

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

October 2019



2019

Award Winner

CenCal

Know More: HPV – Addressing HPV vaccination rate disparity with a digital, in-office patient intervention.

Runner-up

Anthem Blue Cross

Live video access on personal mobile devices in a home setting for physician, psychiatrist and psychologist access.

Fifth Annual Innovation Award, October 30, 2019

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 asked to submit one vote, but were not allowed to vote for their own MCP.

DHCS received twelve nominations from ten MCPs.

AWARD NOMINATION SUMMARIES

Alameda Alliance for Health

Whoop, there it is.

There were over 9,000 cases of pertussis reported in CA in 2010. In 2014, 11,209 cases were reported, including 2 infant deaths and hundreds of hospitalizations. In 2018, Alameda county reported more than 300 cases of pertussis. Recently, in April 2019, the first confirmed infant pertussis death was reported in Orange County. Infants are the most vulnerable population and require protection from this disease until they are old enough to begin their vaccination series. Alameda Alliance for Health (AAH) has partnered with the Immunization Division of Alameda County's Public Health Department to minimize and ultimately eliminate pertussis cases in the county.

The American College of Obstetricians and Gynecologists, the Centers for Disease Control and Prevention, and California's Department of Public Health advise that the most effective practice to protect infants from pertussis is encouraging the timely transfer of maternal antibodies. This program aims to vaccinate pregnant women with the tetanus, diphtheria, and pertussis (Tdap) vaccine between 27 - 36 weeks gestation.

In August 2018, AAH analyzed Tdap claims, California Immunization Registry (CAIR) data, and encounter data for women who delivered within the previous 12 month period. Through this analysis, we determined the following: (1) High performing sites and compiled a best practices tip sheet. (2) Low performing sites (19 clinic sites identified); low performing defined as having greater than 30 deliveries with Tdap rates less than 80 percent. The low performing sites received the following: (a) A nurse-led training that was disease focused with a public health background, including best practices information; (b) Tdap flyers in English, Spanish, Chinese, and Arabic; and (c) Nurse/Medical Director visit to discuss member level data, identify and resolve barriers, and determine opportunities to appropriately report and capture data. Identified barriers included: lack of a refrigerator, lack of referrals to a pharmacy or pediatrician, and misunderstanding the claims and reimbursement process. The barriers were overcome by education regarding the facility site review requirements, linkage with the Local Health Department (LHD) for a Tdap "starter kit", and connecting providers with our MCP's utilization management team. The strong relationship between AAH and the LHD helped identify opportunities and pro-actively promote the Tdap vaccine with the intent of decreasing pertussis cases in the county we serve. We were able to work towards the newly announced Prenatal Immunization Status (PRS) Healthcare Effective Data and Information Set (HEDIS) measure.

Over the last 12 months, AAH has witnessed an average of eight percent increase in Tdap rates; the goal is to improve Tdap rates to 90 percent by January 1, 2020. This initiative has led to productive conversations and relationships with providers outside our scope of target sites. We predict continued movement that will increase Tdap awareness and decrease pertussis cases in Alameda County.

Anthem Blue Cross

Live Video access on personal mobile devices in a home setting to board certified doctors (24/7 in-demand urgent care), psychiatry appointments (0-21 days), and psychology appointments (0-4 days).

Medi-Cal beneficiaries have significant challenges accessing medical doctors and mental health providers due to issues such as provider shortages and transportation. According to the Public Policy Institute of CA, "Emergency Department (ED) outpatient use has increased substantially across all demographic groups and for all reasons. Non-elderly adult visits increased by 38 percent between 2005 and 2016...and one in ten ED visits among adults were potentially preventable."

This intervention has been made available to all of our MCP's Medi-Cal member counties. It is expected to most benefit populations with high ER utilization, limited access to mental health services, and challenges in transportation and convenience. Members who visit the ED in search of

medical or behavioral health services can now have increased options to conveniently access a provider better equipped to address their acute concerns.

Traditional telehealth requires a patient to be at an originating site to see a provider at a distant site. This intervention allows the MCP's members to visit a medical doctor for urgent care needs from the comfort of home, school, or work without an appointment, 24 hours a day, 7 days a week, 365 days a year. Visits with psychologists, therapists, social workers, and psychiatrists are available by appointment, 7 days a week, including on nights and weekends, and within days instead of waiting for months.

