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

October 2021

California Department of Health Care Services

2021

Award Winner

SCAN

Leveraging Mobile Integrated Healthcare and Emergency Medical Technicians (EMTs) to deliver COVID-19 vaccines homebound members, their caregivers and family members

AND

Runner-up

Inland Empire Health Plan

Medi-Cal PCP Auto Assignment Redesign

Sixth Annual Innovation Award, October 27, 2021

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

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

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

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

DHCS received fifteen nominations from eleven MCPs.

AWARD NOMINATION SUMMARIES

Central California Alliance for Health

1.Your Health Matters Outreach Program

With the Coronavirus Disease 2019 (COVID-19) pandemic, health inequity became apparent early on as access to vaccine for underserved populations was challenging due to accessibility, rural areas, language, and other barriers. The Plan engaged in regular calls and collaborative work with county leaders and local organizations to plan support in improving county equity measures in our service area. The Plans Outreach team shifted efforts from face to face engagement in the community to making calls to members within the underserved populations identified by each county. The staff provided essential information needed to assure members take a safe approach avoiding infection of COVID-19.

Low-income, Latino, mono-lingual Spanish speakers, and essential workers were disproportionately impacted by COVID-19 in terms of higher rates of infection, hospitalizations, and deaths in our service area. These members were identified as California began the implementation of the health equity metric that was used to determine a county's tier regarding COVID-19 infections. The Plan used a data-driven approach to identify the most vulnerable members.

To accomplish our strategy, our efforts required us to work hand in hand with the local Health Departments and address local needs as well as, following state and federal guidelines and goals. With the information and data received from these efforts, the intervention was innovative because the Plan was able to immediately mobilize staff from the “Your Health Matters” program - an already existing program that utilizes volunteers from the entire organization for community outreach. Pre-pandemic, this was once an in person only member outreach program and shifted efforts to telephone outreach calls to members. There were over 30 trained volunteer staff from within the ranks of the organization, who stepped up and became the critically needed workforce to reach out to our most vulnerable members. Staff provided essential information needed to assure members take a safe approach to preventing infection of COVID-19: get the flu shot, stay home if you are sick, and no group gatherings were messages included in the outreach. When the vaccine became available, we were strongly positioned to quickly transition from education and resource sharing, to vaccine promotion. The ability to shift efforts as information and guidelines changed was our most valuable asset during these trying times. Staff making calls were able to provide accurate up to date information to our most vulnerable members.

The Plan engaged in several call campaigns to inform and educate members regarding COVID-19. The calls began with general information around staying safe during the pandemic and vaccine readiness for high-risk members, residents of nursing facilities, and members ages 75 and older. When the vaccine became available, the Plan shifted to promoting the vaccine within the populations eligible at that time. The Plan has been able to call more than 15,000 members and to successfully reach over 9,000 members. Those who were not reached were due to disconnected/wrong number, no longer living in the home, or no answer. Approximately half of the individuals successfully reached are fully vaccinated or have received their first dose. This aligns with the Plan’s overall vaccine rate of 53 percent. A few members were working with their doctors as they have health complications and were unsure if they are eligible for the vaccine. We also found that there is misinformation about the vaccine safety/side effects and members are wanting to learn more and deciding to wait to speak to their doctors. We also learned that the efforts during the call campaigns have assisted members in guiding them away from misinformation they have received, addressing challenges with members who have low health literacy, and providing COVID-19 vaccine information and other supportive resources to extended family members.

2. Primary Care Physician Visit Bypass

The Plan collaborated with targeted providers on the Breast Cancer Screening (BCS) HEDIS measure to address breaks in measure trending identified by National Committee for Quality Assurance (NCQA). Having recognized locally the downward shifts in BCS rates, innovative

Provider-ready plans were quickly drafted to reinvent the process for members left unscreened due to COVID-19 restrictions. With a goal to reduce Provider overhead while reengaging members eligible for screening mammograms, a Primary Care Physician (PCP) Visit Bypass protocol was introduced.

Due to COVID-19 restrictions, it could be expected that any non-compliant member eligible for Breast Cancer Screening was not being scheduled for a screening mammogram across all providers.

In leveraging already existing Provider and Imaging Center infrastructure, the Plan was able to act in good stewardship and offer a light-weight, no-cost platform to assist in returning Plan members to care. To do so, the Plan recalled the lists of unscreened members, based on measure eligibility, the lists were disseminated to partnered Providers. It was requested that all member charts be reviewed by each Provider, confirming that no contraindications were present, that a PCP visit occurred within one year of the intervention start date, and that no instances of documented mammography were present. If all conditions were met, clinical staff would then submit referrals to the partnered Imaging Center, enacting the PCP Visit Bypass protocol. The Imaging Center would then track, manage, and process the results of each member appointment, to be reviewed weekly by the Plan.

