# *Third Annual Innovation Award for Medi-Cal Managed Care Health Plans*

October 2017

California Department of Health Care Services

2017

# Award Winner

## Inland Empire Health Plan

Behavioral Health Integration & Complex Care Initiative

# Runner-up

## Kern Family Health Care

Medical Respite: Rest and Recovery Program

# Third Annual Innovation Award, October 4, 2017

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 beneficiaries. 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 the summaries of the nomination to MCPs for voting. MCPs were asked to submit one vote, but were not allowed to vote for their own MCP.

DHCS received eighteen nominations from twelve MCPs.

# AWARD NOMINATION SUMMARIES

## Anthem Blue Cross

### 1. Business Change Management: On-Site Staff Support - Provider Consultation

Provider offices requested assistance from Anthem in determining when and how to implement preventive care for their patients to satisfy quality, safety, and facility site review recommendations. The offices required assistance to develop action plans to improve scheduling procedures, management of members requiring preventive care and back office process flow. The target offices consisted of low performing medical record review (MRR) scores on Facility Site Reviews (FSRs) and those with lower HEDIS® rates. A dedicated Anthem Registered Nurse or designee worked onsite to evaluate practice patterns and conduct a MRR working with the physician, mid-level provider, and all other office staff. This innovative project brings both the MCP and provider office into a joint collaborative environment to create change. The development of Plan-Do- Study-Act (PDSA) facilitates bringing traditional quality tools into a provider office to improve systems and processes. Anthem was able to provide identification for consistent and accurate MRR utilizing practice guidelines, resolution of competing priorities for front and back office staff for enhanced flow, and strategies for bringing in members for preventative care to influence closing gaps in care. The outcomes of the program identified best practices while supporting preventive care. The provider office improvements included (1) A decrease in room wait time for vital signs by a medical assistant from a baseline average wait time of 5-20 minutes to an average wait time of 1-6 minutes; (2) The identification of all Gaps in Care for members – the baseline results varied based on registration staff but improved to 100% identification at time of registration; (3) Adult MRR also improved from 56.76 percent to 80.56 percent (24.22% improvement).

### 2. Onsite Care Coordination: Member Centric Approach

Anthem noticed high readmission rates and challenges with engaging members to coordinate post discharge care. Anthem: targeted specific hospitals with high risk members 18 years old and older, with three or more readmissions in the last 12 months, who were unresponsive to previous telephonic case management (CM) interventions, and who were non-compliant with post discharge follow up care. This program involved the deployment of an interdisciplinary care team (Registered Nurse (RN), Social Worker (SW), non-clinical support) onsite in a facility to start member engagement and care transition with the hospital discharge planner. Another important element of this program is the partnership with the hospital, which has allowed Anthem Care staff to meet face to face with the member during hospitalization; allowing staff to start building relationships and maintaining engagement post discharge. The intervention included scheduling primary care physician (PCP) appointments within seven days of discharge and attending the first discharge appointment with the member; performing home visits to ensure a member centric action plan is in place and improving communication along the continuum of care. The Anthem Care team seeked to understand and eliminate the member's unique barriers to self-care and provide education on frequent readmission indicators. The face to face interventions have shown significant increase in member engagement and in reducing readmissions. Member engagement via the phone has increased from less than 40 percent to greater than 85 percent. During the initial roll out in 2016 a particular facility in Fresno had a 39 percent reduction in readmission. In 2017, Anthem rolled out this program in three other counties, with three facilities, and year to date results show an average of 17 percent readmission reduction.