Comparing January 2019 to June 2019 visits using this service have increased by 69 percent for urgent care, 200 percent for psychiatry, and 96 percent for therapy. Each visit has a post satisfaction survey where a member is asked how satisfied they are and where they would have gone for medical care had there been no access to the services. The overall member satisfaction rate is 4.8 out of 5 stars and 45 percent said they would have visited the ED or urgent care. The MCP assumes at least 1/4 of the 36 percent that did not answer the survey also would have gone to the ED or urgent care, bringing the total to 55 percent. A cost savings analysis is underway, but not ready at this time.

CenCal Health

Know More: HPV - Addressing HPV vaccination rate disparity with a digital, in-office patient intervention.

The human papillomavirus infection (HPV) annually infects 14 million people and causes more than 33,000 people in the U.S. to develop cancer each year. The HPV vaccine prevents infections that can lead to six types of cancer. Nonetheless, HPV vaccination rates remain low. In 2016 the Centers for Disease Control and Prevention (CDC) found that only 58 percent of teens in CA completed the HPV vaccination series. Healthy People 2020 and the American Cancer Society each set a goal to achieve 80 percent HPV vaccination by 2020 and 2026, respectively. In 2016, CenCal Health achieved only a 38.36 percent HPV vaccination rate in Santa Barbara County. Because HPV vaccination prevents cancer, we felt that this low vaccination rate was an important issue to address. To do so, CenCal sought to implement a unique, scalable, and measurable intervention.

CenCal identified a significant geographic health disparity in HPV vaccination rates: north Santa Barbara county had an HPV vaccination rate of 48.72 percent while the south Santa Barbara County rate was only 31.03 percent. In order to address this geographic health disparity, CenCal approached a high-volume, low-performing provider located in south Santa Barbara County, an FQHC whose HPV vaccination rate was only 19.05 percent, to target members ages 11-12 who were due for one or more HPV vaccine, and provided the members and their parents with the intervention while they were in the clinic.

CenCal collaborated with the American Cancer Society to develop a digital, interactive, tablet-based educational program to educate parents on the importance of HPV vaccination at a critical moment: when the child is already at the provider's office. The collaboration between three distinct entities, CenCal Health, the FQHC, and the American Cancer Society, allowed for the development of a program guided by unique perspectives and areas of expertise. The use of a digital educational program offered directly to parents in the clinic setting is not a widely used strategy to improve HPV vaccination so, CenCal Health created its own program, Know More: HPV. The program included a slideshow, question and answer, and a video. CenCal produced the program in-house allowing for staff to participate and become advocates for the HPV vaccination. Because the program was built with internal software, it can be easily modified remotely, without interfering with the daily use. The program gives providers a starting point from which to have a conversation with vaccine-hesitant parents. It also increased clinic workflow efficiency, and it educates and primes parents to discuss HPV vaccination during the visit. Another added value is that it is something productive for the parents to do during perceived long wait times. The simple implementation ensures that it is sustainable and easily scalable.

Know More: HPV is proving very successful. As of July 2019, the HPV vaccination rate at this particular FQHC increased by 29 percent in just five months. Patient satisfaction with Know More: HPV is measured through a survey at the end of the program. Weekly survey results report that patient satisfaction is very high. Monthly reporting by the FQHC indicates positive provider satisfaction with the program. The marked improvements in vaccination rates as a result of the program have added value to the patient, provider, and community. Patients receive high-quality, engaging, and creative health education that has made an impact on increasing HPV vaccinations. Providers are able to offer their patients a targeted no-cost educational resource right in the clinic. The community at large has been informed of the collaboration, which has highlighted the importance of the HPV vaccination to the community. CenCal is so happy with the program that we plan to expand it to additional network providers and create a series for additional health education topics. To view the program demo, go to <https://rise.articulate.com/share/TVIn1TAJwHxDNiutxJxey3YnYcqytK9u#/>

Gold Coast Health Plan

Postpartum Visitation Program

Access to postpartum visits (PPV) for Medi-Cal women in Ventura County was not consistent with best practices as evidenced by lower HEDIS scores in Measurement Year (MY) 2017. Gold Coast Health Plan had a PPV incentive that was poorly utilized. It was identified that these women were unaware of the importance of the visit or resources to help overcome social determinants of health barriers.

