

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

October 2019



2019

Award Winner

CalViva Health

CalViva Postpartum Visit Disparities
Project with United Health Centers
Mendota Clinic.

Runner Up

**Health Net Community
Solutions, Inc.**

Cervical Cancer Screening Disparity
Project among Chinese Women in
San Gabriel Valley.

The Second Annual Health Equity Award, October 30, 2019

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

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

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

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

DHCS received ten nominations from seven MCPs.

AWARD NOMINATION SUMMARIES

Anthem Blue Cross

1. Addressing Maternal Health Disparities in African Americans in Fresno and Alameda Counties through a Multi-level Approach (August 2018 – January 2019)

African American women in California have the highest rates of preterm birth and infant mortality according to the March of Dimes and the Centers for Disease Control and Prevention. Anthem Blue Cross (Anthem), identified the highest rates of maternal health disparities in Fresno and Alameda counties for our Medi-Cal members. Our work focuses on mobilizing community partnerships by strengthening our role as a connector between the member, provider, county and community-based resources.

Anthem's vision is to improve birth outcomes for African American women and their babies and our goals are: (1) Improve the identification process of women with the highest risk and connect them to timely and appropriate care resources; (2) Increase awareness of Birth Equity among providers and of local county nursing programs; and (3) Pioneer a claims payment methodology enabling the provision of doula services to Medi-Cal members.

Anthem used multiple sources of quantitative data for the disparity analysis. Year-end Healthcare Effectiveness Data and Information Set (HEDIS) data was used to compare prenatal and postpartum rates among different racial groups using DHCS enrollment data. A chi-square test of independence was used to confirm the statistical significance of the disparity. In addition, other quantitative data included claims and encounter data which was used to understand impatient utilization in relation to preterm labor and delivery. Public county data was also used to confirm county trends and rates.

Anthem conducted key informant interviews with local county health program staff and with subject matter experts from organizations such as the California Maternal Quality Care Collaborative, March of Dimes, and First 5. These organizations have conducted focus groups in the community and Anthem relied upon their footprint in the community and learnings from focus groups to guide our work.

The intervention was customized to the target population by meeting with local community partners in multiple counties to learn about the barriers and challenges that influence the identified disparities. Through these discussions, Anthem created a root-cause analysis and mapped out interventions that would address the identified barriers. The interventions that have been implemented resulted from ongoing dialogue with stakeholder organizations where they provided input on their community needs. A roadmap has been shared with internal and external stakeholders throughout the year to ensure continuous feedback and collaboration. For example, the local county nursing program and both target counties expressed the need for health plan support to provide doula services. Anthem developed a doula payment project, which we are currently piloting with the recommendation of someone who is embedded in our target population.

Anthem utilized an innovative approach to address the target population needs through predictive modeling and developing the doula payment system. The predictive modeling enabled the identification of pregnant women by race who have a history of prior preterm labor and delivery. This was accomplished by connecting demographic race data from the DHCS enrollment file to various pregnancy notification data and finally, to prior claims history. The doula payment system is the first contract of its kind to be developed in California, to our knowledge, as other programs have

been grant funded. This new payment model enables payment of doula services through a claims based system.

Anthem identified a group of process measures and outcomes measures, in order to evaluate the intervention's effectiveness. Those measures include: (1) the number of women who are identified, engaged with high risk obstetrician case management, and their final outcome; (2) the number of attendees to webinars and the number of educational visits to providers; and (3) the number of members in our cohort, the number of doula encounters, and their final outcomes.

The outcomes are not yet available.