## CenCal Health

### Diabetes: Retinal Eye Exams Performance Improvement Project

Comprehensive Diabetes Care (CDC) is a priority for CenCal Health and while performance is exceptional for most of the CDC sub-measures, in 2015 a disparity existed in the rate for diabetic eye exams for HEDIS®. CenCal Health achieved a rate of 71.36 percent for the Santa Barbara County (SB) population, surpassing the nationally established High Performance Level (HPL) benchmark of 68.04 percent. In comparison, the rate achieved for the San Luis Obispo County (SLO) population was 65.59 percent. In 2015, CenCal Health's largest provider, a Federal Qualified Health Center (FQHC), had clinic sites in both counties and had the greatest percentage of SB and SLO members combined (58.45%) in CDC sub-measure for diabetic eye exams. Staff identified one of these FQHC sites as a high volume, poorly performing site, with the 3rd lowest rate of all SLO provider sites. CenCal Health's Performance Improvement Project (PIP) targeted SLO diabetic members with that site as their PCP. Innovative use of EyePACS telemedicine, supported by new delivery system workflow efficiencies and coordinated patient outreach, were the PIP's basis to achieve extraordinary increases in retinal screening utilization. New implementation of standing orders for retinal photography empowered PCP medical assistant staff to efficiently increase access to

retinal photography and eliminate specialist referrals for routine screenings. The PIP partner site's retinal eye exam rate improved from 51.7 percent to 82.5 percent, or more than 30 percentage points over the prior year, equal to a 59 percent improvement in the site's HEDIS® rate. The overall rate in SLO County improved more than 11 percentage points, or a 19 percent improvement over the prior year, surpassing the HPL. The FQHC is using lessons learned from this project to sustain and spread best practices throughout its clinic system, while CenCal Health is expanding the successful model for delivery system innovation to additional provider partners.

## Central California Alliance for Health

### Shared visions: Activating a community's strengths to address MAT network adequacy

The escalating rates of opioid prescriptions, overdoses, and deaths challenge the ability of communities to meet the demands of the opioid epidemic. Central California Alliance for Health (Alliance) has aligned its efforts with California Health Care Foundation (CHCF's) Smart Care goals supporting our provider network, expanding our medical benefits, and implementing guideline-driven formulary changes. Leveraging the unique strengths of our Plan, the Alliance instituted several innovations: (1) an opioid registry - integrating state carve-out data with opioid claims to identify/trend high-risk members and prescribers for targeted interventions. (2) Primary Care Physician Medication-Assisted Treatment (PCP MAT) Incentive (Pending Board approval) - Incentivizing PCPs $1,000 to acquire an MAT-prescribing X-license. (3) Pain management website – delivering resources to providers and members on chronic pain management and MAT services. (4) Payment Reform – reimbursing PCPs fee-for-service over capitation for member provided MAT. To strengthen MAT-provider network growth, the Alliance partnered with a community coalition developing a Peer Mentoring Program rooted in the strengths and identity unique to the Santa Cruz/Monterey Area: community and collaboration. The first meeting was a shared meal held at a clinician's home. Thirty providers from Santa Cruz/Monterey convened for a panel discussion of MAT strategies. The personal and professional connections cultivated during this meeting cemented vital relationships among the providers. Embracing a supportive, community model, with clinicians engaged as both teachers and learners, sharing responsibility for managing these complex encounters while feeling greater connection and purpose.

## Gold Coast Health Plan

### Child Developmental Screening Improvement Project

A study by *Pediatrics* indicated that 67.5 percent of children with delays are not detected by physician observation alone so the information collected from parents on developmental screening questionnaires is critical because the home is the ideal setting for detecting developmental issues. However, a national survey of children's health conducted in 2007 by the Center for Disease Control and Prevention showed only 21 percent of parents with 10 to 47-month old children had completed a developmental screening questionnaire. Children on Medicaid are particularly vulnerable to acquiring developmental issues due to living in households with lower socioeconomic status. In 2016, Gold Coast Health Plan's (GCHP) findings from an analysis of claims data for services between January 1, 2015 to December 31, 2015 showed significantly low utilization of developmental screenings in children ≤ 24 months. Due to these findings, GCHP implemented an improvement project to test an intervention with a local clinic that had low child developmental screening rates. GCHP focused on full-scope Medi-Cal children who are 8 to 11 months of age and assigned to Sierra Vista Family Medical Clinic. GCHP partnered with Help Me Grow (HMG) Ventura County, a local and national organization that promotes and trains healthcare providers on standardized child developmental screening tools. HMG trained the clinic's staff on the Ages and Stages Questionnaire third edition (ASQ-3) developmental screening tool and provided multi-lingual reference guides the clinic could use to help parents complete the questionnaires. The clinic's 9-month ASQ-3 rates increased from 23.08 percent to 80.00 percent. The clinic reported that parents were more prepared to discuss their child's development and answer questions on the ASQ-3, pediatricians abandoned their perception that the ASQ-3 was time-intensive, and the ASQ-3 was incorporated into all well-child exams.

