

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

October 2018



2018

Award Winner

Inland Empire Health Plan

IEHP Housing Initiative

Runner-up

**Central California Alliance for
Health**

Academic Detailing, new uses for Familiar
Tool: Increasing Narcan use and
decreasing Opioid deaths in a Rural
County

Fourth Annual Innovation Award, October 11, 2018

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

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

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

MCQMD reviewed all of the submitted nominations and provided 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 sixteen nominations from eleven MCPs.

AWARD NOMINATION SUMMARIES

Anthem Blue Cross

1. Health and Wellness - A Click Away using Text Messaging

Anthem is continually looking for new and innovative ways to reach out to members and encourage them to have their required health screening completed. HealthCrowd was able to collaborate with us to bring a multi-modal communication to targeted members in all counties statewide. Anthem targeted members that were non-compliant for the identified measures in all our counties statewide. Anthem focused on the following External Accountability Set (EAS) measures for the text messaging and interactive voice response (IVR) call campaigns: Breast Cancer Screening (BCS), Cervical Cancer Screening (CCS), Childhood Immunization Status – Combo 3 (CIS-3), Immunization for Adolescents (IMA-2), and Well-Child visits in the 3rd, 4th, 5th, & 6th years of life (W34).

This intervention is innovative because it utilized the advanced technology members have and use every day to bring them reminders to complete their needed health services. This program is new to California but early reports show that Anthem had a high number of members opting into the text messaging program. During the first two months Anthem had 32 percent of members opt into the program. Per HealthCrowd, the normal opt in rate is five to twenty percent. Once the program has been running for six months, we will use claims data to determine if compliance rates have increased for the targeted measures.

2. The Story of a Farmers Market and A Health Plan- San Benito Farmers Market- Closing Gaps In Care Innovatively

Member compliance for scheduled appointments is low. Different strategies have been executed in order to increase compliance, such as in-home preventive care services through contracted vendors and partnerships with providers to encourage members to obtain preventive care in-office on specific days while providing member incentives; however these were not very successful.. For the past three years, Anthem's data has shown a low denominator for Comprehensive Diabetes Care (CDC). Anthem targeted any non-compliant Anthem Medi-Cal managed care member in San Benito County, identified in the denominator for the CDC measure. Anthem attempted various methods to reach members in San Benito County and while navigating through the different strategies, Anthem realized that offering medical services had never been part of the San Benito Farmers Market. Anthem developed a strategy to engage with our members where they typically would gather. This approach allowed Anthem to close gaps in care. This strategy proved that members were receptive to having their preventative health screenings delivered at a Farmers Market.

Anthem's services included providing hemoglobin A1c (HbA1c) tests, blood pressure screenings, health education, and retinal scans through Anthem's contracted vendor, MedXM. A total of 45 members attended four clinic day farmers markets. MedXM performed a total of 45 HbA1c tests, 44 diabetic retinal exams (DRE), and 44 blood pressure screenings. Health Educators distributed over 290 health education collateral pieces. Anthem participated in two more clinic days in September, closing additional gaps in care with diabetic members. Anthem is planning to attend Farmers Markets in 2019 and targeting other counties in California.

California Health and Wellness

Provider Partner Performance Based Compensation

The Healthcare Effectiveness Data and Information Set (HEDIS®) outcomes have been the focus of provider incentive programs for the past several years. Provider incentives have primarily been outside of provider contracts, dependent on available funding, and also limited to a narrow focus of quality that does not take into account other influencing factors on HEDIS® outcomes. California Health and Wellness (CHW) targeted provider groups and physicians contracted with the health plan, providing services to Medi-Cal members.

CHW created two programs for providers and provider groups to be compensated. The first program involved capitation rates plus an incentive model based on encounters and HEDIS® performance. This program is discretionary and not included as part of the provider contract. The second program is a contracting structure that is available to targeted strategic providers. Providers will be compensated based on encounter data and HEDIS performance, improvements in member retention, member choice participation, and access and availability. A proposed rate increase will be agreed upon and a portion will be withheld and released upon meeting performance standards. The second program, is a type of performance based on contracting. It creates a long term commitment and defines quality parameters that go beyond traditional HEDIS and encounter measures to support a broader vision of quality for our members and the provider network. The results of the first iteration of the second model, reflect all measures reaching the minimum performance level (MPL) or better for Reporting Year (RY) 2017. This was after repeating multiple measures below the MPL year over year. The results of recent redesigns and contractual relationships are not yet available.