2. Health Days: Connecting Disengaged Members Experiencing Homelessness to Preventative Care Services (January 2019 – Ongoing)

According to the Kings/Tulare Homeless Alliance, there are over 950 people in Kings and Tulare counties who are experiencing homelessness and utilizing transitional housing, emergency shelter or unsheltered living situations. In collaboration with our internal data analytics team, we are able to generate a monthly disengaged members report. This report consists of members that have not had any visits with their Primary Care Physician (PCP) in 12 –36 months and show any gaps in care. Over 200 members in Kings County with “general delivery or post office box” were identified and a telephone outreach project identified many members as experiencing homelessness. Anthem partnered with a faith-based agency and local clinic with mobile units to bring urgent care and preventative health care services to existing bi-weekly shower ministry events at a local church, where homeless individuals have access to showers, clean clothes, toiletries, and meals. Anthem referred to these events as Health Services Days and services included: health assessments, immunizations, and diabetes glucose screenings.

Based on our disengaged member report, Anthem gathered quantitative data, which is developed primarily from claims and encounter data. Additionally, Anthem was able to identify members with post office boxes and general delivery addresses and examined the services that they needed to complete based on HEDIS data. Anthem worked with First Church of God in Kings County to provide qualitative data from community members who seek basic services such as personal hygiene and food, due to homelessness. Anthem also conducted outreach calls to assist with appointments, transportation and referrals to case management.

Anthem customized the intervention by meeting with Aria Health Clinic's Quality Director and First Church of God's Pastor and administrative staff. A partnership was created with the faith based organization to provide a Medical and Health Education component to our members as they attend the bi-weekly shower ministry event. The innovative approach used to address the target population included the following: partnering with a clinic and faith based organization in order to bring health care access and education to an existing community event, telephonic outreach to disengaged members, and health educators on site for one on one education involving key health topics (diabetes, tobacco cessation, controlling blood pressure, immunizations, and nutrition).

This intervention is evaluated through monthly provider encounter and claims data. Anthem performed 255 telephonic outreach calls to members, mailed out 78 letters to members on a do not call/disconnected list, and attended five health events. A total of 113 members received non-emergency health care services. Sixty seven members received one on one health education on the following topics: (15) diabetes, (31) tobacco cessation education, (22) blood pressure control, (17) immunizations, and (67) nutrition. During the ongoing health education, 15 members confirmed they decreased or quit smoking, 10 members found a new medical home, and four members followed up with a PCP for ongoing care.

Blue Shield of California Promise Health Plan

1. Art Therapy Project (July 2019 – Ongoing)

Blue Shield of California (BSC) Promise Health Plan partnered with the Boys & Girls Club of Metro Los Angeles, Challengers Clubhouse, and Wellnest (formerly Los Angeles Child Guidance Clinic) to launch a Blue Shield Promise community art therapy program in South Los Angeles. The goal of the program is to help at-risk youth express their emotions and assist them in building relationships with others. The program enables kids who are undergoing physical, emotional, or mental crises to increase their ability to explore, discover, and interpret reality in a safe place.

The death of famous rapper Nipsey Hussle served as an inspiration for the Art Therapy Project. Nipsey Hussle served as a role model for youth, and was admired for his community activism, funding improvements to the neighborhood schools, spending time with students, and participating on panels about growing up in the area and the influence of gang culture. Social workers and behavioral health specialists from BSC Promise and Wellnest joined accomplished community artist Moses Ball who encouraged youth aged 11 to 17 to lend their creativity as they participated in the program. Art was used as a tool to help the program participants share their feelings and talk about difficult issues in a safe and nurturing space. As part of the program, a “Promise” theme mural was painted on the 20-foot by 60-foot wall outside the playground of the Boys and Girls Challengers Clubhouse. The colorful mural was painted over an eight week period.

Based on qualitative and quantitative data, South Los Angeles experiences the highest rates of assault-related trauma and homicide in the county, according to the local Department of Public Health. Homicide rates in South Los Angeles are nearly four times higher than in the rest of the country. The surrounding neighborhood is ranked nineteenth for the most violent crimes out of the 202 Los Angeles neighborhoods analyzed by the Los Angeles Times.