A great determination of innovation is when a change in output bears success over its predecessor. Given the achievement noted from the PCP Visit Bypass effort, the results-based outcome lent the mark of innovation. Given one Provider's efforts utilizing the PCP Visit Bypass protocol, out of 106 members contacted, 48 members were screened, all in less than 60 days, rendering a 400 percent improvement when compared to the 60-day average compliance run rate noted in subsequent periods. In this example, Plan members delighted in their return to care, rates increased, and the Provider was left unburdened to address greater care needs.

Gold Coast Health Plan

Using a cascade-of-care model to integrate member and provider interventions focused on improving asthma management across a continuum of care.

In 2020, our plan's Asthma Medication Ratio (AMR) rate was 50.09 indicating that half of the eligible population didn't maintain a clinically recommended greater than or equal to 50 percent ratio of controller to total asthma medication. A barrier analysis, to evaluate performance by six social determinants of health (age, gender, residence, spoken language, ethnicity, and race), and to evaluate medication and provider utilization, revealed three primary barriers. Members between 19-51 years of age and members residing in a specific area within the county had the lowest compliance. However, the most significant barrier, that was prevalent in all categories analyzed, was inappropriate utilization of asthma medications with significantly low utilization of controller medications and high utilization of rescue medications.

Since the primary barrier within this population was mismanagement of asthma medication, we developed a health plan and clinic-based asthma outreach program, that targeted all full-scope Medi-Cal members with active Gold Coast Health Plan (GCHP) membership that were between 5 to 64-years of age, had a diagnosis of persistent asthma, and had a less than 50 percent ratio of controller medication to total asthma medication. Also, this population was using healthcare services, but not receiving medical attention for their asthma during their clinic visits, confirming missed opportunities by both the member and healthcare provider to manage the asthma. The health plan outreach included two groups: Group A was a health disparity group that lived in a specific area, and Group B was the remaining population.

According to the Centers for Disease Control and Prevention (CDC), the prevalence of people diagnosed with asthma has increased over the past decade, demonstrating the need for improved care and medication management. Asthma can be a lifelong disease that can potentially limit a person's quality of life, but an effective asthma care and management plan can significantly improve health outcomes. The National Heart, Blood, and Lung Institute advises that effective management requires performing frequent assessments, monitoring asthma severity and control, providing self-management education, controlling environmental factors and comorbid conditions, and providing

medications to meet patient needs and circumstances. Understanding the challenges with improving the AMR rate, the demographics and characteristics of the target population, and the need to develop an innovative approach to improve asthma management that integrated both provider and member engagement, we applied a cascade-of-care approach that utilized successive health plan and clinic led interventions to promote the same message across a continuum of care: (1) schedule an asthma exam, (2) complete and/or update an asthma action plan, and (3) assess current asthma medication regimen. The interventions included (1) a health plan lead telephonic outreach program; (2) health plan/clinic outreach partnerships with contracted providers; and (3) the development of the GCHP asthma exam member incentive program.

Both the health plan and the clinic outreach programs resulted in improved asthma management. The health plan's two outreach programs included telephonic outreach by Health Navigators to (1) promote the importance of routine asthma exams with a PCP; (2) maintain a current asthma action plan; (3) take asthma medication as prescribed by the PCP; (4) assess barriers to asthma management; and (5) assess the need for asthma education. A post-intervention analysis showed the AMR rates for both Group A and B increased; three point sixty five percent and four point eight five percent respectively. Follow-up calls were made to Group A and 72 percent of the members contacted confirmed they had scheduled an asthma exam with their PCP. For the four health plan/clinic coordinated outreach programs, each clinic received GCHP-developed outreach tools and the GCHP asthma exam incentive forms to contact members and promote the incentive program and schedule office or telehealth appointments. The incentive program awards members with a $40 gift card if the provider completes the following three components during the clinic visits: asthma exam, new/updated asthma action plan, and assess asthma medication. Based on completed outreach to date, asthma exams were scheduled for 70 percent of the members contacted. The clinics also reported that the member incentive program requirements alerted the providers to complete all three components during the clinic visit and engaged members to complete the appointment.

Health Net
In collaboration with California Health and Wellness

1. Member Engagement Score

Low engagement between members and the primary care network (particularly among Medi-Cal and Expansion members) is associated with low rates of recommended and needed preventive care. We have developed a Member Engagement Score to help our team mates and partners identify those members most and least likely to engage with the primary care network in the coming year. The Member Engagement Score targets all members excluding Medicare. It takes advantage of recent developments in predictive modeling and machine learning in order to predict a member's probability of not engaging with the primary care network in the coming year. These predicted probabilities calculated across the entire membership (excluding Medicare) of being a Member Without Office Visit (MWOV) are broken into quartiles to create a Member Engagement Score (1-4).

The Member Engagement Score is a tool to first identify opportunities to foster members' engagement with the primary care network and second to assess whether member engagement (or some other process) is a barrier to the desired goal/outcome. Where member engagement is low, the Member Engagement Score assists team members and provider partners in assessing the breadth and depth of outreach needed to reach the membership in a particular cohort - e.g. provider panel, HEDIS denominator, demographic or geographic cohort, etc. - and helps with resource planning.