Gold Coast targeted members who had given birth at a local hospital. The health education team worked with one large hospital to receive daily notifications of members who had recently given birth and had not yet been discharged. Informational packets in the threshold languages were created to emphasize not only postpartum care, but also well child care during the first year of life. Health Navigators made rounds in the hospital three times a week to greet and congratulate the new mothers, provide a reusable insulated lunch-like bag, and packets of information in the preferred language, and to explain transportation benefits and other incentives (the PPV incentive). Health Navigators then made three phone calls to the member's home after discharge to answer questions and offer assistance in scheduling appointments. Additionally, the Health Navigators made direct referrals to Complex Care Management for cases that had multiple barriers or needed case management services.

As a result, access was increased for postpartum women as evidenced by the significant increase in postpartum visits within 21 to 56 days after delivery. HEDIS PPV moved from the 50th percentile in MY 2017 to the 90th percentile in MY 2018. Additionally, members who needed Complex Care Management services were identified earlier, which resulted in better outcomes.

Inland Empire Health Plan

Model Practice Program

Inland Empire Health Plan's (IEHP's) primary care network has a great deal of variability in its ability to provide population health and ultimately achieve success in a value-based care environment. With numerous business models, sizes, and mission statements, these practices do not provide a standard level of primary care as evidenced in HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) performance data. Furthermore, there are less than 50 practice sites among nearly 400 IEHP contracted primary care practices that are recognized by NCQA's Patient Centered Medical Home (PCMH). The Model Practice Partnership between IEHP and selected primary care practices provides a significant opportunity to address fundamental competencies to move these practices towards a population health approach and to address the quadruple aim.

The Model Practice sites were selected based on the following criteria: primary care practice; practice with an Electronic Medical Record (EMR) that is operational for all members; practice with four PCPs with assigned IEHP members; practice with a minimum five-year horizon as a practice;

the practice's current IEHP Global Quality Pay-For-Performance (GQ P4P) score is at, or below, 40 percent.

IEHP's Model Practice initiative transforms its primary care delivery system to provide foundational competencies that move the practice towards the Quadruple AIM: improved health outcomes, decreased utilization, and improved patient and team experience. The main vehicles for this work are the IEHP Practice Coaches who engage and coach partner practices. Coaches perform an initial assessment of the practice to identify competencies identified by the Bodenheimer Building Blocks of Primary Care. Model Practice work focuses initially on the first four foundational competencies: 1). Engaged Leadership, 2). Data-Driven Improvement, 3). Empanelment, and 4). Team-Based Care. The practice sites will choose 1 to 3 GQ P4P outcome metrics as the primary focus as they develop these new skills. In this way the practice stands to improve their infrastructure and skills all while improving outcome metrics and leveraging revenue opportunities.

The current practice sites have completed their initial assessment and are scheduled for the post assessment, September through November 2019. Initial assessment results show a significant range in competency by practice site and a great deal of opportunity for improvement. All sites have moved into the testing and implementation phase of the work and IEHP will be evaluating the GQ P4P outcomes in the intervention year compared to a baseline year. Overall, IEHP's Model Practice strategy is currently being implemented, and it is too early to publish results.

Kaiser North

Kaiser Permanente CalFresh Referral Program: Medi-Cal member referral to 211 Sacramento to Address Food Insecurity.

During Q1 2018, a multi-functional internal working group formed to develop and deploy interventions aimed at increasing CalFresh (Supplemental Nutrition Assistance Program [SNAP]), enrollment for eligible Kaiser Permanente (KP) members in Sacramento County. In November 2018, KP launched an intervention to enhance the Sacramento onboarding process by connecting members who screen positive for food insecurity to 211 Sacramento for SNAP enrollment assessment. Stakeholders from national, regional, and local departments convened to execute an aggressive timeline by end of Q4 2018. The 211 Referral Program is now operationalized as part of the Medi-Cal onboarding team's work.