It is reported that Los Angeles is home to 200,000 youth living in poverty, 68,000 disconnected youth, 30,000 youth arrests, and over 3,000 homeless youth. Youth in Los Angeles are disproportionately impacted by poverty and neighborhoods in East Los Angeles make up the highest share of the homeless youth population. BSC Promise Health Plan’s team of community advocates, social workers, and behavioral health specialists are making continuous efforts to engage with these vulnerable populations and identify interventions that will help tackle socioeconomic gaps that leave kids stuck in a cycle of violence and poverty.

BSC Promise Health Plan utilized an innovative approach to address our target population’s needs through art. For-at-risk and justice-involved youths, the arts can provide an outlet for addressing emotional and/or behavior problems through opportunities to learn new skills, develop new talents, and express thoughts and ideas in creative and therapeutic ways (Ezell and Levy 2003). Similarly, for youths dealing with trauma or victimization (including exposure to violence), the arts can help them to cope with painful experiences by fostering resiliency (Heise 2014). Creating art can strengthen a youth’s problem-solving skills, autonomy, sense of purpose, and social competence. Moreover, art can help encourage positive emotions and strength, allowing youths to view themselves as survivors and not as victims (Van Westrhenen and Fritz, 2014).

Our measures for success for this effort included engagement of the youth participating and the ability of the program to sustain beyond this initial effort. What started as an eight week initiative has turned into a permanent program, expanding to other high school and middle school sites.

The mural, 20 feet tall and 60 feet wide, shines brightly on a blue wall at the site of one of the Boys & Girls Challengers Clubhouse, a few miles southwest of downtown Los Angeles. The work shows the faces of five children and highlights their dreams about future occupations. At the start of the Art Therapy Program, kids talked about the murder earlier this year of rapper and entrepreneur Nipsey Hussle, who was gunned down March 31, 2019 in front of his clothing store, Marathon, in Los Angeles. His death sent shock waves throughout the community, city and beyond. The loss of Hussle served as inspiration for the mural. The work reads at the top, “Believe in the Promise,” which serves as an overarching theme. One of the images shows a young male rapper inspired by

Nipsey Hussle's music and his community work. Another is of a young girl inspired by Bessie Coleman, the first woman of African-American and Native American descent to hold a pilot's license. The girl is dressed like a pilot with an image of a plane taking off behind her, with the words "Take Flight."

The Program was launched in the summer of 2019 and has been greatly appreciated by middle school/high school students and their families. This initiative has also caught the attention of several media organizations.

2. Due Date Plus by Blue Shield Promise Health Plan (March 2018 – Ongoing)

BSC Promise Health Plan focused on pregnant Medi-Cal members in San Diego county for this intervention. BSC Promise Health Plan and Wildflower Health partnered to provide health care information and education to pregnant BSC Promise members through Wildflower Health's maternity smartphone application, Due Date Plus. The application is designed to help women have healthier pregnancies by letting them track pregnancy and postpartum milestones on their smartphone, look up symptoms and issues, and connect to healthcare providers and services available through their health plans. The Due Date Plus application is made up of Wildflower Health's core maternity content and BSC Promise Health Plan configured content, which is derived from best-in-class sources such as the American College of Obstetricians and Gynecologists, American Academy of Pediatrics, Centers for Disease Control and Prevention, and the National Institutes of Health. The Due Date Plus application enables easy access to plan benefits such as the Nurse Advise Line, transportation services, behavioral health services, domestic violence hotline, and more.

Our research has shown us, in California, 25 percent of the female population are at or below the federal poverty level, but they make up 43 percent of the births in the state. Women covered by the Medi-Cal program face an array of challenges and are more likely to experience adverse birth outcomes than the non-Medi-Cal population. Other modifiable risk factors frequently associated with poor birth outcomes, such as smoking during pregnancy, substance use, and pre-pregnancy weight outside of normal ranges, were more prevalent among Medi-Cal mothers. Furthermore, Medi-Cal women have lower educational attainment (less than a high school diploma) than non-Medi-Cal mothers, which is correlated with higher infant mortality rates. These women also often confront barriers to access to care.