CalViva

1. Breast Cancer Screening Outreach Pilot: CalViva Health and The Susan G. Komen Foundation

Breast Cancer Screening (BCS), a new HEDIS® measure for Medi-Cal, rates fell below the minimum performance level (MPL) for CalViva in Fresno county for RY 2018. CalViva conducted a survey in 2017 which highlighted the top barriers and motivators to BCS care. The top barriers included: (1) poor access to services (no transportation), (2) lack of knowledge regarding the importance of breast health, and (3) fear of the results. In an effort to better address member barriers to care, CalViva is partnering with the Susan G. Komen Foundation to launch an outreach and mobile mammography program in Fresno county. This is the first time that the Susan G. Komen foundation will be collaborating with a health plan. A specific cohort of BCS non-compliant CalViva members will be identified and geographic information system (GIS) mapping will be used so that the mobile mammography events will be situated in locations that are most convenient for members and where minimal transportation is needed, such as: churches, parks, and local community centers. The pilot program will target approximately 2,000 BCS non-compliant members, focusing on specific neighborhoods that contain the highest concentration of non-compliant members.

CalViva is excited to partner with the Susan G. Komen Foundation, who has vast experience working around BCS care and who is already well-known in the community as a positive force. Through this collaborative program, CalViva will also learn from the Komen outreach and educational expertise what will be the most impactful to members and motivate members to get BCS care.

The pilot program is scheduled to launch mid-September 2018 and results are pending.

2. Using a Bundled approach to improve Annual Monitoring for patients on Persistent Medication compliance

Annual Monitoring for Patients on Persistent Medication (MPM) compliance is multi-faceted and requires a multi-faceted approach for success. Some barriers that contribute towards non-compliance include: members unaware that an annual laboratory test is needed; some members think it's not important based on the fact that "they feel fine": members forget to stop by the lab before leaving the doctor's office; and some members forget to attend their scheduled appointment. A big shift in today's society is that members do not answer telephone calls, therefore outreach approaches are not successful. Additionally, the MPL for MPM is relatively high making it difficult to exceed, especially in more rural areas.

CalViva partnered with a high volume low compliant clinic in Madera county. The targeted population for this intervention were non-compliant members for the largest Federally Qualified Health Center in the county.

CalViva built upon the lessons learned from several Plan Do Study Act (PDSA) cycles. We continued our efforts to reach members by telephone with a new twist: the clinic used our provider profile to identify the patients. Members will more often answer the phone if it is their doctor calling rather than the health plan. We added a member incentive to reduce "no shows" which are a challenge for the clinics even when an appointment is scheduled. We found the "Point of Service" incentive more popular among our members versus the "enter me in a drawing or mail me a gift card" approach. Finally, we added a new approach to outreach: texting. We instituted two types of text messages. The first text message reminds members to complete their labs if they are on blood pressure or heart medications. The messages were sent in either English or Spanish based upon the member's preferred language. The text informed the member that upon completion of the lab work, they would receive a gift card at the time the labs were completed. The second text message was an appointment reminder which included the appointment date and time along with a reminder about the point of service gift card upon completion of lab work. The clinic's phone number was also provided in the text to facilitate scheduling/rescheduling appointments when needed.

The results from the texting campaign were as follows: from a total of 108 members, 100 confirmed mobile phone numbers received the first text message and 80 members received the text message the 2nd, 3rd, and 4th time. There were 77 members who received the message for the 5th time and only 5 members replied "STOP" to opt out of all text messages. Of the 108 members, 63 members completed their laboratory tests and received the member incentive card. This intervention was our first attempt at reaching the MPM population. Implementing the texting campaign demonstrated that 58.3 percent (63/108) of our members completed their annual laboratory testing for MPM by the end of Jun 2018, thereby exceeding our Specific, Measurable, Achievable, Realistic, and Timely (SMART) Aim.