Health Net

1. 2020 Dynamic HEDIS Dashboard – Health Disparities

Health care disparities are closely linked to inequities that are adversely experienced by certain groups of people. Among California's Medi-Cal beneficiaries, gaps in access to care and quality of

care are often more prominent when narrowed by racial/ethnic affiliation, language, and other broader Social Determinants of Health (SDOH) factors. Efforts to improve health outcomes among underserved populations must fully consider culturally responsive approaches at the community, member, provider, and system levels. To that aim, Health Net sought to develop a tool that would help identify the most current health disparities affecting members, using the latest HEDIS performance data available to guide the planning and development of appropriately-tailored interventions. Health Net maintains a very diverse membership. As of December 2020, Health Net had 1,571,750 Medi-Cal members across seven counties. Females made up 53 percent of members. Nearly 47 percent were within the ages of 22-65, and 42 percent under the age of 22. Seniors aged 66 and older made up 11 percent. Nearly 54percent of members identified as Hispanic, 16 percent as White, nine percent as Black, and 11 percent as Asian/Pacific Islander. English was the preferred spoken language by 63 percent, followed by Spanish (28 percent) and Cantonese (one point four percent). An estimated 38 percent of all members were Limited English Proficient. Seniors and Persons with Disabilities accounted for 17 percent of subscribers. Poor housing was experienced by six point three percent of all members, with San Joaquin and Stanislaus Counties having the highest proportions. An estimated 18 percent lived in a rural or frontier-type geography. Obtaining HEDIS data segmented by race/ethnicity or other variables involves access to multiple datasets, requiring data analyst support. Turnaround timeframes varied, at times delaying the planning and execution of member-based equity projects. Health Net's dynamic HEDIS dashboard gives users the immediate ability to stratify and compare HEDIS performance by multiple variables. Furthermore, embedded data are updated monthly, ensuring use of the latest information available. To begin, users are presented with a self-guiding interface, with drop-down menus selecting the desired line of business, HEDIS domain (prevention and screening, pediatric health, women's health, behavioral health, cardiovascular conditions, diabetes, etc.), and geography (county level or statewide). Next, users specify the variable to segment the data: options include race/ethnicity, sex, housing status, household size, disability aid code, provider type, urban/rural residence, and Healthy Places Index Quartiles, to name a few. Using race/ethnicity as an example, a dashboard output would populate HEDIS measures of interest, and compliance rates by individual ethnic groups. Rates are color-coded, with gradients corresponding to performance percentiles. Other tools include hot-spotting maps and multivariate regression outputs. Overall, this dynamic dashboard enables Health Net to impact overall HEDIS performance by identifying and targeting groups with compliance rates lower than their counterparts. The HEDIS dashboard is an example of Health Net's commitment to the reduction of health care disparities for communities most impacted by inequities. The identification of disparity patterns by HEDIS measure improved, population targets became narrowed and specific, and program planning overall became more efficient through a culturally sensitive lens. Furthermore, data segments by geography allowed for more strategic, place-based community partnerships. Health Net's dynamic HEDIS dashboard will be of continued value in the development of future improvement projects, disparity analyses, and population needs assessments.

Inland Empire Health Plan

1. Final Administrative Risk Stratification Tool

Prior to the design and implementation of the Final Administrative Risk (FAR) tool, Inland Empire Health Plan's (IEHP's) risk stratification approach and algorithm did not include any data or consideration of the effects of the social determinants of health (SDOH) or social needs on a Member's risk profile. The tools used to stratify Members were only able to use clinical information (e.g. claims, encounters, lab, and pharmacy data) to build a risk profile of Members. Because of this limitation, Population Health leadership within IEHP determined that the current risk profiling approach needed to be more comprehensive and include SDOH and social needs data to better determine how to target Members for specific programs or special sub-population programs and initiatives.

The FAR was initially developed and implemented within the sub-population of cardiovascular Members as determined by cardiovascular-related diagnoses. Care Management teams within

IEHP needed a way to prioritize and rank the tens of thousands of Members that were part of this population and to develop a targeted outreach strategy to engage and enroll the riskiest Members into a cardiovascular-specific care management program. Without the ability to distinguish risk with more detail, including the risk associated with potential social factors that may lead to poorer health outcomes across this population, the care management teams would have had difficulty understanding who to target for program engagement.

The construction of the FAR tool combines IEHP's current internal clinical risk stratification algorithm with the California Healthy Places Index (HPI) in a simple yet innovative way to arrive at a risk stratification approach that includes both clinical and community-level and social factors that may influence a Member's overall health and risk of poor outcomes in the future. The current three-tiered clinical strata were given a single digit numerical value (three, six, and nine for Low, Rising, and High respectively) and the quartile categories of the HPI were given a single digit numerical value (zero, one, two, three for Less Healthy to More Healthy respectively) and these were added to determine the FAR risk category with numeric ranges of zero to five, six to eight, and nine to twelve for FAR Low, FAR Rising, and FAR High respectively. The combination of Member-level clinical data and community-level HPI data presented a challenge due to the attribution of community-level SDOH factors to individuals in those communities. Population Health leaders within IEHP recognized that although there is broad potential for bias in risk modeling when attributing community-level data to a specific Member, it provides a way forward and takes a first step in building a risk model with social and community factors in mind. Future iterations of the FAR will include a validation mechanism so the Plan can ensure the social and community factors assigned to a Member are actually true for that Member.