The application experience has been customized to meet the needs of pregnant Medi-Cal BSC Promise Health Plan members. Since the population is lower income and many are Spanish speakers, the application has a 5th grade reading level along with being available in Spanish. In addition, Wildflower Health and BSC Promise Health Plan partnered with a local nurse midwife, who reviewed the app to ensure that it was culturally relevant to the population.

The application combines front-end mobile engagement with enterprise architecture, engaging each BSC Promise Health Plan member via configurations that reflect client branding, benefits, and clinical programs. Research shows 81 percent of the United States population uses a smartphone and of those that are lower income, 70 percent to 90 percent use a smartphone. The application is optimized to work on lower end smartphones and can work offline as well. The use of the mobile application by Medicaid populations in other states has found to have a 73 percent reduction in low birth weight babies and a 62 percent increase in prenatal visit compliance in the first trimester.

BSC Promise Health Plan and Wildflower Health partnered with the California Health Care Foundation to evaluate various quality measures related to maternal and postpartum health such as at what gestational age do women register for Due Date Plus, outcomes among application users, and the monthly rate of patients receiving a postpartum visit between 21 and 56 days of delivery.

On average, users are in the application 4.4 times a month engaging with various tools and content. On a monthly basis, 73 percent of users are accessing screens in the application that have BSC Health Plan Promise specific links, phone numbers, and information; with 66 percent of users going to the Resources page that provides information on BSC Promise Health Plan and local community resources. The Due Date Plus application on average has 41 percent of women enrolling in their 1st trimester, 25 percent in their 2nd trimester, and 33 percent enrolling in their 3rd trimester.

CalOptima

CalOptima's ongoing Homeless Health Initiative (HHI) (April 2019 – Ongoing)

In response to Orange County's ongoing homelessness crisis, CalOptima's Homeless Health Initiative (HHI) seeks to encourage immediate access to care with the goal of building trusting relationships that bridge to the existing care delivery system.

CalOptima reviewed a variety of data elements when seeking to understand the health disparities facing its members experiencing homelessness, versus those not experiencing homelessness, versus other sub-populations. These elements included but were not limited to: cause of death by reviewing claims/encounters and Coroner's data; utilization rates by reviewing emergency department, inpatient, PCP visits, specialist visits, and pharmacy data; behavioral health by reviewing behavioral health and substance use disorder diagnoses and records of individuals who are in and out of treatment; pharmacy by reviewing the comparison at the Global Coordination Mechanism and control of non-communicable disease level and opioid use; the number of chronic conditions regressed against cost, and overall per member per month cost. In addition, HEDIS quality measures were reviewed in order to identify health care disparities.

CalOptima and the Orange County Health Care Agency (HCA) began meeting for knowledge sharing, to identify needs, and to find solutions for unmet needs of this growing population. Orange County's HCA had a Child and Family Team (CFT) that provided information on existing and new shelters/hotspots to support development for increased clinic access at the shelter/hotspot.

CalOptima's most innovative element is the rapid mobilization of community partnerships - including the county Health Care Agency - to implement a nimble person-centered "pop-up" mobile clinic model leveraging a quality incentive strategy. The biggest differentiator from most street medicine programs that rely heavily on part time volunteer teams and limited resources is CalOptima's Homeless Health Initiative care delivery design.

Although the program is in its infancy, CalOptima started collecting baseline data in order to evaluate the effectiveness of the program. The CFT pilot program monitors its effectiveness by process measures, such as numbers of person's services, and emergency room and unplanned hospitalizations. The proxy outcome measures will include HEDIS preventative service measures and cost of care. One anticipated outcome will be a decrease in the homeless person mortality rate in Orange County. The outcome of the baseline results are not yet available.

CenCal Health

CenCal Health Recuperative Care Program (RCP) (October 2018 – September 2019)

CenCal Health Recuperative Care Program (RCP) is addressing health disparities by providing respite care services for individuals leaving the hospital that are also experiencing homelessness. CenCal Health RCP is a collaborative program amongst contracted hospitals, shelters, and providers that provides safe recuperative care to local homeless who are not sick enough to be hospitalized, but are too frail to recover from their illness or injury on the street.