California ranks 45th for SNAP/CalFresh benefits in the United States. KP identified that within Sacramento County, 32 percent of its Medi-Cal members have CalFresh benefits. That reality provided an opportunity to come up with innovative solutions to assist more members in receiving their entitled benefits. Once KP Medi-Cal members are identified by Member Engagement Specialist staff as food insecure through a comprehensive questionnaire that asks members about social determinant factors, they are then asked if they would like a referral to 211 Sacramento. Those who are food insecure or are in danger of becoming so, are the target population among the Medi-Cal population.

Thanks to a live, warm-handoff referral to 211 Sacramento, KP Medi-Cal members have a greater likelihood of accessing enough healthy, nutritious food which is important in achieving total health. KP is supporting 211 Sacramento to increase the number of eligible Medi-Cal members enrolling in CalFresh. Sacramento County KP Medi-Cal member onboarding and care coordination teams ask members about their food security, creating an opportunity for a direct referral and warm handoff between KP and 211 Sacramento. KP also provided extra infrastructure support for 211 for a dedicated phone line and staff for members, which facilities follow up and data tracking. With monthly results, both KP and 211 are able to measure the program's effectiveness and make necessary modifications in response. As of July 2019, there have been over 350 referrals to 211 Sacramento.

KP and 211 Sacramento County conduct regular check-ins which allows us to track not only assistance outcomes, but the actual enrollment into CalFresh, which is completed by the county. Our innovative data has allowed us to capture other types of food security information that helps to further assist Medi-Cal members.

Qualitative data results:

Members: Increased SNAP enrollment, increased likelihood of sharing social needs, and improved overall member experience and satisfaction with the MCP.

Staff: Increased likelihood of asking patients about food insecurity, improved job satisfaction among frontline clinical staff.

Operational Standards: Integrated seamlessly into clinical workflow, effective referrals made to the community based organization (CBO) partners, successfully tracked referrals and outcomes with CBO partners.

Quality of Care: Improved care experience and improved clinical outcomes (reduced HgA1c for food insecure diabetics).

Kern Family Health Care

Avoiding or delaying onset of diabetes through a year-long in-person Diabetes Prevention Program (DPP).

Diabetes, or diabetes-related complications, are becoming the leading cause of death in the United States. With an estimated 13 million California adults at risk, DHCS added a Diabetes Prevention Program (DPP) as a member benefit in January 2019. There are over 70,000 Kern Health Systems (KHS) members falling into this category. The health plan had already begun initiating a diabetes and pre-diabetes program and had one registered nurse (RN) Certified Diabetes Educator (CDE) and two diabetes paraprofessionals certified as DPP lifestyle coaches during 2018.

KHS has an estimated 30 thousand members with diabetes, and an estimated 40 to 50 thousand members either diagnosed with pre-diabetes, or at risk for developing diabetes. The organization identified 1,700 members who had an HgA1c between 5.7 and 6.4 and were over the age of 21. In January 2019, our outreach team contacted over 400 members before achieving our goal of 100 participants. Of the 74 members that responded to the follow-up confirmation letter, 48 attended the initial class on March 4, 2019.

KHS decided to offer our in-person group DPP classes in both English (Monday mornings and Wednesday afternoon) and Spanish (Monday afternoons and Wednesday mornings). Participants were welcomed to attend any class of their choosing during that week, and this option dramatically reduced the rate of missed classes. No participant has missed more than one class. To keep the members engaged and motivated, the lifestyle coaches conduct healthy cooking demonstrations and raffles for gift cards or selected gifts each week. The gifts include food scales, infusion water bottles, grocery bags, gym bags, lunch pails, measuring cups, stress balls, etc. \$25 gift cards were given to each member for attending 10 and 15 sessions. Seven raffles with prizes of gift cards and/or cooking appliances have been completed. Members that lost 5 percent or more of their weight by the 16th session each received a \$25 gift card. All 27 members received an Air Fryer for completing the core 16 weeks. At the end of the 20th session, 11 members received an additional gift card for reaching, or maintaining, the 5 percent weight loss. All gifts or gift cards were distributed in the class; this “instant gratification” concept resulted in an element of excitement and gratitude. In addition to weight loss, participants are required to complete 150 minutes of activity each week. The members were encouraged to form walking groups each week and are having fun as well as developing great support groups.

