COVID-19.

Our first response to the COVID-19 crisis was to remove barriers to care for our members and eliminate administrative hurdles for our providers. We created innovative, best-in-class funding mechanisms to make sure our providers have resources to care for patients. We created first-of-their-kind emergency amendments with our county hospitals to make sure they have cash flow. We purchased Personal Protective Equipment for local hospitals, providers and counties. We partnered with food pantries to distribute food to homebound members. We utilized GIS mapping to identify geographic regions of high-risk members in COVID hotspots for outbound call campaigns. Our teams made outbound calls to more than 29,000 of our most vulnerable members. Our new social isolation texting program helped us reach out to the more than 94,000 members who are seniors and have disabilities. We provided oxygen to patients post emergency department, and home monitoring. We teamed up with Federally Qualified Health Centers to provide a $100,000 grant to support COVID-19 testing. We supported county homeless initiatives, community food bank and delivery systems, and a first-of-its-kind county-211-Nurse Advice Line strategy to support 400,000 uninsured residents. IEHP's commitment to fiscal prudence, careful management of reserves and financial emergency preparation have allowed for such expenditures and innovative programs. And we did all this under the guidance of an internal cross-discipline committee of IEHP leaders when 96 percent of our more than 2,200 employees worked from home.

As of August 10, about 13,500 IEHP members have been impacted with COVID-19. Some 4,146 members were suspected of COVID-19 infections and 1,582 members became positive Out of 1,582 positive cases, 1,365 were discharged to home and a lower level of care. There were 61 out of 118 contracted facilities impacted by COVID-19 with 658 members testing positive. To date, there are only 90 patients testing positive. IEHP has also pushed virtual care strategies. Over the past four months, the percent of members accessing virtual care services has increased from just under five percent to about fourteen percent. IEHP has also transported a total of 299 COVID-19 suspected/or positive members for 812 trips. No adverse effects or outcomes for our members on Skilled Nursing Facilities watch lists or on out-of-network discharges from emergency care with home monitoring have been reported. More recently, however, San Bernardino and Riverside counties, IEHP's service area, have seen increases in COVID-19 cases and have recorded higher percentages of COVID-19 cases than the state average. These are unprecedented statistics and are difficult to comprehend in terms of success or innovation. IEHP can say the following with certainty and pride: our employees are healthy, safe and working; our community relationships and health care partnerships are stronger; and IEHP members continue to have access to the care they need, especially our most vulnerable members and those with the most health disparities.

Kern Family Health Care

KFHC Baby Steps Pregnancy Member Engagement Program

Kern Family Health Care (KFHC) pregnant members have historically struggled with obtaining routine prenatal and postpartum care which is key to early identification, treatment and monitoring of complications during pregnancy. In 2018, 57.16 percent of pregnant members did not access regular prenatal care prior to delivery; 22.34 percent were identified as having interrupted prenatal care (missed three consecutive visits); eight point forty nine percent of all births were reported as a premature delivery; and five point seventy three percent of all births resulted in a Neonatal Intensive Care Unit (NICU) admission. Measurement year (MY) 2018 HEDIS rate for Prenatal and Postpartum Care – prenatal measure (PPC-Pre) declined by one point twenty-one percentage points in comparison to the prior year's rate and Prenatal and Postpartum Care – postpartum measure (PPC-Post) missed the High Performance Level (HPL) by six point thirty-three percentage points. Analysis by geographic area also identified the 93305 and 93308 zip codes as being less likely to access timely care.

KFHC targeted all pregnant and postpartum members who were actively enrolled in the plan with the exception of members assigned to Kaiser Permanente. A special emphasis on targeted subgroups were also identified. These subgroups consisted of pregnant and postpartum members

who identified as Black or African American, members residing in the 93305 and 93308 zip codes, teen pregnancies, and deliveries via Cesarean section.

KFHC expanded its outreach efforts and partnerships in the community in an attempt to reach the targeted groups. Information on KFHC's pregnancy benefits, services and resources were shared with local pregnancy centers, hair and nail salons, parks and recreation centers, local college campuses, and retail stores with special emphasis on the targeted zip codes. The HealthyWe pilot was established with the local Public Health Nursing (PHN) department to perform outreach and education to all pregnant and postpartum members identified by KFHC as being Black or African American or residing in the targeted zip codes in order to encourage timely access to care and assist with appointment scheduling, transportation and other social service resources. A file of newly identified members is shared every month with the PHNs along with monthly meetings to provide updates and share challenges. Member and provider surveys are initiated to gain further insight on the challenges to accessing care as well as identify a baseline on member behavior patterns and perspectives on access to care. Member-specific report cards were created for pregnancy and after delivery which provided customized information on each member's open and closed gaps in care, available benefits, and community resources. Plan-wide reporting for identification of all pregnant members along with prenatal care activity was also streamlined and added as a key performance indicator.