## Health Plan of San Joaquin

### 1. New take on Collaborative Provider Partnership

HPSJ had seen gradual declines in HEDIS® measures over the last few years. After a deep-drill, a way forward emerged: The road to HEDIS® success would run through a different kind of focused collaboration with our provider network. HPSJ Provider Partnership Pilot began in 2016. The mission: directly impact our members where we were scoring below the Department of Health Care Services' (DHCS) "Minimum

Performance Level" (MPL). HPSJ assembled an in-house, multi-disciplinary team of experts, including Quality Division nurses and HEDIS® Coordinators, Provider Services Representatives, and Claims and IT leads. Invited to participate were 10 practices covering 54 percent of HPSJ's membership. HPSJ started by listening to the providers. We asked, "What do you need from us? What tools can we tailor for you?" This collaboration caused practice staff to dive into an intense partnership with us, including enhanced online GAP Reports, dedicated HPSJ team members regularly connecting at practice offices, quick problem-solving such as help resolving prior authorization hold-ups, enhanced care management and coordination, and new tools to better understand claims and compliance issues. Best practices were cascaded among pilot partners – and then refined, together. HPSJ had 23 measures below the MPL. After six months, 14 measures were below the MPL. Building on pilot success, for 2017 we've kicked off Provider Partnership 2.0, now with 17 practices covering 68 percent of our members. Pilot tools are also proving valuable for ALL of our providers.

### 2. Call Center Outreach – Asthma Medication Management

With a Minimum Performance Level (MPL) for Medication Management for People with Asthma – 50 percent at less than the MPL for three consecutive years – HPSJ was facing increasing challenges in controlling persistent asthma for members from ages 5 – 64. HPSJ boiled it down to this: non-compliance for "controller" medication. Despite past member/provider interventions, MPL numbers had not budged. The normal practice of outbound calls to members conducted by messaging through automated calling was not working. With limited time remaining for HEDIS® year 2016, HPSJ convened a partnership of HPSJ staff, providers caring for asthmatic HPSJ members, pharmacists – and the members themselves (or the parent or caregiver for non-compliant children). With HPSJ's Quality Department coordinating, a script was developed by Pharmacy staff, then sent to HPSJ Customer Services Representatives (CSR). Team CSR took the lead to make outreach calls to non-compliant members. CSR staff are very familiar with our population. With their persuasive skills, and their ability to probe the various challenges facing the non-compliant member, CSRs were able to educate on the controller med, address specific challenges (from getting a timely provider appointment, to transportation barriers), and they could immediately answer other questions. Going above and beyond compliance, CSR staff offered practical supports. Their caring approach helped members understand HPSJ's very real concern for their health. Beyond compliance numbers, staff demonstrated to each member: we are invested in your health. Out of a 3,411 member call list; 718 were completed. Of these: 133 members (18.52%) filled controller prescriptions within 10 days; 318 filled within 30 days (44%) and 391 within 62 days (54.5%). The MPM 50 percent compliance had been below the MPL for HEDIS® MY 2015, for both our counties. Due to this intervention, increased results put Stanislaus County over the MPL in 2016, with San Joaquin County close to that level.