The original CenCal Health RCP pilot was based on the Boston Health Care for the Homeless Program, which started in 1985. This program experienced 50 percent lower odds of early re-admission or death, one less inpatient day, and \$1,740 less inpatient charges at 90 days. A similar program in Orange County, CA experienced a 4.8 year average of homelessness, 79 percent history of substance abuse and 71 percent history of mental illness. Their program demonstrated an annual cost savings of \$7 million, and 84 percent reduction in Emergency Department visits. In

CenCal Health's service area, the homeless person count on a single day in 2019 in San Luis Obispo County increased by 32 percent compared to 2017 numbers, according to a report released by the county's department of social services. A rise in the homelessness ranks in San Luis Obispo County comes as Santa Barbara County's homeless population is shrinking and Ventura County is seeing a 45 percent rise with housing affordability as a common issue across the Tri-Counties.

In 2017, CenCal Health, along with Community Action Partnership of San Luis Obispo (CAPSLO), successfully completed a RCP pilot in San Luis Obispo County, which included supervised shelter, meals, showers, patient education and transportation to medical appointments among other supportive services. In October of 2018, CAPSLO moved the RCP to their new 40 Prado Homelessness Service Center in San Luis Obispo, where they were able to increase their available RCP beds by 50 percent. Primary medical services and a pilot to provide behavioral health services are now available at 40 Prado. Integrated primary care and behavioral health services are also provided at Good Samaritan Shelter in Santa Maria, and People Assisting the Homeless (PATH) center in Santa Barbara.

Utilizing an innovative approach, CenCal Health contracted with their network hospitals to partner with service area homeless shelters to provide RCP services to their members. There are considerable challenges providers experience in identifying appropriate discharge options for patients who do not have safe, clean homes to go to. This situation often results in unnecessary hospital stays, preventable readmissions, and increased costs for the health care system. To circumvent those negative outcomes, the Recuperative Care model provides: 24-hour bed with supervision of meals, showers, clothing, and basic activities of daily living (ADL); transportation to pharmacy and medical appointments; nursing education and support; medication reconciliation, dosing, and set up; review of compliance and patient education; coordination with home health; mental health, drug/alcohol, and other supportive services; referrals and linkages to housing, self-sufficiency and social services.

CenCal Health's RCP effectiveness is best described by the stories of the population it serves. One success story comes from a CenCal RCP recipient in San Luis Obispo. A member who was a young woman, experienced complications from childbirth due to a history of drug abuse and had a history of a child being removed from her care due to neglect from drug use. After she gave birth to her second child, the child was immediately placed in foster care. This member was homeless and needing respite care due to complications from her delivery. Our member was admitted to RCP and transported to multiple monitored visits with baby and foster mother, per week. RCP staff participated with the Child Welfare Services to develop a plan for reunification based on the member's success in RCP. This member was transported to drug and alcohol and mental health services, where she resumed medication for a bipolar condition. A RCP nurse accompanied the member to her PCP and reproductive health care visits and RCP staff advocated for her to have her baby at the shelter while awaiting a move to Sober Living. Our member and her baby are doing well. To see how CenCal Health is changing lives with their Recuperative Care Program, go to <https://vimeo.com/312012314>.

The initial pilot utilization data indicated improved health outcomes by decreased inpatient utilization data, which was analyzed and indicated that pre-admit to program there were 196 bed days at a total cost of \$336,242.00. During the program year bed days equated to 11, with an annual cost of \$28,822.00. There was an increase in PCP services when patients were admitted to RCP and a significant decrease in emergency room visits. In the most recent data from the Santa Barbara Program, the average age of the participant is 58 years of age, 78 percent are males, and 22 percent of females. The average length of stay at the RCP for a member is 54 days.