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 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 eighty-six percentage point increase in members completing 13 or more scheduled visits. Furthermore, 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 Managed Care Accountability Set rates also demonstrated a two point nine percentage point increase in PPC-Pre and a 13.58 percentage point increase in PPC-Post in comparison to MY 2018. PPC-Post also exceeded the 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 Reporting Year (RY) 2018 and RY 2020 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 or 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 or African American members.

Partnership Health Plan

Perinatal Provider Engagement to Drive Improvement in Maternity Care

High quality pregnancy care can have positive impacts on the pregnancy. For the MCP, HEDIS MY 2018 rates for the Timely Prenatal and Timely Postpartum Care measures ranged from the 25th to the 90th percentile across the MCP regions. This variability in access and the quality of care pregnant patients receive, indicates a need to improve and standardize the care members receive across all regions. The Perinatal Quality Improvement Program (PQIP) optimizes performance in perinatal quality measures through an incentive and reporting program and through intensive engagement directly with providers and staff to emphasize the importance of these measures and share best practices.

The target population was the pregnant and post-partum women served by large and medium sized perinatal providers outside of Kaiser. The PQIP was offered to select Comprehensive Perinatal Services Program (CPSP) and non-CPSP providers with more than 50 deliveries per year. In 2019, 7,553 deliveries took place across the MCP, and of those deliveries, providers invited to participate in the PQIP administered perinatal visits to 4,460 (59.04 percent) of those members.

While other MCPs often incentivize performance on HEDIS perinatal measures for their sub-contracted health plans and Independent Physician Associations (IPAs), the PQIP program is directly with perinatal and CPSP providers. Additionally, several structural elements of the PQIP program are innovative: (1) Practices submit monthly reports detailing the perinatal services administered. The submission of this report requires attestation by the practice that clinical documentation of all required components of quality perinatal care is complete. Spot audits were performed to assure accuracy of attestations. (2) Additional non-HEDIS measures were included in the measure set: administering influenza vaccination, Tetanus, Diphtheria, and Pertussis (TDaP) vaccination, perinatal depression screening and post-partum depression screening. (3) The intensive PHC-medical director-led engagement meetings with clinicians and their support staff discussed not just the measures within the PQIP, but a variety of other topics related to quality, including perinatal substance use, and the American College of Obstetrician and Gynecologist (ACOG) prenatal care recommendations. Current data on perinatal services looking at state, county and practice specific performance was also reviewed. Provider practices were eager to review current practice guidelines and discuss data relevant to their practices and communities. Practices discussed their best practices which were shared with other practice sites. With the onset of COVID-19, these engagement activities changed from in-person to video format.

HEDIS performance for the Timely Prenatal and Timely Postpartum Care measures improved in all MCP reporting regions for MY 2019 to above the 90th percentile. While pre-intervention data is not available around depression screening rates, all visits required depression screening to be payable, which may have increased consistency of depression screening. We believe the addition of in-person visits to the expanded incentive program was the key to this success. Twenty three site visits were completed across the entire region, including all large and medium sized perinatal practices outside of Kaiser. Providers expressed a high degree of satisfaction with these engagement activities, requesting that they be conducted annually in the future. Some clinicians were not aware of the existence of financial incentives prior to these visits. The practice site visits revealed some challenges in connecting members with behavioral health services in certain communities. This provided PHC staff an opportunity to inform providers and practices regarding systems for accessing these resources effectively and efficiently. Communication between the practice and MCP staff allows the health plan to evaluate how services are provided, and assess billing practices, leading to improved communication between providers and MCP regarding visits, documentation, and billing practices, while building relationships.

Rady Children's Hospital

Ensuring Continuity of Care and Closing Care Gaps for California Kids Care (CKC) Members

Children with medical complexity have expensive, complex, and chronic conditions. These children may have functional limitations, need substantial services to maintain health, and are higher health resource utilizers. By redesigning how care is delivered, we can add value through improved quality, satisfaction, and costs. Prior to CKC, families often experienced communication challenges across multiple healthcare providers, supply delays, fragmented care, and were often disconnected from their medical home as they spend a large amount of their time in specialty care. The CKC whole child model of care is invaluable to our population as it provides a holistic approach to deliver and manage medical care, while also addressing social influencers to effectively meet needs of families.