## Inland Empire Health Plan

### Behavioral Health Integration & Complex Care Initiative

The health care system serving the Inland Empire has too few providers and isolated partners who are disconnected from the behavioral health system. This results in poor quality of care, poor health outcomes, and prohibitively high costs. A lack of technology infrastructure further compounds the problem. The Behavioral Health Integration Complex Care Initiative (BHICCI) aims to engage provider teams to test and implement fundamental practice changes in order to develop an array of "health homes" and integrated complex care management teams within local health organizations. BHICCI, focuses on individuals who have two or more chronic conditions: a chronic medical condition and a mental health disorder and/or a substance use/addictive disorder, individuals who will benefit from care management, and individuals who are Inland Empire Health Plan (IEHP) members. Through the BHICCI, IEHP provides funding to 12 healthcare organizations with 30 participating clinics to develop integrated, multidisciplinary care teams to care for the most complex patients served by these primary care, behavioral health, and specialty clinics. The complex care team is comprised of four core members: a behavioral health clinician, a nurse care manager, a care coordinator, and a primary care physician champion. Together the team manages and cares for a caseload of people with complex needs including co-occurring chronic medical, mental health, and/or substance use conditions, who also may be frequent utilizers of emergency room or inpatient services. An analysis of physical and behavioral health outcomes data collected between January 1, 2016 and June 2, 2017 shows the following preliminary results: (1) Participants whose baseline PHQ-9 was > 10 (n=828) showed on average a 4.7 point reduction in total score at latest follow-up. Average baseline Score: 17.1; Average score at latest assessment: 12.4. (2) Participants whose baseline systolic blood pressure was > 140 (n=364) showed on average a 16.6 point reduction at latest follow-up. Average baseline Score: 151.9; Average Score at latest Assessment: 135.3.

# Kaiser Foundation Health Plan

## The Permanente Medical Group's Opioid Safety Initiative

The US makes up less than 5 percent of the world's population but consumes 80 percent of the global opioid supply. Between 1999 and 2015, over 180,000 people died from prescription opioid-related overdoses, and in 2012 alone, nearly 170,000 Americans were admitted to hospitals due to opioid abuse issues. To combat this epidemic, Kaiser Permanente Northern California launched the Opioid Safety Initiative (physicians from the Permanente Medical Group – TPMG). The goal of the Opioid Safety Initiative is to improve the safety with which TPMG physicians prescribe opioid medications to all patients throughout Northern California, particularly close attention is paid to patients who are on higher dose, chronic opioid medications. Initially, the threshold was set at approximately 100 MME (morphine milligram equivalent) per patient per day; however, as the initiative has grown and become more successful, the threshold was lowered to approximately 50 MME per day. Physician education experts developed curricula that were didactic and tailored to the needs of the specific service line. "Opioid Leads" (physicians with a specific interest and expertise in improving opioid safety) were established throughout northern California to provide local oversight and guidance as the initiative was rolled out while also reporting back to regional leadership to ensure implementation was done consistently and that any "bright spots" or best practices at one medical center could be adopted and spread to all. Between August 2016 and August 2017, KP Northern California Medi-Cal members on high dose opioid medication (a three-month average of 50 MME per day and above) decreased by 14.2 percent from 1,568 to 1,345 members. Additionally, the percentage of that population with a signed opioid medication agreement (a safety agreement or contract between the patient on opioids and the prescribing physician) increased from 63 percent to 72 percent. Finally, the percentage of that population with a recent Urine Drug Screen (another recommended safety monitoring practice) went from 67 percent to 73 percent. Since the inception of the Opioid Safety Initiative, KP Northern California has seen a 42 percent reduction in opioid prescriptions across all KP members.

# Kern Health System

## 1. Kern Health Systems PCP Connect Program/Use of an ED Navigator

Bakersfield Memorial Hospital (BMH) data shows that Level 4 Emergency Room (ER) Visits (Level 1 = Highest) are represented as over 50 percent of the total visits in their ER from July 2014 - June 2015. These visits are lower acuity and often best managed and resolved in a visit to the PCP or Urgent Care, which would alleviate over usage of the Emergency Department (ED), allowing more efficient treatment of higher acuity emergencies. The ED Navigator/Primary Care Physician (PCP) Connect Program at BMH is unique and entails a dedicated Medical Social Worker residing directly in the Emergency Room. The Medical Social Worker (MSW) meets with Kern Family Members as they discharge from the ED in order to connect them with their PCP, ensure discharge orders are addressed, and educate them on coordinating their healthcare while addressing identified barriers and providing referrals. The goal is to connect the member to their PCP and prevent inappropriate ED usage in the future. From 11/1/16 to 5/31/17, there were 1,114 member contacts of which an average of 55.9 percent were scheduled for an appointment with their PCP and with 64.3 percent who kept that appointment. Future ER utilization after that PCP contact is in the process of being analyzed.