CalViva Health

CalViva Postpartum Visit Disparities Project with UHC Mendota Clinic (August 2018 - June 2019)

CalViva implemented two interventions, the first intervention, the “OB Alert”, involved the creation of a Postpartum Visit (PPV) appointment in the clinic’s scheduling software 21 - 56 days after the estimated date of delivery (EDD) for all pregnant women as soon as the EDD was established to promote a timely postpartum visit. Although the appointment may need to be rescheduled for some women after the actual delivery, the fact that it is in the computer system triggers attention and follow up by the clinic staff via the automated reminder system. The second intervention involved a revision of the OB history form utilized for all pregnant women to include questions pertaining to cultural practices that may impact PPC timely completion.

The target population for these interventions included all pregnant women at a rural Fresno County Federally Qualified Health Center (FQHC), which was found to be disparate when compared to similar clinics with a rate of 50 percent for visit completion versus 74 percent at similar clinics. This trend was validated for a three year period. The clinics in the study serve predominantly Hispanic women (90.7 percent) with the targeted FQHC demonstrating a significant number of women from El Salvador (39.7 percent).

Both qualitative and quantitative data were utilized in the analysis of the interventions and outcomes of this project. A variety of internal and external sources for both the targeted clinic (Mendota) and the comparison clinic (Kerman) were included. Key data elements included, but were not limited to: focus groups with members/clinic patients, social determinants of health data, PPV compliance rates across ethnic groups, key informant interviews, demographic data, and clinical data. Key measures included: PPV completion rate, OB Alert/PPV scheduled/Total number of pregnant women at targeted clinic, and cultural preferences taken into consideration when scheduling PPVs.

CalViva customized both interventions and used an innovative approach to address the target population needs. The OB alert intervention was modified to be compatible with the clinic’s new electronic medical record (EMR) that went live mid-way through the project. Once an EDD is documented in the EMR, staff are trained to schedule a PPV within 21- 56 days of the EDD. The OB history form was modified to include a question regarding cultural preferences and the staff were trained on how best to ask for this information. The options included on the revised form came from the focus groups in order to be consistent with the clinic’s population.

The effectiveness of the intervention was evaluated using the following measures: (1) OB alert/PPV rate, (2) OB history form documentation, (3) cultural preferences; this was a small sample size, however we did consistently see that women who identified la cuarentena as a practice completed their visit timely, but after 40 days. The SMART Aim goal was to improve the rate of timely postpartum visits completed at the targeted clinic from 50 percent to 64 percent. This was achieved, surpassed and sustained with a rate at or above 80 percent for the last 6 months of the project.

The improvement interventions were successful in reducing the disparity at the targeted clinic with a rate at or above 80 percent for postpartum visit completion for the last six months of the project.

Gold Coast Health Plan

Improving the Rate of Breastfeeding in Medi-Cal Women in Ventura County (2017 - 2018).

Breastfeeding is the first step to a healthy life. In addition to the bonding between mother and infant, the more the mother breastfeeds, the greater the benefits to both mother and baby. Through a series of partner, community, and vendor meetings, it was identified that women were choosing to not breastfeed based on the poor quality breast pumps being provided. Along with Comprehensive

Perinatal Services Program (CPSP) providers, Women, Infants, and Children (WIC), and Early Start partners, Gold Coast Health Plan (GCHP) partnered with a vendor to provide a higher quality breast pump to members at the Medi-Cal rate. The purpose of the project was to increase the incidence of breastfeeding in GCHP mothers as evidenced by an increase in utilization of breast pumps through the first year of a child's life. A higher quality electric breast pump was encouraged and provided through partnerships with community agencies who interact with members (i.e. WIC, CPSP, and Early Start partners) to increase the incidence and duration of breastfeeding in managed care Medi-Cal mothers in Ventura County.

GCHP worked with WIC, CPSP, and Early Start community partners to identify perceived barriers to breastfeeding in the managed care population. Member opinions were sought out through care management and health education contacts. This identified the high rate of dissatisfaction with the quality of breast pumps. GCHP also examined utilization data for breast pumps using the following service codes: E0602, E0603, E0604, A4281, A4282, A4284, A4285, and A4286. Data was extracted from paid claims, then trended and reported quarterly.

