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

October 2018

2018

Award Winner

# Molina Healthcare of California Partner Plan, Inc.

# Mothers of Molina (MOM) Program

**The First Annual Health Equity Award, October 11, 2018**

# 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 Medi-Cal 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. Please note due to the low number of submissions this first year, a runner up award was not presented. In the future, DHCS hopes to present both a winner and a runner up for this award.

DHCS received five nominations from four MCPs.

# AWARD NOMINATION SUMMARIES

## Anthem Blue Cross

### Addressing Medication Management for Hypertension within the Asian population in Fresno County

In order to address a health disparity among the Hmong population in Fresno county, Anthem will be working with the providers at Kings Winery. Anthem will discuss cultural competency training, including a more culturally tailored approach for working with members who may be utilizing Eastern medicine techniques. Anthem will also work on addressing cultural barriers between members and providers such as, language and education through direct one to one health education. In order to address cultural barriers, Anthem will be engaging with the community and identifying key Eastern medicine practitioners in order to collaborate on educational opportunities. Anthem will be conducting key informant interviews with providers and participating members.

While this intervention is currently in the planning stages, Anthem has used demographic data and the 2017 year-end Healthcare Effectiveness Data and Information Set (HEDIS®) reporting data to conduct a disparity analysis. Anthem examined the Annual Monitoring for Patients on Persistent Medication (MPM), angiotensin converting enzyme (ACE) inhibitor/angiotensin receptor blockers (ARBs) measure using Tableau software, which allowed Anthem to visualize racial disparities. We then used the chi-square test of independence to determine if there was a disparity compared to the Non-Hispanic White population. After a comprehensive review of all HEDIS® measures based on race and ethnicity, Anthem narrowed down the list of statically significant disparities and looked at groups that were further from the minimum performance level (MPL) for each measure.

In order to evaluate the interventions effectiveness Anthem will monitor pharmacy data and MPM rates of Asian members in Fresno who fall into this measure. Anthem will compare the year end data with baseline year data. For member-level intervention, Anthem will establish a cohort and evaluate the effectiveness of the intervention at the individual level.

Anthem believes that a large portion of this disparity group consists of Hmong people, given the large Hmong population in Fresno. Anthem will conduct key informant and stakeholder interviews in order to gain insight into the cultural beliefs and traditions that will allow Anthem to develop a culturally tailored intervention.

## Health Net Community Solutions, Inc.

### 1. Postpartum Disparity Project

Health Net created a health disparity project focusing on African American women in Antelope Valley. Health Net analyzed demographic, encounter, and administrative data as well as, completed a comprehensive literature review in order to identify barriers and strategies that have been successful in reducing disparities. Our existing community collaborations comprised of local nonprofits and service agencies was utilized as a resource and advisory body for this project, which included a detailed barrier analysis and community assessment. Helath Net conducted significant research on disparity models produced through foundations such as Robert Wood Johnson and Kellogg and modified its model

By analyzing the Healthcare Effectiveness Data and Information Set (HEDIS®) data and segmenting the data by race, ethnicity, geography, provider group, and clinics, Health Net used a two sample test of proportion that established a target and reference group.

Health Net's prioritized disparity reduction project is based on priority HEDIS® measures and year over year performance trends. Our disparity project was selected based on volume of the disparate population and projections if the county rate improvements of the disparity was not successfully reduced. Additionally, Health Net developed a tool to support the disparity project prioritization which included a disparity analysis, volume and county rate calculations based on disparity reduction. Health Net understands projects that can impact the county rate have the narrowest geographic scope and addresses priority measures while leveraging the strengths of the provider groups and clinics.

.The disparity project was deployed with multi-pronged interventions targeting the member, provider, and system level to address barriers identified through the community and collaborative partner feedback. Formative research and barrier analysis was fundamental in identifying and isolating the key barriers. This is best reflected by the numerous multicomponent member level interventions that were put in place for this project to help address the multifaceted barriers faced by African American women in Palmdale/Lancaster in getting timely postpartum care. For example, a transportation program was implemented in order to provide transportation for women and their dependent children to postpartum visits and baby showers provided by the targeted clinic sites.

The evaluation analysis for the postpartum project has shown directional improvement with African American women postpartum compliance rate, improving from 17 percent in2014, to 33 percent in 2016, and 36 percent in 2017. The gap between African American members and Caucasian members' compliance rates in Antelope Valley reduced from 10 percent to 6 percent from 2015 to 2017.