Central California Alliance for Health

1. Academic Detailing, New Uses for Familiar Tool: Increasing Narcan Use and Decreasing Opioid Deaths in a Rural County

Escalating rates of opioid prescriptions, overdoses, and deaths challenge the ability of communities to meet the demands of the opioid epidemic. California Health Care Foundation (CHCF) Opioid Dashboard data reveals significant geographical disparities in several opioid-related measures between two counties within our service area. The rate of opioid prescriptions and opioid overdose deaths are significantly higher in Merced County compared to Monterey County, 43 percent and 185 percent higher, respectively. Central California Alliance for Health (CAAH), targeted high opioid prescribing Primary Care Physicians (PCPs), specialists, and high opioid dispensing pharmacies in Merced County. CCAH aligned its efforts with CHCF's Smart Care goals

supporting our provider network, expanding its medical benefit, and implementing guideline-driven formulary changes. Leveraging the unique strength of our plan, we instituted several innovations: (1) Opioid Registry: Integrating state carve-out data with opioid claims to identify/trend high-risk members and prescribers for targeted interventions (Provider Portal availability forthcoming); (2) PCP MAT Incentive: Incentivizing PCPs \$1,000 to acquire a MAT-prescribing X-license; (3) Pain Management Website: Delivering resources to providers and members on chronic pain management and MAT services; (4) Payment Reform: Reimbursing PCPs fee-for-service over capitation for member-provided MAT; (5) Academic Detailing Program: Targeting high opioid prescribing PCPs, specialists, and high opioid dispensing pharmacies in Merced county. As part of our Academic Detailing Project, CCAH gathered data from our Opioid Registry to identify and prioritize providers/pharmacies and reached out to them regarding adopting best practices and prescribing Narcan. A Quality Improvement (QI) Registered Nurse (RN) and pharmacists attended a training course to gain skills and acquire materials for presentations.

Through a variety of innovations, CCAH has achieved a 34 percent decrease in opioid prescription fill rate as well as a 524 percent increase in Narcan fill rate since the beginning of 2017. CCAH is awaiting state data to evaluate the effects of these interventions/results on local opioid death rates. This effort has led to meetings and relationships with retail pharmacy chains and their regional leaders promoting stocking and furnishing Narcan. Next steps include reaching out to local hospital emergency rooms to encourage Narcan co-prescribing along with Suboxone induction. Efforts have now begun to spread to our other two counties, as well.

2. High Prescriber Intervention, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

During HEDIS® 2016/2017, Merced County fell to the 25th percentile for the Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) measure. A PDSA cycle intervention both revealed and proved that individual prescriber interventions were the greatest source of rate improvement. A full scope intervention was systematically rolled out during HEDIS® 2018, taking CCAH's rate for AAB to the National Committee for Quality Assurance's (NCQA's) 90th percentile in Merced County. The target and focal point of intervention were prescribers who had inappropriately prescribed more than three instances of antibiotics per quarter, or greater than ten during the previous measurement year.

CCAHA, had access to pharmacy data analytics in real time, which allowed plans of action to be quickly put in place. High prescribers were provided histograms that compared data of their performance with that of their blinded peers. For example, if Dr. X averaged 30 inappropriate instances in one year, yet the network average was less than one, there is a very compelling reason for Dr. X to change his prescribing habits; graphs and notices of this were sent, comparing individual performance against blinded peers and network averages. Many high prescribers utilized this cost-effective, innovative approach. Our small team consisted of a Medical Director who advised executive staff, a clinical nurse lead that led physician level dialog, a QI coordinator that compiled the data so that fast shifts could be both recognized and addressed, and a Program Advisor that oversaw the efforts of all. The intervention was cost effective, efficient, welcomed by medical staff, and extremely successful without a lot of complicated concepts. It was smart success that happened fast, and for that it deserves to be considered for the Innovation Award; if not for being complicated, then instead for being extremely effective. The AAB rate went from 22.57 percent (HEDIS® 2017) to 39.40 percent (HEDIS® 2018).