The implementation of the FAR tool in IEHP's cardiovascular population has allowed the care management teams engaging with that population to identify and target their outreach efforts for engagement into a program specifically designed for those Members. The program itself aims to improve rates of advanced care planning, function status assessments, medication review, statin therapy adherence, and controlling high blood pressure. With the assistance of the FAR tool, the teams have been able to engage with and enroll the sickest Members ranked as "FAR High", as indicated clinically, and those living in areas with the lowest Healthy Places Index quartile, indicating the presence of levels of social determinants that lead to poorer health outcomes, into the program to improve their rates of those listed above. Because Care Management resources are limited, the FAR tool has provided a way for Care Management to use those resources in the most appropriate and efficient ways possible through this targeted intervention. Supporting the sickest Members in our communities improves their experience with the Plan, their overall healthcare journey, and their lives.

2. Medi-Cal PCP Auto Assignment Redesign

IEHP's current Medi-Cal PCP Auto Assignment algorithm does not include quality factors. As a result, IEHP Members may be randomly assigned to lower quality providers when higher quality providers are available.

The target population for this project is new and reinstated Medi-Cal Members enrolling with IEHP, who have not selected a PCP.

IEHP's redesigned Medi-Cal PCP Auto Assignment algorithm incorporates over a dozen weighted provider attributes related to quality, allowing us to assign Members to higher quality PCPs. These attributes include overall quality performance, board certification, facility site review audit scores, utilization of electronic medical records, and offering extended office hours. For overall quality, IEHP aggregates performance on select HEDIS measures, then categorizes all PCPs based on their percentile – 75th, 50th, 25th, and less than 25th. The 75th percentile is considered high quality and is assigned the highest weighted value of all the attributes. The 50th percentile, considered average, receives no additional weighted value. The 25th and less than the 25th percentiles are considered low quality and receive negative weighted values. All attributes have positive or negative weighted values, which IEHP aggregated for each PCP. High aggregated scores indicate higher quality while low aggregated scores indicate lower quality. In our redesigned

algorithm, the PCPs identified as high quality, who as a result have the highest aggregated scores, receive a higher percentage of the unassigned enrolling Medi-Cal Members.

After the first year of this auto assignment redesign, the overall IEHP Member assignment to high quality (75th percentile) PCPs increased from 27.2 percent to 31.3 percent and the overall IEHP Member assignment to low quality (25th and less than 25th percentile) PCPs decreased from 30.1 percent to 22.4 percent. Phone calls from Members to IEHP's Member Services Call Center for PCP changes decreased. The call-to-Member ratio was 1:142 prior to this implementation and an average of 1:117 in the year following implementation. PCP-related grievances filed by Members to IEHP have also demonstrated a downward trend since this project's implementation. The grievance-to-Member ratio was 1:2,717 prior to go-live and the grievance-to-Member ratio decreased to 1:2,482 in the year following implementation.

Kern Family Health Care

1. Member Engagement Rewards Program

With 2020 being amid the COVID-19 Pandemic, Medi-Cal beneficiaries had more than just their regular day to day worries, including: numerous closures of schools and businesses, limited access to resources, and preventive care needs were once again put on hold. Unfortunately, getting preventive care should not be something put on hold as it helps in the reduction of the risk for diseases, disabilities, and death. Kern Health Systems (KHS) reviewed all measures in preventive care and determined that a program needed to be developed to help encourage members to seek preventive care while receiving a reward at the same time, due to the historically high rate of non-compliance in certain measures.

The target population for the Member Engagement Rewards Program (MERP) program were newborns, children, adolescents, and all pregnant and postpartum members who were actively enrolled in the Plan. This population was selected based on the rate of non-compliance for preventive health care services in general. Specific areas that showed significant non-compliance included well care visits for infants, children, and adolescents. In addition, rates for prenatal and postpartum visits dropped significantly, likely due to the pandemic. The low level of compliance reflects lack of active follow-up and the importance of aiming preventative messages at parents and physicians.