The intervention was identified and customized through discussion with the community partners, providers who advocate for breast feeding, and a knowledge of the types of breast pumps available and being dispensed. Pictures of the breast pumps were shared and a higher quality product was chosen.

Evidence in Ventura County shows that most women want to breastfeed their infants, but are adversely affected by the ease, or lack thereof, of the process once the women return to work or daily routines. The use of a high quality electric breast pump encourages longer and more productive breastfeeding due to ease of use. GCHP worked with vendors to find an alternative that would not be more costly, but meet the quality needs for ease of use to promote breastfeeding in the population. Through identification of vendors, Hygeia offered to provide a high quality electric breast pump at the Medi-Cal rate. The health plan worked with WIC, CPSP, and other community based providers to distribute the Hygeia breast pump instead of other alternatives.

In order to track the effectiveness quarterly data pulls were trended and graphed, then shared with community partners in quarterly meetings to track progress. Additionally, through this ongoing trending, GCHP has been able to identify and correct claim issues to increase vendor satisfaction.

Outcomes demonstrate an 82 percent increase in breast pump utilization from baseline 2016 to first year results (2017) and 185 percent increase in utilization for the second year of the project (2018). History of claims: 2013 = 163 claims, 2014 = 364 claims, 2015 = 499 claims, 2016 = 958 claims, 2017 = 1768 claims, and 2018 = 2735 claims.

Health Net Community Solutions, Inc.

1. Health Net Community Doula Program (March 2019 – Ongoing)

Health Net is implementing a pilot project with the Association of Wholistic Maternal and Newborn Health (AWMNH) targeting 150 African American Medi-Cal births. The Health Net Community Doula Project is a collaborative effort between the Health Net departments of Medical Affairs, Quality Improvement, Cultural and Linguistic Services, and Health Education. AWMNH hired and trained 10 African American doulas to engage with Health Net members and offer free doula services during this pilot project. The AWMNH doulas will engage our members in three prenatal visits, childbirth education, labor and delivery, and at a three postpartum visits. The program will also provide nutrition education, lactation support, childbirth classes and a father's support group.

Health Net collected quantitative data from the California Department of Public Health, Los Angeles County Department of Public Health. The Maternal, Child and Adolescent Health Division provided supportive data for this intervention. African American women make up 9.2 percent of all

women in L.A. county, but 31.8 percent of all maternal deaths. White women make up 28.9 percent of women in L.A. County, but only 4.5 percent of maternal deaths. African American infants are 2.5 times more likely to be born low birth weight than Caucasian infants. Health Net performed a health disparity analysis; member demographic, encounter and administrative data was utilized. Descriptive and Geo Spatial mapping was conducted on the member and provider data from the HEDIS data set.

One of the needs expressed by the African American community in Los Angeles County was to have more healthcare providers that were from the same cultural background. In an effort to accommodate this need, ten African American Doulas were hired and trained to provide services to enrolled members. Studies suggest that increased access to doula care, especially in under-resourced communities, can improve a range of health outcomes for mothers and babies, lower healthcare costs, reduce cesarean sections (C-sections), decrease maternal anxiety and depression, and help improve communication between low-income, racially/ethnically diverse pregnant women and their health care providers.

This is an innovative approach because doula care is not routinely covered by health insurance. The community doula program established a consistent pay rate/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.

Health Net uses descriptive disparity analysis to develop population group targets for disparity reduction efforts. This analysis is overlaid with Geo Spatial mapping to analyze HEDIS outcomes at the geographic level. The Health Disparity model gives Health Net a unique ability to understand target population(s) and implement tailored disparity reduction efforts to improve the quality of health care.

In order to evaluate the effectiveness of the Doula Program, AWMNH doulas will input member level data into a platform called Maternity Neighborhood, a doula data collection platform. Maternity Neighborhood platform will track C-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. AWMNH will share the member level data with Health Net and our plan will analyze the claims and encounter data for enrolled participants. Health Net will track the following outcomes: medical interventions, induction and augmentation of labor, c-sections and repeat c-sections, maternal mood disorders, maternal satisfaction with birth experience (prenatal and postpartum), and preterm or low birth weights.