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 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 many serious challenges including health status, socioeconomic level, and access to services. Given the complex nature of these conditions and the health disparities seen in Medi-Cal and served racial and ethnic members, CKC aims to offer innovative care navigation so that providers can better assess, monitor, and meet member needs to close care gaps and improve overall health outcomes.

CKC's holistic, whole-child model of care has proved effective in providing necessary support to families of children with complex conditions, and as an important component to close care gaps key to overall well-being. CKC Team is integrated into Rady Children's Hospital San Diego (RCHSD), which is a part of an established integrated delivery system with partnerships between primary care providers and specialty physicians. Through this established relationship, CKC Care Teams have a direct line of communication with all providers that serve our members and often work together to optimize care, re-establish medical homes and provide navigation to close care gaps. Through a team-based approach, families work together with their care team to attain the highest level of well-being. CKC's model of care includes highly skilled Nurse Care Navigators (Registered Nurses and Clinical Nurses) that have a background in each condition to reinforce pertinent education and provide individualized support. RNs and CNs work closely with Patient Care Coordinators (PCCs) to coordinate services and close care gaps by re-establishing medical homes with PCPs. Shared Electronic Medical Records (EMRs), care plans and dashboards are available to users for real-time information. RN and CNs attend comprehensive clinic visits and California Children Services (CCS) Case Conferences to support member needs, and meet regularly with clinical teams. This offers a unique opportunity to facilitate more efficient care of chronic medical conditions and avoid delays in care.

The goal of CKC is to offer innovative care management so that the entire team can better assess, monitor, and help meet their patients' needs to define and alleviate any unnecessary stressors for families that already face substantial socioeconomic barriers and health disparities. To measure our success, the CKC team has deployed a Quality Management Plan to monitor outcomes that is comprehensive and data driven. We provide framework, structure, and methodology to support the provision of care, the flow of information, performance improvement, and accountability for goal attainment. Results show that our approach to care is benefiting members. When comparing Fiscal Year (FY) 2019 and 2020 data we measured the following improvements: Annual Comprehensive Clinic Visits (54.6 percent to 87.0 percent), Annual Well Child Checks (W34) (54.9 percent to 73.0 percent), Dental Screening (79.1 percent to 94.3 percent), Annual Vision Screening (42.8 percent to 94.3 percent), Food Security Screening (15.8 percent to 56.4 percent), Transportation Screening (20.9 percent to 55.8 percent), Annual Influenza Vaccine (68.4 percent to 70.4 percent), Immunizations (35.7 percent to 62.4 percent), and MyChart Enrollment (61.8 percent to 75.5 percent). Our results from FY19 compared to improvements in FY20 show the profound impact our work has had on closing care gaps and improving preventive care measure for an extremely vulnerable CCS population of children. Improving member connection to their medical home, while building upon relationships with specialists, continues to be an area of success for CKC.

San Francisco Health Plan

Field Testing and Good Design Elements to Improve Comprehension of SFHP Notice of Action (NOA) Letters

San Francisco Health Plan (SFHP) sends out over 1500 Notice of Action (NOA) letters every month. When members receive these letters, they are confused and don't understand what they mean which can have concerning consequences for a member's ability to act on and utilize information accurately. Members often call SFHP's Customer Service department for assistance in helping explain NOA letters. This and other staff and member feedback led SFHP to conduct market research, which helped us identify an opportunity to improve our NOA letters. Themes from member and staff feedback are that letters are too text heavy, verbose, bland and the lack of formatting makes it difficult for members to sift through the information and know what, if any, action they need to take.

SFHP designed three versions of an NOA letter to field test with members via an independent market research firm. Usability and comprehension were assessed with three language specific groups: English (n=51), Spanish (n=21), Chinese (n=36). Field testing involved listening to members describe how they understood the letters' intent and what action they thought the letter was directing them to take. A field test moderator asked probing questions to assess usefulness of

letter design elements. Field testing outcomes were evaluated and a final version of a revised NOA letter was completed.