KHS launched the MERP in the 4th Quarter of 2020. The program was created to encourage members to complete preventative screenings by offering an incentive upon completion. The MERP was designed to boost member participation in services for preventive care and chronic condition management. The program leverages two primary approaches in supporting members toward self-management. The first approach is providing multiple options for contacting, educating, and engaging members, such as: Interactive Voice Recognition calls, text messaging, letters, website, member and provider portals, social media postings, and live phone calls. The Quality Improvement Department has two non-clinical support staff fielding any questions from members that come up regarding the measures and rewards via live calls. The second approach is to provide rewards to members that will encourage them to follow through with completing preventive health or condition management services and activities. With the unpredictable changes and struggles of the pandemic, KHS had to create an innovative approach to the new "normal" while keeping in mind the safety of our members. With movie tickets no longer useful as a reward, KHS decided to reward members with gift cards for online shopping alternatives, including Walmart, Target, and Amazon. This allows our members online shopping at one location for all their household needs, including toiletries, food, clothes, shoes, and diapers

The first campaign began at the height of the pandemic when the public was advised to continue the stay-at-home orders, which likely had a negative impact on the outcomes of the campaign. Despite the challenges being faced at the time, we were able to continue outreach to members and encourage them to continue to follow up on their preventive care services that were included in the MERP. A second campaign was completed in June 2021. KHS attempted outreach to a total of 60,499 members by robocall or mailer between November 2020 and the end of June 2021. A total

of 53 percent of the outreached members met the requirement for their preventive care and received a reward. The total number of gift cards that were mailed to these compliant members were 32,225 for a total dollar amount of $595,704. The following measures demonstrated improvement: Adolescents Well Care Visits with an increase of 11.11 percent. For Well-Child Visits in the 3rd, 4th, 5th & 6th Years of Life, there was a seven point nine-five percent increase in the rate between October 2020 and December 2020. The Postpartum Care measure had an increase of seven point nine-five percent between September 2020 and December 2020.The MERP is focused on monitoring outcomes of the campaigns to leverage the results for planning future campaigns and implementing necessary changes to drive decisions for MCAS compliance. With each outreach we hope to get an increase in engagement and compliance from our members for a result of completed appointments for preventive care.

2. Establishment of Managed Care Accountability Set Committee

It became apparent that a new approach for KHS meeting the Managed Care Accountability Set (MCAS) measures' minimum performance levels (MPL) was needed. This need was identified based on not meeting compliance for certain measures in previous years, the addition of a new, higher MPL established by DHCS, and from the impacts of the pandemic. Based on a Strength, Weakness, Opportunities, and Threats (SWOT) analysis completed in the fall of 2020, we identified a gap with having a mechanism for all departments collaborating on strategies to meet these MPLs.

KHS focused on MCAS measures that are held to the MPL. The Plan identified KHS members who are non-compliant with these particular measures. In addition, the target population included members who have not had their initial health assessment. The MCAS Committee also focused on addressing member needs related to the COVID-19 pandemic. This has included both supporting members to return to their PCP for preventive health services along with encouraging them to get vaccinated.

Preventive health care and chronic condition management are services that require support from many departments in order to achieve success. There are two sayings that illustrate the challenge faced in pulling groups together to achieve a common goal. The first is “You can lead a horse to water, but you can’t make it drink.” This concept lays out that you can establish a forum but gaining engagement doesn’t come naturally. The second is “If you build it, they will come.” This illustrates that if you set up the game properly, people will want to participate and be a part of the effort.

This intervention required a significant amount of innovative strategy to set the stage in a way that participants wanted to be involved. To accomplish this, we first developed a deliberate strategy starting with who should join the effort; heads of those departments were identified as committee members. Second, we developed a communication to these individuals informing them of the goal for the committee and why their involvement was essential. This was accomplished by creating a charter for the committee. Third, our strategy involved how agendas were established and who would present for each item of discussion. The agenda items involved incorporating what we knew other departments were already working on or had a strong passion for some aspect of member wellness promotion. Doing this generated an atmosphere of enthusiasm and open dialogue. That enthusiasm became contagious and caused everyone on the committee to share their input.

Since January 2021, we have had six committee meetings with near perfect attendance. The enthusiasm has been high enough that we have had requests to join the committee. The committee now has representation from the following areas: Quality Improvement, Health Education, Member Services, Case and Disease Management, Marketing, Provider Network Management, Utilization Management, Pharmacy, Compliance and Business Intelligence. The executive sponsor is our Chief Health Services Officer with the Chief Medical Officer serving as the Executive Clinical Consultant. In the first seven months of 2021, the following are some key accomplishments of the committee: first was implementation of the Member Engagement and Rewards Program. The Committee played a key role in identifying which MCAS measures would be included in the first member outreach campaign completed in June. Another major accomplishment was inclusion of many departments in the design of KHS’ Provider Pay-for-Performance Program. Historically, the

design was primarily completed by the Provider Network Management Department. Now it is truly a cross-departmental collaboration. Finally, the creation of the MCAS Committee provided a forum in which the majority of departments at KHS have a voice in determining and evaluating strategies and interventions to improve KHS' compliance with MCAS measures. The strategy and approach used to form the committee is what has driven successful outcomes in completing and evaluating our work toward MCAS compliance.

Los Angeles Care Health Plan

Elevating Care, Access and Reimbursements; Elevating the Safety Net (ESN)! A $155 million initiative addressing Los Angeles County's physician shortage.