The Community Doula Program officially began enrolling members in June 2019. The program is currently in the early stages of collecting outcome data and results. Currently, we have exceeded our goal of having six members enrolled per month. The following data has been collected thus far: June - eight Health Net Medi-Cal members enrolled, July – 14 Health Net Medi-Cal members enrolled, four births total, and all vaginal, no c-sections. The outcome evaluation will be conducted upon conclusion of the program.

2. Cervical Cancer Screening (CCS) Disparity Project Targeting Chinese Women in San Gabriel Valley (August 2017 – June 2019).

Health Net Cervical Cancer Screening (CCS) rates in Los Angeles county were below the minimum performance level (MPL) in Reporting Year (RY) 2017 and two years prior among Medi-Cal members. RY 2018 HEDIS administrative data for CCS in L.A County was 51 percent which was just short of the MPL. A disparity analysis identified lowest compliance rates for CCS among Chinese members whose language preference is English or Mandarin with the target provider group. Based on the analysis findings, Health Net launched a disparity focused Performance

Improvement Project (PIP) in August 2017, with interventions at the member and provider level to address the cultural barriers encountered by Mandarin speaking Chinese women.

The disparity analysis included member demographic, encounter and administrative data. Comprehensive literature review was completed to identify barriers and strategies that have been successful in reducing CCS disparities. Key informant interviews were conducted at member, provider/specialist (PCP and OB), and community level. The interviews revealed that Chinese-speaking members prefer to see a doctor who speaks Chinese. The resultant barrier analysis disclosed the key barriers to health care for Chinese women include low importance assigned to preventive care and lack of education on importance of CCS. Descriptive analysis and Geo Spatial mapping was conducted on the member and provider data from the HEDIS data set. Using California's Healthy Places Index (utilizing publicly available data), social determinants of health (SDOH) analysis was conducted on the target geographic region to identify key SDOH indicators impacting the health outcomes of the community.

In collaboration with two select provider offices, Health Net conducted process mapping of the CCS screening process. Two processes were identified as having the largest impact on improving the CCS rate for Chinese members with preferred language of Chinese and Mandarin; these were: understanding the importance of CCS, and the member-driven responsibility of scheduling an appointment for a well woman exam or CCS. According to the PCP office managers, most PCPs, in particular male PCPs, do not perform CCS. Another barrier is an available appointment to see an OB/GYN or mid-level provider at the clinics. To address the multiple barriers impacting CCS, an intervention using a Prescription (Rx) for CCS, with two select high volume PCPs was implemented. The CCS project team developed a Rx for CCS in English and Mandarin; it contained educational information about the importance of CCS and an option to schedule with a female provider at one of the medical groups Urgent Care locations that has extended weekday and weekend hours. A member incentive program was also promoted in tandem with the Rx for CCS at two provider offices. The aim with the incentive promotion was to convince the Chinese members to schedule and keep an appointment for a CCS at the Urgent Care clinic.

The effectiveness of this program is evaluated through process and outcome evaluation. Process level evaluation involves assessing the impact of the intervention by tracking and reviewing the number of members who received an Rx for CCS from one of the participating clinics and completed a CCS at one of the three Urgent Care locations who were given the member incentive. Data availability for one Federally Qualified Health Center (FQHC) was more robust due to three locations as well as the FQHC servicing a larger Chinese population.

The evaluation at the outcome level has shown directional improvement with the compliance rate for Mandarin speaking members, improving from 59 percent (pre-project and intervention implementation) to 63 percent post implementation for one FQHC. Although this is preliminary evaluation data, the increase of four percent in compliance rate for Mandarin speaking Chinese members at one FQHC is confirmation of the successful partnership between the clinic staff, providers, and health plan. Full post PIP evaluation data (run charts) will be available in September 2019.