## 2. Medical Respite: Rest and Recovery Program

Homeless adult men and women with complex needs are often too sick to be discharged to the streets or shelters, but not sick enough to remain in an acute care facility. Typically presenting with multiple chronic conditions, needing Intravenous (IV) antibiotics or Intramuscular (IM) chemotherapy therapy and/or extensive wound care, requiring home health nursing visits that the homeless cannot be provided, leading to relapse, readmission, and sometimes death. Medical respite care is post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital. Unlike "respite" for caregivers, "medical respite" is short-term residential care that allows homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services. Kern Health Systems has agreed to payroll an eight (8) bed Medical Respite Program available to individuals who are homeless or lack a physical address at the time of discharge from an acute care, inpatient facility. Currently there is no Medi-Cal reimbursement for this service but like other Transition of Care services, safe and thorough discharge arrangements can assist in preventing readmissions. Upon discharge from an acute care inpatient facility, short-term residential medical respite care is provided to homeless adults with physical and/or mental health conditions that would be exacerbated by living on the street, in shelters or other places not suitable for human habitation. Intensive case management services are provided to these members during their stay, including all follow up medical, dental, behavioral health and

social service appointments. Goals for care include: follow up with primary and specialty medical care, case management services, mental health services, chemical dependency treatment and transportation. We estimate that the *Rest & Recovery* program will serve up to 365 individuals annually.

# L.A. Care

## 1. Postpartum Outreach using Safety Net Connect (SNC) Hospital Delivery Data

L.A. Care's Medi-Cal HEDIS® rate for timeliness of post-partum care has been below the National Committee for Quality Assurance (NCQA) 25th percentile since 2011. For this reason, the Healthy Mom Program was initiated to improve the post-partum care visit rate through an outreach program for members who have recently given birth. The limitations of member outreach are the lack of Plan's ability to identify a live delivery on a timely basis due to incomplete set of available data and the lag time from hospital claims data. L.A. Care focused on members who had a live birth. In order to engage more women to seek timely postpartum care, the Healthy Mom Program conducts outreach to women who recently delivered a live birth. The Plan hired Community Health Workers (CHWs) to assist with scheduling a post-partum visit and offers transportation and access to an interpreter if requested. CHW were able to reach a greater number of members due to the Plan's ability to receive hospital discharge data of women who had a live birth. This was made possible by eConnect Platform, a system that links data from 31 network hospitals that are responsible for 80 percent of the Plan's hospital admissions. After the scheduled appointment date, CHW confirms member's receipt of appropriate care through provider validation calls. Since the availability of hospital discharge data via eConnect Platform, the Healthy Mom Program has received over 236 percent additional identified members to assist with scheduling a timely post-partum visit. Preliminary 2017 HEDIS® rate for post-partum care indicates that it has increased by 4.10 percent in comparison to 2016.

## 2. Social Media Ads Promoting Cervical Cancer Screening

Cervical cancer screening (CCS) rates have declined over time. Reminding members to be screened via conventional methods like phone and mail has proved challenging and often expensive, in part due to common issues impacting Medi-Cal members such as disconnected phones and unstable housing. Therefore, L.A. Care purchased advertisements on Facebook that encouraged young women to get screened for cervical cancer. Because of the widespread use, Facebook provides a platform to remind members to seek care and provide education on the importance of preventive screenings (84 percent of households with incomes less than $30,000 per year are users). The Facebook ads targeted women residing in predominantly low-income zip codes with the highest numbers of noncompliant members for CCS. The age range of 21-29 was selected because it had the lowest CCS rate and avoids the more complex messaging related to HPV co-testing. Facebook advertisements were an opportunity for L.A. Care to provide public health messaging to large groups of individuals, many of whom are L.A. Care members. While this strategy is a nonconventional approach to providing health information, it allows for precise targeting of populations by demographics and location at an affordable price compared to traditional media. Multiple messages and images were tested to see which generated more interest. The real-time results of the campaign allowed L.A. Care to make adjustments to optimize effectiveness. The ad was displayed 313,494 times to 157,978 unique individuals over 22 days. With a modest budget of $2,000, this campaign was a fraction of the cost of a mailed reminder or call campaign. This pilot demonstrated the ability to reach a large audience with short, simple messages, at a low cost.