NOA letters appear to be a problem across sister plans. When we discussed what we were doing other plans were impressed and excited to hear about the research conducted and redesign of our letters, as their members were having similar issues. We realized the purpose and implications of NOA letters caused confusion for some members. In addition, some members experienced undue stress as a result of not understanding information provided in NOA letters. We feel that instead of accepting a standard letter template from the Department of Health Care Services (DHCS) that has been used for years, we were going to innovate and create an easy to read, visually clear design to help our members understand the next steps on services they requested. The National Institutes of Health (NIH) "Clear and Simple" guidelines for preparing content for low literacy users states: "Readers appreciate messages that are conveyed simply and clearly." SFHP considers our quest to create more user-friendly NOA letters to be innovative because our design team used principles of visual design to make the content more understandable, simple, and therefore more effective. Rigorous user testing allowed SFHP to gain feedback from members and arrive at a final NOA letter that improves readability and comprehension across a diverse member population. Innovative design that makes the member experience better and increases trust in SFHP can extend to a more positive and trusting perception of healthcare in general.

SFHP employed several design elements to improve comprehension of information contained in NOA letters. The website https://www.usability.gov/ describes these design elements in more detail: SFHP used colors to differentiate information, add emphasis, and organize information. SFHP organized information by importance, using information hierarchy, to show the significance between items. Items at the top of SFHP's revised NOA letters were what members understood to be the most important. For example, the name and contact information of a provider who requested approval of a service was shown in a blue framed text box at the top right corner so that members know who on their care team to follow up with if a specific action is to be taken. DHCS hasn't yet approved SFHP's revised Notice of Action letters, so, we're unable to report on specific outcomes of interest such as percent reduction in phone calls to SFHP requesting assistance with understanding NOA information. A second metric we are hoping to evaluate is the number of member appeals submitted based on poor understanding of NOA letters. SFHP will continue to apply good design principles to all member-facing communications and continue to innovate around how we communicate with our members, founded upon a commitment to better understand and respond to our members' experience.

SCAN

1. The Impact of an Opioid Case Management Program on Opioid Overutilization

Pain is a common problem among older adults and many are prescribed opioid pain medications. Opioids are effective at treating specific types of pain, but carry serious risks such as the development of opioid use disorder, overdose, and death. To reduce these risks in our health plan members, we developed the Reduce Overuse and Misuse (R.O.A.M) case management program for members at highest risk for adverse drug events (ADE) stemming from overutilization of opioids. Three goals of this program are to ensure that the member is receiving proper care, to limit care to one prescriber or pain specialist or group, and ensure that all prescribers within the past few months are aware of the member's medication regimen to reduce Adverse Drug Events (ADEs) associated with overprescribing or therapeutic duplication of opioids.

Members reviewed for inclusion into the R.O.A.M case management program were those considered highest risk for adverse drug events. These were members with fill patterns suggesting overuse or misuse such as those receiving multiple unique opioids, high dose opioids, opioids prescribed by multiple providers and filled at multiple pharmacies, or those with more than one emergency room visit related to pain

What makes the program unique is the inter-disciplinary team (IDT) involved comprised of a pharmacist and pharmacy technician, care managers which include registered nurses, licensed

clinical social workers, and behavioral health specialists, senior fraud investigators, and a physician. The pharmacist conducts the initial review of the following for each high risk member to determine the need for case management (CM): medical claims for psych diagnoses, current/past history of substance abuse, and prescription drug claims and cash payments for inappropriate dosing or dangerous drug interactions. If CM is necessary, the pharmacist refers the case in parallel to the care managers and fraud investigators. The care manager engages with the member and the member's health care team to enhance care coordination so one prescriber or pain management group is managing the pain and ensures that the member receives the services/benefits available to treat pain (e.g., physical/chiropractic/massage therapy, counseling, etc.). The fraud investigators investigate whether fraud, waste, or abuse (FWA) is present. Any FWA information found is relayed to the care managers which helps guide their discussions with prescribers or members when determining the action plan for pain. The R.O.A.M IDT meets on a regular basis to review the program for any changes, discuss difficult cases and lessons learned, and evaluate the outcome of case management to determine whether the goals are being met.