The California Future Health Workforce Commission's February 2019 report, Meeting the Demand for Health, projected that "California will face a shortfall of 4,100 primary care clinicians and 600,000 homecare workers, and will only have two-thirds of the psychiatrists it needs by 2030." Moreover, California Health Care Foundation's July 2020 report, Shortchanged: Health Workforce Gaps in Los Angeles County (LAC), found that of the 10,105,518 people living in LAC, an estimated 3,702,746 live in a health professional shortage area where there are 33 or less primary care providers per 100,000 people. To address the looming physician shortage, Los Angeles (L.A.) Care's Elevating the Safety Net (ESN) initiative aims to recruit, train, and retain health professionals who are coming from and committed to working in underserved communities of LAC.

L.A. Care's ESN initiative prioritizes investments that enable community-based organizations, teaching institutions, and safety net employers to recruit, train, and deploy a new wave of health workers — especially those coming from and committed to working in underserved communities. L.A. Care's initiative goals include increasing the number of primary care physicians (PCPs), including psychiatrists; supporting students by cultivating their pursuit of careers in the health professions; improving diversity in the workforce by increasing the supply of health professionals who come from underserved communities; and expanding the health outreach and prevention roles of community health workers and home health workers who have some of the most trusted relationships in our communities.

To date, L.A. Care's ESN initiative has invested over $85 million, since launching in 2018, to support a diverse set of programs by offering full medical school scholarships for low-income, first generation, and underrepresented students; offering loan repayment awards for PCPs committed to practicing in safety-net settings and underserved communities; offering salary subsidy grants for safety net employers who hire PCPs; expanding primary care residency slots across sponsoring institutions, including universities, hospitals, and clinics; offering grants to teaching institutions to establish new medical education programs with a community focus; offering internships for college students and recent graduates from underrepresented communities who are interested in pursuing careers in LAC's safety net; and expanding training opportunities for community health workers and home health workers who can serve our most vulnerable member populations. With investments under the ESN initiative, L.A. Care's aims to reduce the financial burden many PCPs and employers face when seeking retention in the safety net and expanding on the academic opportunities available for students who express a sincere commitment to a health profession in LAC's safety net.

Since launching the initiative in 2018, the number of program investments has grown from three to ten. To date, with $18 million invested, 101 new PCPs are receiving loan repayment awards (92 percent retention); with over $16 million invested, 137 new PCPs have been hired by safety net employers (81 percent retention); with almost $10 million invested, 34 new residency slots received funding for expanded access; with $10 million invested, two new graduate and medical education programs will expand training for local students in health care and community medicine; with $600,000 invested, 28 medical, nursing and physician assistant students have received fellowship training in safety net settings; with $800,000 invested, 96 student interns will gain experience in managed care and health settings; with over $600,000 invested, 54 Community Health Workers (CHWs) have received comprehensive training to serve in multidisciplinary care teams; with over $8 million invested, 3,861 home health workers have received training to care for vulnerable home-

bound community members. The investments under the ESN initiative provide an immediate benefit for providers and employers delivering primary care for our members. Additionally, by investing in aspiring students from underrepresented communities, L.A. Care will continue to build on current achievements to address gaps in access, diversity, and educational opportunities available for LAC's workforce.

Molina Healthcare of California

Moms Of Molina's Visit Transition to Telehealth

Due to COVID-19, the landscape of how healthcare is administered was forced to adapt. Members were delivering newborns and postpartum care needed to change. Molina's target population are newly delivered mothers on Medi-Cal in Sacramento.

This intervention was innovative as it expanded our established model of administering needed care in the members' home to administering needed care via telehealth practices. This connection allowed for nurse practitioners to continue their work of meeting the member where they needed care.

Due to this expansion of technology, Molina was able to reach the 50th percentile for Sacramento county when the year previously Molina failed to hit the 50th percentile.

Partnership Health Plan

Partnership Health Plan's Wellness and Recovery Program

Substance abuse adversely affects Partnership Health Plan (PHC) members, families and communities. Ten percent of Americans are thought to suffer from addiction, but the estimated problem is greater in poorer, rural communities. Addiction exacerbates or causes many health care problems, in addition to significant community and social concerns. In 2015, the California "Organized Delivery System" model was implemented to help address these needs, but opting in to this program presented significant challenges for PHC's smaller, more revenue-challenged and rural counties. In addition, the features that allow for the most effective approach to substance use treatment - collaboration and integration across the health care system, support from community and social stakeholders – were not in place.

PHC's Wellness and Recovery Program targets Medi-Cal beneficiaries 12 years or older, from seven PHC counties, including those who are not PHC members, needing addiction treatment. In the first year of the program, over 3,000 unique beneficiaries, or one point five percent of those eligible, accessed services in the model. This meets or exceeds the experience of similar programs in their first year. The program also seeks to address the need to strengthen collaboration and integration across the health care delivery system, directly involving the physical health care, criminal justice and child welfare systems in the outreach and activities needed to promote treatment for those with addictions.