Community Health Group – San Diego

Integrated Data to Improve Health Outcomes: A Critical Tool Towards Building a CHG Blockchain

As the push and movement towards “people focused healthcare” increases and the shift away from “disease centric care” continues, there remains the challenges of fragmented data systems, which contribute to fragmented care, leading to bad health and costly outcomes. We at Community Health Group (CHG) rely on data systems to help “tell a story” about members and how we can “wrap around” our most vulnerable populations to help them lead the healthiest life possible. This is how multiple sectors of health care can communicate. However, if the communication is fractured, the care is fractured. This conundrum continues to be the crux of the healthcare industry. CHG has had the privilege to serve San Diego County’s growing and diverse population since 1982. Our target population for our innovation project at this time is our most vulnerable, seniors and those with disabilities. CHG has created a communication platform that allows for an interdisciplinary team and evidence based approach, as well as a focused coordination of care methodology to each plan member’s access to quality care and improved health outcomes. This innovative communication platform allows Community Health Group to be the consummate “wrap around” for each and every member served. This proprietary communication platform, “CHG Net”, built by the CHG application development team, was designed and developed to be our “source of truth”, pulling qualitative and quantitative data together in one space, allowing for data to “tell a member’s story”. “CHG Net” allows for an opportunity to collect, share, standardize, and integrate health data. Using claims data, state data, and qualitative “touch” data by our case management teams. “CHG Net” allows for an easy, operational interdisciplinary care team (ICT) approach at ICT rounds. It allows for an actionable plan to “wrap around” our members, leveraging data from multiple sources to address members’ most pressing needs and concerns. This platform allows for an opportunity to bring together the many inner workings of Community Health Group to become an interdependent “ecosystem.”

CHG’s Informatics team designed an analytics report from CHG Net’s centralized data platform. These reports allow for the CHG ecosystem to better understand our members and the things that affect their lives. These reports are pulled daily, weekly, and monthly to generate a “picture” of who our members are and how we can better serve them. CHG Net’s reports show: (1) Current member population (2) Current member population risk stratification criteria (3) Current population projection for risk through predictive analyses (4) Current member population social impacts on health risks and a (5) Monitoring dashboard for compliance and regulation. Utilizing these reports and analytics, CHG has been able to begin to “hone in” on our most vulnerable members. We have begun to develop intervention programs around social impacts on health. These reports have also allowed us to be laser-focused in our wrap around action plans by our field teams. By doing this, we can better meet our members where they are, and move towards the goal of healthier life outcomes.

Health Net

SHAPE: Stroke and Heart Attack Prevention Every Day for those with Diabetes and Cardiovascular Disease

Persons with diabetes have a two to three times increased risk for heart disease, and heart disease morbidity and mortality rates are two to four times higher. Health Net performed a member analysis and found out the following information: (1) over two-thirds of all diabetes-related coronary events were for stroke or coronary artery disease (CAD); (2) 80 percent of all diabetes-related coronary events are for members with both CAD and Hypertension (HTN); (3) More than 19,000 members with diabetes and a history of CAD represent \$62 million spent with half being spent on cardiovascular care; (4) Only 57 percent of this membership was on the recommend medication bundle. As a result of the analysis, Health Net created and implemented: Stroke and Heart Attack Prevention Everyday (SHAPE) to ensure that targeted members are on the recommended cardio-protective medication bundle which is a daily dose of aspirin (75 -235 mg), Lovastatin (40 mg), and

Lisinopril (20 mg). SHAPE combines an inexpensive medication bundle that could substantially prevent cardiovascular events (all/phase study).

SHAPE targeted all of Health Net's diabetic members age 55 or older with both CAD and HTN in all of Health Net's lines of business (Commercial/Marketplace, Medi-Cal, Medicare, and Dual-Eligible). Our plan identified almost 180,000 members over the age of 55 with diabetes, CAD and HTN. Health Net wanted to ensure that eligible patients were on the cardo-protective bundle. Health Net partnered with providers to help reduce the number of heart attacks and strokes by sending care gap and medication adherence reports and having clinician mentors available at the Plan. SHAPE is member-centric and customized to the level of each member's acuity and willingness to engage in the conversation about understanding their medical condition, as well as promoting and ensuring medication compliance and health behavior modification. The coaches that were available to our members included: pharmacists, nutritional counselors, wellness coaches, and/or dieticians all trained in motivational interviewing skills. The engagement of the coaches would be on-site at the provider's office or via telephone. Health Net focused on consolidating member outreach from different areas of our Plan to make this project most effective.