Forty eight members attended the first DPP class in early March and by the end of the core 16-week sessions at the end of June, 27 members remained enrolled. Of these 27 members, 11 have already achieved the required five percent weight loss, with a total class loss in excess of 215 pounds. Twenty-one members attended all 16 classes, The program has now moved on to the maintenance segment for the remainder of the year. The goal of this eight month segment is to remain committed and motivated to maintaining a healthy lifestyle and to lose more weight, or at least to maintain the five percent loss. At the end of session 20, twenty six members remain enrolled, with all 11 maintaining the five percent weight loss. Four of the participants have lost more than 10 percent, with the most successful of them losing 35 pounds and over 14 percent of their starting weight. The total cohort loss is 248 pounds with an average loss of 4.8%. Three of our

participants have recorded a reduction in their HbA1c with one showing a reduction from 6.3 to 5.6 in the first four months of the program. Due to the remarkable success of the internally supervised DPP, KHS has decided to continue with this pilot program and expand the in-person group method of delivery to include a larger portion of our eligible members next year.

LA Care Health Plan

Elevating the Safety Net

Los Angeles county has a severe health care workforce shortage. Currently, there are 48 primary care physicians (PCPs) per 100,000 people¹, whereas the recommended number is 60,000 - 80,000 people. The demand for Medi-Cal has increased drastically with recent coverage expansions, and the physician supply has not kept pace. Projections show that the regions of Los Angeles, Orange and Inland Empire will need more than 2,000 PCPs to meet access needs by 2025. Additionally, shortages will worsen as the health care workforce pool shrinks as baby boomers retire².

According to the CA Future Health Workforce Commission report, a number of communities of color in Los Angeles County do not have adequate access to primary care. Additionally, PCPs who are representatives of the communities they serve are in high demand. The target population for L.A. Care's Elevating the Safety Net initiative are those individuals who are most likely to practice in primary care and serve the Medi-Cal population. Thus, L.A. Care has targeted a diverse group of medical school students who come from the communities they hope to serve and providers and practices who have committed to working with the Medi-Cal population for future years.

The Elevating the Safety Net initiative targets multiple points of entry to Medi-Cal practice and supports a "pipeline to grow the provider pool in Los Angeles County". By targeting students, recent graduates, and current providers and practices, L.A. Care has built a program that addresses the current demand as well as the future shortage of providers. The three programs under this initiative include: (1) Medical School Scholarships, (2) Physician Loan Repayment Program (PLRP), and (3) Provider Recruitment Program (PRP).

The Medical School Scholarship program provides incoming medical students with full scholarships to pay tuition, living expenses, and school supplies, up to \$350,000. Students selected are from diverse backgrounds and have expressed interest in public health and serving vulnerable populations. The PLRP provides medical school education debt relief up to \$5,000 per month for 36 months to new PCPs in L.A. Care's Medi-Cal network. Finally, in order to assist our safety network, PRP provides grant funds to medical groups, clinics, or individual practices who recruit PCPs new to L.A. Care's Medi-Cal network. Both PLRP and PRP require that providers serve L.A. Care's Medi-Cal members for at least three years to receive continued funding. Overall, the Initiative is intended to assist clinicians who want to practice medicine and serve low-income families and individuals in these settings by lessening the burden of loan debt.

The Elevating the Safety Net initiative began in July 2018. Under the medical school scholarship program, 16 scholars have been awarded. Half of the students are from Charles R. Drew University and the other half are from the University of California, Los Angeles (UCLA). Eighty percent of the students awarded are people of color, which meets one of the Elevating the Safety Net's guiding principles to increase the number of health care providers that can speak the languages and understand the cultures of L.A. County's diverse communities. PLRP has awarded 20 providers to date and continues to grow, as many applicants are under review for future awards. Under the PRP, 92 grants have been awarded to practices throughout the county and 55 new providers are hired and practicing among Los Angeles County safety net providers.

Partnership Health Plan

1. Reframing Neonatal Care for Opioid Exposed Infants.

¹ California Health Care Foundation. California Physicians: Who they are, how they practice. August 2017.