### 2. Childhood immunization Series (CIS) Health Disparity project among Slavic Communities in Sacramento County

Health Net created a health disparity project focusing on Childhood Immunization Series (CIS) among the Slavic Community in Sacramento county. Health Net analyzed administrative data by language to determine whether language barriers affected children receiving the full Combination three course (CIS-3). In Sacramento county, while the Russian speaking population is small (N=113), they had significantly lower compliance rates for both diphtheria, tetanus, pertussis (Dtap) and pneumococcal conjugate vaccine (PCV), as well as the overall combination three series. The Russian speaking population represented point five (0.5) percent of the overall Medi-Cal population in the CIS denominator, but six percent of the Sacramento population (113/1,929).

Health Net used multi-pronged interventions to address identified barriers. Community input was solicited through the community advisor group (CAG). The CAG is specific to the disparate population with recruitment developed through community key informant interviews. The CAG provides oversight and support on the intervention design and implementation. Promising practices were implemented through qualitative research. Health Net used 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 analysis assisted Health Net in making an informed decision about the target metrics, population, and geographic location.

The project results showed directional improvement in the CIS-3 compliance rate for Russian speaking members from less than one percent compliance in 2014, seven percent in 2016, and ten percent compliance in 2017.

## L.A. Care Health Plan

### Tobacco use among African Americans

Between March and October 2016, L.A. Care launched a pilot intervention, Tobacco Use Among African Americans, targeting adult African American Medi-Cal Direct (MCLA), Cal MediConnect

(CMC), L.A. Care Covered (LACC), and PASC-SEIU members identified as tobacco users based on pharmacy, claims, and encounter data. This group received L.A. Care's standard Smoke Free Program packet which contained health education materials, a list of community resources, a California smoker's Helpline flyer, L.A. Care online smoking cessation resources, and a live agent phone call. The live agent was a community health worker trained in the American Lung Association's Freedom from Smoking Program and in motivational interviewing techniques. The agent was skilled in engaging the member to discuss their tobacco usage, ways to stop smoking, address any barriers to stop smoking, and provide additional tobacco cessation resources. The purpose of the live agent call was to assess receipt and helpfulness of the Smoke Free packet, note any changes in the member's behavior and/or readiness to quit, and to offer additional assistance in quitting as needed.

The Tobacco use among African American pilot program was developed based on the Consumer Assessment Healthcare Providers and Systems (CAHPS) 2015 data which demonstrated disparity between the reported rates of tobacco use among African American L.A. Care Health Plan members (31%) compared to L.A. Care's general membership (14%). The higher rate of tobacco use among African Americans has also been documented in scientific literature. The local data from the Los Angeles County Department of Public Health also found disparities in overall smoking rates for adult males, African Americans, and those with lower educational attainment and income[1]. The CAHPS 2015 data identified L.A. Care's African American member tobacco use rate for "everyday use" and "every day plus some days" as differing significantly from other L.A. Care Medi-Cal member race/ethnic groups at the 95 percent confidence level. The United States Medicaid population smoking rate is higher than the general population (30 versus 17%). Medi-Cal members in L.A. county have a higher rate of tobacco use (18.2%) as indicated by education and income level than in L.A. county' s overall adult smoking rate of 14.2%, and African Americans have higher rates than Whites, Hispanics, or Asian Pacific Islanders. The Tobacco Use Among African Americans pilot supports recent state requirements, including the release of DHCS Policy Letter 14-006[2], aimed at reducing the initiation and continued use of tobacco.

The Tobacco Use Among African Americans pilot leveraged process and outcome evaluation techniques which are already being implemented. The process evaluation consisted of a database documenting outreach results and follow up calls. Satisfaction survey calls were used to determine how many people enrolled in a program and the effectiveness of the tobacco cessation mailing. Outcome evaluation is based on member feedback obtained during follow-up calls (i.e., change in behavior, enrollment in a tobacco cessation program, and current tobacco status).

The pilot utilized a multi-dimensional approach by coupling an educational mailer with a live agent follow-up phone call. The live agent call provided an additional member touch-point to assess effectiveness of the written materials, tobacco use status, and readiness to quit, as well as provide additional resources as needed.