# Molina HealthCare of California

## Practice Facilitation

Molina identified that improvement was needed in several of our HEDIS® rates, which fell below the Department of Health Care Services Minimum Performance Levels (MPLs). In 2015, Molina joined the Practice Transformation Initiative, a 4 year Practice Transformation Grant funded by Centers for Medicare and Medicaid Services (CMS) to the Pacific Business Group on Health (PBGH)/California Quality Collaborative (CQC), one of 29 initiatives awarded across the country. Using clinic based fallout analyses, Molina identified clinic settings in Sacramento, the Inland Empire, and Imperial County for the implementation of Practice Facilitation. Practice Facilitation is provided to primary care clinics by a trained team of individuals using quality improvement (QI) and practice improvement approaches and methods to build the internal capacity of a practice to help it engage in improvement activities over time and support it in reaching incremental and transformative improvement goals. It provides a "bottom-up" not "top down" approach to solving problems, and has a bias towards action. Molina created a team approach to help practices improve results including technical and clinical subject matter experts, Quality leadership to engage leaderships at practices, and practice facilitators in the field. Molina was the first health plan to join it's cohort at PBGH. From 2016 to 2017, Practice Facilitation strategies resulted in Molina HEDIS® rates

exceeding the MPL: 28 percent overall improvement for all counties, 78 percent overall improvement in Imperial County, and 47 percent overall improvement in Inland Empire

## Partnership Health Plan of California

### 1. Medication Synchronization: Improving Medication Adherence and Reducing Cost

A 2016 Center for Disease Control and prevention report mentioned, during 2011-2014, 23.1 percent of patients used three or more prescription drugs in the past 30 days while 11.9 percent used five or more prescription drugs. Taking multiple medications may require multiple visits to the pharmacy, which can impose significant burdens on a patient's resources, especially for those residing far from any pharmacies. As a result, prescriptions may be filled late or not at all leading to non-adherence and poor patient outcomes. Medication Synchronization is a tool that syncs all of a patient's medication for a convenient, monthly single day pick-up. For patients taking multiple chronic medications, medication synchronization helps ensure their entire medication regimen is filled and picked up, thus improving adherence. In addition, Medication Synchronization is more convenient for the member and helps reduce member costs associated with traveling to pharmacies, especially important in rural areas without local pharmacies. In the typical model for medication refills, the patient calls the pharmacy to order their refills. Some refills may require the prescriber's authorization while for others the medication may be out of stock. Both situations often result in delays and sometimes a second or even a third trip to the pharmacy. Medication Synchronization assigns the same day each month for chronic medications to be picked up, thus providing an opportunity to address any issue prior to the appointment date. Pharmacist counselling is routinely provided at this monthly visit. A few pharmacies in PHC's network offer Medication Synchronization services. Implementing a Medication Synchronization program requires commitment, time, and energy of pharmacy managers and staff. PHC is working directly with receptive network pharmacies to provide education, resources, and incentives to develop, improve, and expand their Medication Synchronization programs.