Eighty three members were enrolled in the program from 2013 to 2019. Sixty percent of these members were older than 65 years of age and fifty two percent were male. The top three pain diagnoses amongst these members included chronic pain, low back pain, and chronic pain syndrome. Fifty one percent of members had an average daily morphine milligram equivalent (MME) dose of more than fifty. Fifty three percent of members were on opioids for one to three years, twenty five percent were on opioids for more than three years and 22 percent were on opioids for less than one year prior to CM. To determine the impact of the program, the following metrics were reviewed three months pre and post CM: number of ER visits related to pain, average daily MME, unique opioid count, opioid prescriber count, opioid dispensing pharmacy count. When comparing these metrics pre and post CM, the following statistically significant results were observed: 39 percent decrease in the proportion of members with ER visits related to pain ($p = 0.02$); forty eight percent of members with an MME greater than fifty prior to CM had an MME less than fifty 50 post CM ($p = 0.023$); thirty nine percent decrease in the count of unique opioid claims per member per month ($p < 0.001$); fifty five percent decrease in the number of opioid prescribers used per member ($p < 0.001$); thirty five percent decrease in the number of opioid dispensing pharmacies used per member ($p < 0.001$). The results indicate that the CM program is an effective way to reduce opioid overuse and misuse. It serves as a means for increasing collaboration between plans, prescribers, and members which improves care coordination, reduces adverse risks, and helps keep our members safe.

2. Leveraging Technology to Meet the Behavioral Health Needs of the Medicare Advantage Population: A Payer-Provider Collaboration

As SCAN continues to focus on its mission of keeping seniors healthy and independent, we have continued to study where we can make the greatest impact in partnership with our network provider groups. SCAN recognizes the following: older adults present with depression and or anxiety, which impacts quality of life, and their ability to manage chronic conditions. Older adults encounter access to care challenges with respect to qualified behavioral health clinicians. Access to care challenges arise with the shortage of trained, bilingual clinicians, especially in remote geographies. Stigma associated with seeking and receiving behavioral health care deters patients from scheduling and showing up for appointments. Challenges with following through on primary care physician (PCP) referrals to behavioral health clinicians.

The target population included older adult members who were not currently under care and who could potentially benefit from tele-behavioral health. Other population characteristics include the following: number of chronic conditions with a behavioral health diagnosis and not currently under care for a predefined period of time; patterns of increased utilization of health care system resources (e.g., presenting at ED, acute admissions or readmissions); discharged from acute hospitalization or other facility setting, newly diagnosed with behavioral health condition.

To address the challenges experienced by the most vulnerable and high risk members, SCAN partnered with a network medical group to pilot an established tele-behavioral health solution. SCAN’s goal was to integrate behavioral health with medical health and provide access to culturally

and linguistically appropriate care. Specifically, SCAN and its provider partner engaged a virtual health company specializing in behavioral health with the following operational features: recruits and employs qualified clinicians, including bilingual clinicians; virtual visits accessible from the medical group's site office location (extended to at-home access in response to COVID-19); telehealth clinician integrated into client's clinical team and operations (includes ability to document directly in client's EMR system); streamlined coordination and communication with the member's referring PCP; continuity of care by having the same clinician assigned to the member. The in-clinic telehealth solution resonated well with the target population, evident with strong adoption and positive results. As a result of the pre-COVID-19 success, SCAN observed the tele-behavioral health company pivot quickly to offering virtual health services from the patient's home. A segment of high risk members was able to utilize at-home services, barring any technology issues or limitations (e.g., member's lack of access to smart devices with video or reliable internet connection).

SCAN strived to spur innovation with its network provider partners by introducing technology-enabled solutions to solve use cases deemed critical in patient care. Through attention on defining a clear business case, SCAN envisioned providing pilot partners with an opportunity to test digital solutions which may demonstrate value long-term and warrant continuation post-pilot. Since the pilot program launch in early 2019, the following results have been observed: Initiated tele-behavioral health visits of which a number have been for Spanish-speaking patients. Initiated visits in-home during COVID-19 pandemic (by both video and telephone). Number of days for first available appointment significantly less than traditional face-to-face, brick-and-mortar psychiatry. No-show rates also significantly less than traditional face-to-face, brick-and-mortar psychiatry. High number of patients surveyed responded favorably to their experience with virtual visits. With process-based measures and patient satisfaction scores pointing to the pilot program's success, the solution company's services will be expanded. A formal third-party program evaluation of this pilot will be completed; results are forthcoming at this point in time.

United Health Care

Quality Toolkits: A resource for Primary Care Providers

The Plan reported low HEDIS® rates for Measurement Year 2018, with just 44 percent of reported measures meeting the MPL. The Plan developed a strategic plan to expand provider engagement programs to increase HEDIS® performance rates. The Plan administered a survey to assess what could be done to better support providers in meeting HEDIS® measures. The Plan learned that many providers were in need of HEDIS®-related training. The Plan provided HEDIS® rates and custom reports on the Plan's Provider Portal. However, upon analysis of utilization, the Plan learned that very few practices accessed their custom HEDIS® reports and were therefore unlikely to use these tools to better manage members with gaps in care.