In today's automated environment, the Tobacco Use Among African American pilot project utilized an old-fashioned approach by bringing back the personal touch of a live agent call. The specially-trained live agent was able to customize the interaction based on member feedback and self-report. The live agent was further able to utilize motivational interviewing techniques to assess readiness to quit and provide additional resources, such as a warm transfer to the CA Smoker's Helpline as appropriate.

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[1] L.A. County Department of Public Health link: http://publichealth.lacounty.gov/ha/reports/habriefs/2007/Cigarette_Smoking_Cities_finalS.pdf

[2] DHCS Policy Letter 11-006: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2014/PL14-006.pdf

During the Tobacco use among African Americans pilot, there were 598 African American members identified as smokers. Of those members, 184 were successfully reached by a live agent (31%). Of the 184 members reached, 103 African American members (56%) indicated they were current smokers. Of the 103 self-identified as smokers, only 22 (21%) said they had received and read the tobacco cessation mailing. For those who had read the mailing and asked if they found the mailer helpful on a scale from 1 (not helpful) to 5 (very helpful), the average rating given to the materials was a 4.375. Of 103 African American members that identified as being current smokers and were reached via live agent call, 46 (45%) asked to be connected to the California Smokers Helpline (1-800-No-Butts) for additional support and services. Preliminary findings indicate that reaching members via a live agent call (45%) may be a promising addition to reaching more members than a mailing alone (21%).

## Molina Healthcare of California Partner Plan, Inc.

### The Mothers of Molina (MOM) Program

African American women are more likely to miss their postpartum visits compared to other races. The dangers of sporadic postpartum care may lead to serious consequences. According to a recent summary analysis by National Public Radio, the Robert Wood Johnson Foundation, and the Harvard T.H. Chan School of Public Health, "African-Americans have higher rates of C-section and are more than twice as likely to be readmitted to the hospital in the month following surgery. They're twice as likely as white women to have postpartum depression, which contributes to poor outcomes, but they are much less likely to receive mental health treatment." In June 2016, Molina launched the MOM program to reduce the postpartum health disparity. The program was fully operating in all counties at the start of 2017. The program entails a nurse practitioner providing postpartum care to new Molina mothers in their home. The nurse practitioner screens the women for postpartum depression, as well. The program is currently ongoing in 2018. Our results compare 2016 to 2017 data in Sacramento County.

Molina used internal administrative claims/encounters data to analyze our internal health disparities. Molina utilized public health survey data and DHCS's Health Disparity analysis to confirm the trend that African American women were less likely to have a postpartum visit. Additionally, we met with the local Black Infant Health leaders to share our analysis and receive feedback on our program. The chi-square statistic was also used to compare postpartum compliance rates between Molina's African American women with women of other races combined. We found that 70 percent of African American women were not getting postpartum care versus 59 percent of women of other races.

Molina focused on this health disparity because Molina’s postpartum compliance rates were significantly lower than the 25th National Committee for Quality Assurance (NCAQ) percentile, trending closer to the 10th percentile, for three consecutive years. We knew that we needed to prioritize an intervention to improve this poor care trend and the associated health disparity found among our African American women. Molina also partnered with met with Black Infant Health county leaders to understand the issues that African American women face to obtain timely prenatal and postpartum care. We shared ideas and received strong endorsement of our program.

Molina used a two prong approach to address two primary barriers associated with receiving postpartum care: Access to care and member engagement in their own care. The nurse practitioner going to the home to provide the care addressed the access to care issue. We offered a gift card to women at the home after the visit was completed to address member's engagement of care issue. Several factors contribute to lack of engagement in one's care: competing priorities, transportation issues and also perception of racism at the doctor's office. The gift cards were critical to reduce the no show rates that we experienced in the first six months of the program. Together, this two prong

approach was significant to reaching the improved postpartum rates among African American women.

Molina consistently faces the challenge of wrong or disconnected phone numbers for our Molina members. Molina created an internal platform entitled Member360 which compiles all administrative, care management and pharmacy data into one platform for a member. Callers can go to one platform to scan for any different phone numbers associated with the member. The use of this innovative platform increased our contact rates for scheduling appointments.

In our analysis, we found a 37% increase in African American women completing a postpartum visit comparing 2016 calendar year rates with 2017 calendar year rates.