Designed by PHC and the seven counties, the model involves new pathways of collaboration. Counties vary in their case management approaches and may designate licensed staff, such as criminal justice or child welfare clinicians, empowered to place clients in treatment. The managed care structure includes tools not associated with the County-administered plans, such as Interqual guidance; NCQA accreditation standards; and use of a capitated structure. Comprehensive care is provided through case management and close coordination with contracted MCP services.

Integration will be strengthened by more directly involving the physical health network into key Substance Use Disorder (SUD) related services including clinically observed withdrawal; enhanced screening and brief intervention practices; and continued promotion of medication assisted treatment. The fiscal model itself uniquely melds county and MCP financing, applying capitation and managed care funding principles to the county fee-for-service model, and an annual reconciliation process to ensure that state and federal funding requirements are met. Service quality involves the standard tools (e.g., recidivism rates, client perception surveys), by applying HEDIS and related data, and strengthened by a PHC-funded incentive program targeting providers'

identifying and addressing the needs of clients with co-occurring mental health and substance use needs.

Basic outcomes to date include the treatment of over 3,000 individuals with addictions; a preliminary 12.6 percent recidivism rate among clients using residential services; development of different case management models; broad outreach efforts which rely on the Plan's physical healthcare providers as well as community and county resources to reach members in need; the testing of strategies to improve alignment with the criminal justice system; use of telehealth to better address clients with co-occurring mental health needs; and case conferences to serve those with complex treatment needs. More broadly, however, the approach represents a unique and comprehensive shift in the way that the managed care plan works with its communities, strengthening ties to the criminal justice and child welfare systems; familiarizing county clinicians and programs with managed care approaches and vice versa; and increasing the interest among our communities and our providers in effective substance use treatment. This is evidenced by recent requests from MCP contracted Federally Qualified Health Centers (FQHCs) and Indian Health Service providers to look into Drug Medi-Cal certification; or hospitals and emergency rooms seeking help to more quickly identify and get into treatment those with addictions. A significant outcome has been the collaboration and increasing alignment among PHC, the seven counties, and DHCS as we work to improve the system of care for our shared beneficiaries.

SCAN

Leveraging Mobile Integrated Healthcare and licensed Emergency Medical Technicians (EMTs) to deliver COVID vaccines to SCAN Health Plan's homebound members, their caregivers and family members in the comfort and safety of their homes for no cost.

At a time when priority for COVID-19 vaccine distribution was going to mass vaccination sites and retail pharmacies, and no "in-home" vaccination efforts were launched by any entity, SCAN wanted to design an innovative approach to bring vaccines to homebound members' in a cost effective manner.

The target population for the program included unvaccinated members that met Center for Medicare and Medicaid Services (CMS)'s homebound criteria, have a documented history of Serious Mental Illness (SMI) or are functionally homebound due to additional Activities of Daily Living (ADL) needs. Members' caregivers and other eligible family members living in the same household were also given the opportunity to receive vaccines at no cost.

SCAN used a person-centered care (PCC) approach to understand what mattered to homebound members with respect to their health and the pandemic, and applied those findings to design this approach. This was the first in-home COVID-19 vaccination program launched in California leveraging a mobile logistical geo-mapping platform and Emergency Medical Technicians (EMTs). Homebound members that met the criteria to be part of the program were grouped into cohorts based on geographic locations to allow for maximum efficiency and routing of EMTs. The initial outreach was followed by text messages with a link to vendor application to schedule their in-home vaccination appointments. Members with limited computer literacy were offered assistance via phone to complete the scheduling. Automated confirmations, reminders and arrival messages via calls or Short Message Service (SMS) were sent by the vendor to ensure smooth run of the process. A key element of this approach was also to provide education regarding the importance and safety of COVID-19 vaccines. SCAN and the vendor used bi-lingual care navigators, customer service agents and EMTs to deliver this message with a heavy emphasis on vaccine confidence, at the time of initial outreach, during and after vaccination events.

SCAN analyzed the effectiveness of this program by comparing costs of vaccinating homebound members, which at $148 per individual is significantly lower than the cost of preventable COVID-19 related hospitalization, which averaged nearly $22,000 per older American per visit*. Of the members that opted in for the program, 92 percent of them actually received the vaccine. Primary declination reasons among members that opted out of the program included: 1) Already received the vaccine or scheduled to receive the vaccine, 2) Feel they do not need the vaccine, 3) Concerns

regarding side effects, and 4) Medical reasons. Overall member satisfaction ratings were also taken into consideration to evaluate the qualitative aspect of the program. On a scale of one through five (one being poor and five being excellent), SCAN received an overall score of five on all patient satisfaction surveys conducted post vaccination events. The in-home COVID-19 vaccination effort acted as a strong use case to demonstrate Mobile Integrated Healthcare and its ability to address some of our most vulnerable members' access to care needs in their homes. This effort was first launched in Los Angeles County and quickly expanded to Orange, Riverside and San Bernardino counties. In efforts to leave no senior behind in getting vaccinated and ensuring equity, being able to serve these vulnerable members in their homes was a strong step for SCAN.