Providers delivering Primary Care Services were targeted, sorted, and prioritized based on number of gaps in care. Based on PCP feedback, the Plan created a Toolkit which contained HEDIS® training, information on provider and member engagement programs, regulatory updates, and custom enrollment and member care gap reports. The Toolkits were delivered in person to each PCP office and contents were reviewed with the Office Manager, Quality representative, or the PCP. All targeted practices were contacted by the designated Clinical Practice Consultant to coordinate the on-site trainings.

The Toolkit contents and in-person trainings were reported by PCPs as being innovative, and increased engagement with the Plan, as well as supporting HEDIS® improvement. Content addressed provider training needs regarding HEDIS® measures. The Toolkit visits afforded the opportunity to meet with staff and provided a forum for direct feedback regarding Quality and HEDIS®. The visits bridged communication gaps with practices. Our goal was to ensure the practices were informed on Health Plan services and to offer a seamless connection to Plan staff if needed. The staff conducting the trainings prepared for visits to the PCP offices by completing role play scenarios to anticipate potential questions that could arise during the visit. The visits also resulted in coordination to address unrelated needs, therefore increasing provider satisfaction. The

consultant was able to offer hands-on training to teach the staff how to access reports online. This led to an increase in office staff accessing reports on the provider portal. Provider offices were most interested in the custom reporting, incentive programs, HEDIS® training materials, member engagement programs, regulatory updates, and Health Education services. Provider feedback indicated a positive response; they welcome communication and were pleased to have time to meet with the Plan. Almost all practices requested subsequent routine meetings to ensure ongoing communication and prompt engagement for new requirements.

The Plan analyzed effectiveness of the program by monitoring completion of visits, timeframe for each session, and quality of the meeting. Almost 60 percent of targeted offices completed the in-person visit. Overall effectiveness of the intervention was based on the total number of measures meeting the MPL. The Plan reported an increase from 44 percent to 56 percent in the total number of MCAS measures meeting the MPL from 2018 to 2019, respectively. The Plan did observe value and success with this program and will continue to implement annually. Notably, the Plan was able to establish a relationship with practices, meet the designated staff in person, and build a collaborative rapport. Based on provider feedback and requests for frequent engagement, the Plan developed a quarterly Network Provider Quality meeting. The Plan has observed significant improvements in provider engagement including: 1) identifying at least one current point of contact per practice; 2) timely responsiveness to e-mail inquiries; 3) practices readily offering feedback or recommendations; and 4) practices are now asking to partner on quality initiatives and are sharing their best practices with the Plan.

MCP Collaboration

Blue Shield of California (Promise Health Plan) and Los Angeles (L.A.) Care Health Plan

Improving health outcomes in local communities by transforming health care.

Research shows that while medical care contributes to about 20 percent of health outcomes, social factors such as food and income security have a much greater impact on individual health. Blue Shield Promise and L.A. Care combined their capabilities to connect under-resourced communities with much-needed services and resources, helping to address the most pressing social needs. Through this unique collaboration and a combined $146 million investment, they will jointly operate 14 safe and inclusive Community Resource Centers across L.A. County that aim to improve health outcomes by keeping members and communities active, healthy, and informed. Health is local and a key principle of this effort is to customize programs based on the specific health and wellness needs of each resource center community.

The Community Resource Centers are located throughout Los Angeles County in areas where the health plans can provide more support and better serve low-income, marginalized and under-resourced communities that experience a high degree of health inequity. All health plan and community members can visit the resource centers and participate in the free classes, programs and services offered. When the Community Resource Centers are fully operational – seven of the planned 14 centers are built out, but temporarily closed due to COVID-19 – they will serve more than one million community members annually.

This collaboration marks the first time two health plans join forces to bring services and resources to community members through the jointly-operated resource centers. Through health plan community outreach representatives, on-site care managers, and community health workers, the resource centers will enhance community connections, address social needs and improve overall health outcomes for members and the entire community through a wide range of free health education and wellness classes, health screenings, and enrollment support for social services programs. Further, the onset of COVID-19 and shelter-in-place orders have resulted in a significantly higher demand for telehealth services. To improve health care access during the ongoing pandemic, the Community Resource Centers, upon reopening, will provide health plan members and the community a secure high-speed Wi-Fi connection for telehealth services. The Wi-Fi connection will enable those who do not have robust mobile data plans to access Teladoc and

other telehealth services at the resource centers. Members and the community can request use of the Wi-Fi connection and a private room to conduct telehealth visits with their providers.