### 2. PHC@PHC - (Partnership Healthplan of California at Project Homeless Connect)

Since 2009, Project Homeless Connect has been offered annually in Shasta County as a one-day multi-service event for individuals that are experiencing homelessness. Many of the healthcare services offered by volunteers and donors in the past were offered pro bono and thus not measurable. Those attending this event are experiencing homelessness. Partnership Healthplan of California (PHC) sought to engage attendees who were identified as PHC members and offer help in closing gaps in preventive care. Intensive health plan participation in this homeless outreach event had not been done previously. By utilizing a member incentive, PHC was able to engage 254 medically vulnerable, hard-to-reach members in one day. We communicated the value of seeking care from a Primary Care Provider (PCP) while capturing their most current contact information. Some were genuinely unaware of their benefits and learned for the first time about their coverage. From there, members identified to be in need of targeted screenings were incentivized to complete them. Incentives were offered for screenings to address HEDIS® Measures: CCS, MPM, and CDC – HbA1c testing, CDC – Nephropathy and CDC – Eye Exam. Additionally, initial prenatal exams were available on-site for pregnant members. Of the 315 attendees we engaged, 254 or 81 percent were Partnership Healthplan members with address origins from Humboldt, Mendocino, Shasta Siskiyou, Sonoma, and Trinity Counties. Of the 254 members, 104 (41%) were found to have had an Affordable Care Act Aid Code affiliated with their Client Identification Number, 196 (77%) updated their contact information, 209 (82%) stated that they are receiving care from their assigned PCP and 31 (12%) elected to change their PCP. Of presenting members, 22 percent (46) members were on *recommended* gap lists for cervical cancer and diabetes screenings. Twenty (20) HEDIS® preventive screenings (CCS, CDC-N, and CDC-HbA1c) were completed on-site. PHC Care Coordination offered assistance in following-up on 25 additional screenings that could not be completed at the event.

## San Francisco Health Plan

### 1. San Francisco Health Plan (SFHP) & Flywheel Non-medical Transportation Initiative

Transportation is a common barrier for members in SFHP's Care Management programs, which impacts appointment compliance and healthcare access. To address the transportation barrier, the program historically supplied Coordinators with taxi vouchers. Often, however, Coordinators experienced long call wait times for scheduling, late pick-ups, and a high number of taxi no shows, causing clients to arrive late or miss appointments. SFHP's Care Management clients are members with complex medical conditions and/or

high emergency department and hospital utilization. Clients often experience additional transportation barriers due to their complex medical conditions and mobility impairments. In 2015, Care Management leadership piloted and instituted a new taxi service system using Flywheel, a mobile application that connects passengers with licensed drivers. By allowing passengers to order taxi rides in real-time, track arrival with GPS and automatically pay fares via an online account, this system simplified taxi use for Coordinators and their clients. Additionally, Flywheel was proactive in ensuring that the service adequately serves passengers requiring wheelchair accessibility and consulted with SFHP in the development of this application feature. This is the first partnership between a Medi-Cal Managed Care Plan and Flywheel and has been featured by the Center for Health Care Strategies in a February 2017 brief for its innovation in leveraging technology to serve the transportation needs of some of the most vulnerable members of the Health Plan. Coordinator and client feedback has been overwhelmingly positive. Additionally, the system has enabled the Care Management program to track pickup and drop-off locations, frequency of rides per month and by staff, and cost, which has increased efficiency of tracking taxi spending and provided insight about use of the service. Data is available upon request.

## 2. Priority Five Pay-for-Performance Incentive Structure

Since 2011, San Francisco Health Plan (SFHP) has offered a pay-for-performance program to drive improvement in quality care and experience for Medi-Cal members. SFHP saw great provider engagement in this program, and an opportunity to improve the rate of clinical improvement in measures such as cancer screening, pediatric immunizations and preventative care, and diabetes management. Through surveying participating providers, SFHP determined that the program had too many metrics for providers to focus improvement efforts. As a result, there was overall less improvement than SFHP and providers thought to be possible, due to how the incentive was structured. Many pay-for-performance programs incentivize performance by offering the same incentive for each indicator. The Priority Five scoring mechanism is different by giving providers greater incentive to improve their lowest five indicators, as well as a smaller, separate incentive for maintaining performance in the other metrics. The underlying assumption is that improvement across many indicators is harder than across fewer. If successful, SFHP expects clinical quality performance to sustainably improve across all indicators over the next several years. As of the current cycle 75 percent of priority measures have attained the HEDIS® 90$^{th}$ percentile or rewarded relative improvement, a 25 percent improvement from baseline. Additionally, 86 percent of non-priority measures have maintained their baseline. This aligns with and supports SFHP's overall clinical performance in reporting year 2017, achieving the 90$^{th}$ percentile in 43% of clinical External Accountability Set (EAS) measures.