*United States. News & World Report. (n.d.). Average COVID hospital bill for U.S. Seniors Nearly $22,000.

United Health Care

1. Care Navigator Program

Practices with limited resources are not able to recall members or dedicate services to follow up with members to coordinate needed care. This can impact member's health outcomes, access to preventive care, and follow-up care. Furthermore, staff that are dedicated to assisting with gap closure are serving patients from multiple health plans and payers, making a dedicated focus on a specific population more difficult. Staff may also not be incentivized to ensure important visits take place, and members with immediate needs will have priority in a busy office practice setting.

One practice was designated as a pilot site. This pilot site employed two full-time Care Navigators who would offer direct support to all members assigned to the health plan for both preventive health, initial visits, and care coordination needs.

The Plan funded two full-time employees at one specific clinic practice who did not have robust support to effectively manage recall activities. This novel approach integrated recall and follow-up efforts directly into the practice. The program cultivated a culture of Quality Improvement and staff were able to directly develop outreach efforts and tailor support based on a member's specific needs. Rates of successful contact were higher than the Plan's reach rates through standard outbound call campaigns or welcome calls. The practice was able to quickly identify opportunities to best serve the member and pivot to offer timely support to the member. Staff are knowledgeable about clinic services and operations and could better support the member than the Plan could. Staff were incentivized to meet certain targets, and expressed enthusiasm and pride in achieving these targets.

The program proved to be successful in impacting positive member outcomes such as immediate support following hospital discharge, coordination of care, establishing care, and preventive health screenings. The Care Navigators performed outreach to 100 percent of members with select gaps in care, successfully contacting 68% of members via telephone. Of these members, 43 percent of members were scheduled a visit to address a specific gap(s) in care. The Care Navigators scheduled appointments for members, of which 53 percent completed their visit. The Care Navigators coordinated care for members and conducted in-person sessions with 63 percent of these members. Members submitted testimonials remarking on the benefits of having someone to help them navigate the healthcare delivery system. The pilot site met the Minimum Performance Level for 58.3 percent of all measures reported. Comparable sites of the same size met eight point three percent of all measures reported. The pilot site significantly outperformed any other practice. The Care Navigators were found to greatly improve the care and experience of members.

2. Remote Blood Pressure Monitor Program

The Plan identified low utilization rates for routine medical visits due to COVID-19. As a result, the Plan identified opportunities to better support members with diagnosed chronic diseases, including hypertension. Members reported challenges to completing medical visits due to fear of contracting COVID-19 and offices offered telehealth visits primarily. Telehealth visits served as an innovative solution to combat access challenges but presented unique challenges to patient care as key components of the visit were missing. Providers are unable to assess blood pressure values in

a telehealth visit, and therefore unable to document BP control, or make adjustments to medication regimen to achieve control.

All members with a diagnosis of hypertension, as of November 1, 2020, were included in the program. Members included in the mailing were designated as the Experimental Group in this pilot project. Members who became eligible after program mailing or whose kit could not be delivered were placed in the Control Group.

All members with diagnosed hypertension were sent a blood pressure monitor kit with the capability of storing blood pressure readings, and with capability to transmit data to the provider's Electronic Medical Records (EMR) or office if available. The kit included multiple components: the monitor; pictograph instructions for how to use the monitor; instructions for when to check blood pressure and how to interpret results; a health education insert about the importance of blood pressure control; a physical log to track blood pressure readings; and a postcard with a link to the product manual available in English and Spanish. Providers were notified about the program and oriented to the program, including the mailing date. Discussions about the feasibility of the program took place with the Provider Advisory Committee who had several suggestions to improve adoption and connectivity between the members and the providers. When the providers were informed of the program, they were given a "best practice" recommendation to integrate the monitor into medical visits, including telehealth visits. The program served an immediate need that was identified early into the pandemic, to help providers keep track of this important but often silent population.

The Plan called members to assess their feedback on the kit and use of the monitor. Members reported the monitor was easy to use and compatible with smart phones. Members preferred tracking their readings using the paper log that was included in the kit over storing and transmitting blood pressure data via their phone. One member reported that the monitor saved his life. He started checking his blood pressure on a daily basis and was alerted to go to the Emergency Room when his blood pressure was reported as extremely elevated. This resulted in immediate medication management and cardiac testing and treatment. Members were coached on self-management activities to use the monitor on a frequent basis and track results. Results could be downloaded from the monitor directly to the EMR and providers were able to easily integrate blood pressure readings into televisits, although members noted their preference for recording and verbally reporting their results to their providers on a televisit, rather than downloading. Upon analysis of blood pressure control between the Experimental and Control Groups, the Plan determined statistical significance between the two groups. Members who received the monitor were more likely to have controlled blood pressure.