² California's Primary Care Workforce; Forecasted Supply, Demand and Pipeline of Trainees, 2016 – 2030. August 2017.

Nationwide, an estimated 39 percent of pregnant woman insured by Medicaid consume opioids at some point in their pregnancy. From 2013-2015, 1.9 percent of babies born were diagnosed with neonatal abstinence syndrome. The rate in counties served by Partnership Health Plan (PHP), ranged from 2.8 percent to 11.7 percent. Customary care of infants with neonatal abstinence syndrome often includes admitting the baby to an intensive care nursery (separating mothers and infants), using the Finnegan Scale for assessing neonatal withdrawal, and administering many doses of opioid medication to the infant if they show symptoms. Collectively this results in long lengths of stay in the hospital (early 2018 rate for our health plan was 18 days, a rate that had been rising annually for 3 years). PHP's target population was pregnant woman consuming opioids in pregnancy and neonates exposed to opioids before birth.

Matthew Grossman, a pediatrician at Yale University, reduced the average length of stay for these infants from 30 days to four days, based on systematically proving that these traditional interventions were harmful. The core elements of this approach are: infants rooming in with mother (no Intensive Care Nursery admission), not using the Finnegan scale to drive treatment (developing a new Eat, Sleep, Console standard), and only using opioids to manage withdrawal symptoms on an as needed basis. Standards of care for mothers taking opioids is also inconsistent. The California Maternal Quality Care Collaborative has developed a toolkit of best practices in the treatment of these women during the prenatal, delivery and postpartum periods. Our health plan sought to widely spread these strong new evidence-based practices throughout the hospitals that have maternity services, with the following activities: (1) Identifying contact list for major prenatal care and newborn care clinicians. (2) Planting the seed for these new approaches with email communication. (3) Hosting a high-quality, widely-publicized convening of national experts promoting these new evidence based approaches connecting with all providers. (4) Facilitating prenatal care providers at hospitals in four counties participation in a Substance Abuse and Mental Health Services Administration (SAMHSA) funded learning collaborative on these new methods.

Comparing average length of stay before and after the large convening, the average length of stay for infants diagnosed with Neonatal Abstinence Syndrome dropped from 18 days to 11 days, the first drop in length of stay for this population in four years. If this drop is stable, it will result in estimated savings of \$1.55 million per year in hospital expenses. Some hospitals noted barriers in the physical configuration of their rooms as a barrier that may take longer to fix, slowing down adoption of co-rooming of mothers with their infants. We will continue to monitor average length of stay and provide focused additional re-framing education where needed. During the same comparison period PHP found a doubling of the number of pregnant women prescribed buprenorphine in pregnancy, from 0.8 percent to 1.6 percent. For additional information, see this article from CHCF: <https://www.chcf.org/blog/opioid-dependent-newborns-get-new-treatment/>

2. Shared Data Quality Dashboard

Health plans receive, process, and analyze tremendous amounts of data from many different sources, often stored in unconnected silos. Organizing and presenting this data in an actionable and timely way to drive quality improvement is challenging, even for the largest plans. There are significant opportunities for health plans to improve the health outcomes and experience of our members by incentivizing high quality health care and increased access. Absent a robust data analytic and visualization tool, these goals can only be achieved in a limited capacity. Our health plan developed a Quality Dashboard to facilitate real-time analysis of provider-level performance data over time. And to assist our efforts to drive improvement.

Data for all health plan members is represented in the Quality Dashboard. Primary Care Providers (PCPs) who use the Quality Dashboard system are able to view data related to their assigned patient population.

The Quality Dashboard is a Tableau-based, online, analytic platform that enables PHC providers and staff to prioritize, inform and evaluate quality improvement efforts through visualization, trending, stratification and comparison of quality metrics. It is a groundbreaking innovation for many reasons. It lets providers know our calculations of their performance, as well as estimates of their potential incentive earnings monthly. It offers actionable data in multiple formats, allowing providers to see big picture trends as well as member level drill-downs. The Quality Dashboard supports

provider leadership decision-making and is a model in transparency. We have sought examples of other health plans, private and Medi-Cal, offering similar data platforms and have found none.

Before implementing the Quality Dashboard, PHP did not have an easy, real-time way to understand our performance at the provider site level. Analysis was ad hoc, with results stored in various locations across the organization. Processes were manual and time consuming. The Quality Dashboard has reduced the amount of time health plan staff spend on generating reports by automating approximately 80 percent of them. This frees up our time so we can focus on and prioritize improvement activities, and support our members and providers. Providers have reported that the Data Quality Dashboard is useful: 89.55 percent of providers of the PCP pay for performance program report it is helpful and easy to use. Health plan Medical Directors use the Quality Dashboard to facilitate conversations on quality with providers. In the first year of its implementation, we saw more providers hit the 75th percentile in eight out of ten of our quality metrics; we also saw more providers achieve the 90th percentiles in seven out of ten metrics.

Positive Healthcare (AIDS Healthcare Foundation)

Increasing Compliance and Decreasing Barriers for Retinal Eye Exams amongst Diabetic Patients.

AIDS HealthCare's managed care division Positive Healthcare – California (PHC) - constantly monitors the health outcomes of our members. PHC focused on a particular area of the Healthcare Effectiveness Data and Information Set (HEDIS) measures it wanted to focus on: retinal eye exams for diabetic members. Using administrative data for the 2018 Reporting Year (RY), PHC had a compliance rate of 40 percent, which was below the goal of 48 percent set at the beginning of the year. Similarly, using administrative data for the 2017 RY, PHC had a compliance rate of 32.1 percent.

PHC worked to increase member's access to care by removing as many barriers as possible. The plan's member population consists only of HIV/AIDS positive members who subsequently suffer from high rates of mental illness, drug abuse, homelessness, disability and social disparities. Some of the barriers the members have in regards to health care are access, transportation, and ability to complete the visit with a licensed eye care professional.

PHC purchased RetinaVue, a handheld retinal camera used to take a scan of the member's eye. This scan is immediately transferred via a HIPPA-compliant, FDA-cleared software to a network of board certified ophthalmologists and retina specialists who review and provide feedback. With the camera's portability and ease of use PHC wants to meet the member where they already are receiving services and provide the Retinal Eye Exam as an added test. By utilizing this camera, the diabetic patient can receive their eye exam while they attend their PCP visit. This innovative care method provides a "one-stop shop" for diabetic care to non-compliant members in the healthcare centers. Members going to see their PCP are now able to undergo this exam without any additional action required.

The RetinaVue camera initiative is currently being piloted in two Los Angeles area healthcare centers. The program intends to take the findings of the pilot to officially launch the project to be available for all patients by October 2019.

United Health Care

HEDIS Call Campaign

United Health Care (UHC) experienced compliance rates below the Minimum Performance Level (MPL) for selected measures. As a result, UHC focused this intervention on members with eligible care gaps for Cervical Cancer Screening (CCS), Comprehensive Diabetes Care (CDC), Controlling High Blood Pressure (CBP), Children & Adolescents' Access to Primary Care Practitioners (CAP), and Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34).

UHC trained and deployed a team of bi-lingual staff from the health plan's quality department to place outbound calls to members with open care gaps. The team aimed to achieve meaningful member engagement with a goal of obtaining member buy in and scheduling a PCP appointment, rather than focusing on the quantity of calls. These team members had prior experience working in a clinical care setting and were equipped to engage members through motivational interviewing

techniques to encourage patient care visits. Additionally, being an employee of the plan enabled the team to support member needs and immediately take action to address member requests such as changing their PCP and coordinating appointments for the entire family. The team contacted the PCP office to schedule a visit and arrange transportation with the member on the call.

The team was significantly more effective in scheduling visits with an effectiveness rate of 21.9 percent compared to that of our comparable vendor's success rate of 4 percent. The plan garnered valuable member feedback that would otherwise have been captured by a third- party vendor. Feedback included: unaware of the importance of need for the medical appointment; member did not establish care with their PCP; lack of knowledge regarding screening requirements; and lack of understanding of the PCP role or need for preventative care. The team placed calls at various times during the day and evening to ensure member contact and found that calls were most effective when placed in the afternoon.