SHAPE is a multi-year project with phased implementation of the project which began during the middle of 2017. We are conducting data analysis to determine if any racial/ethnic health disparity gaps exists. If a statistically significant gap is identified, additional interventions will be developed as needed.

Inland Empire Health Plan

Inland Empire Health Plan Housing Initiative

Inland Empire Health Plan (IEHP) recognizes that access to health care is only one part of what keeps our members well. Unstable housing makes it nearly impossible for an individual to consider behaviors such as healthy eating, exercise, and attending medical appointments. Studies have shown that a "housing first" approach, in which safe permanent supportive housing (PSH) is provided alongside medical care, results in better health. In fact, homeless individuals who receive housing as part of their care may end up with overall lower medical costs. IEHP is working on access to housing not only because it's the right thing to do, but because it also results in better member health and cost outcomes.

In the first two years of the housing initiative, IEHP will provide PSH (including intensive case management services) to a total of 350 homeless members. Half of the members will be drawn from the population of homeless members residing in long-term care or skilled nursing facilities because they have nowhere else to go, while the remainder of the members are literally homeless. The program criteria includes: (1) at least one chronic medical or behavioral health condition that is stable enough to be managed in the community; (2) a confirmed need for help with activities of daily living; (3) members not in long-term care or nursing facilities; and (4) at least seven inpatient bed days in an acute facility in the past 12 months.

In designing and implementing the housing initiative, IEHP has pushed itself beyond traditional health plan roles and functions to address a critical social determinant of health. With respect to the pursuit of knowledge and partnerships, IEHP has become a leading health agency across two counties in the field of low-income housing and homelessness services. In terms of infrastructure, IEHP has built a unique internal housing team composed of clinical and non-clinical staff experienced in working with homeless and chronically ill individuals. Within just a few short months of program implementation, the housing team was successful in identifying eligible homeless members and coordinating their transitions into permanent supportive housing in partnership with housing case management and tenancy support service providers. With innovative financing

models (e.g., a flexible housing subsidy pool), the plan is using reserve funding to support and formally evaluate the impact of the housing initiative.

IEHP launched its housing initiative in March of 2018. In the following six months, 134 members have been enrolled and 24 leases have been signed. The average time from enrollment to lease signing/move-in is approximately 60 days for street homeless participants and approximately 90 days for participants entering housing from custodial or skilled facilities. These benchmarks are within housing authority standards at this time.

LA Care Health Plan

Housing for Health & Brilliant Corners Grant Partnership

LA Care Health Plan, has a high volume of members experiencing homelessness. Research shows that homeless people have higher risks of morbidity and mortality, and the “10th decile” experience high health care costs. L.A. Care’s targeted population for the housing health program is Medi-Cal and Cal Medicconnect members who are homeless, have the ability to live independently, and have evidence of intensive healthcare needs over the last 12 months.

L.A. Care partnered with L.A. County Housing for Health and its fiscal intermediary, Brilliant Corners, to invest in permanent supportive housing for some of our most vulnerable members. Through this collaboration, we are able to jointly offer a full-scope service model that provides Intensive Case Management Services (ICMS) pre- and post-housing, move-in assistance, and a housing subsidy, for 300 new L.A. clients. Referrals are clinically reviewed and screened to ensure that clinically-appropriate individuals are matched with the available resources. Over the five years of the program, we will have provided housing and supportive services for 300 individuals; to date, we have already added 270 individuals who are receiving intensive case management services through Whole Person Care, of which 96 have already been placed in permanent supportive housing.

Because homelessness adversely affects a person’s health, this initiative is focused on securing housing first in order to meet members’ health needs. L.A. Care is the first private payer to invest in L.A. County’s Flexible Housing Subsidy Pool, and we are using a “housing first” approach to address members’ health needs. In addition, L.A. Care’s investment in housing subsidies allows LA County to direct county funds toward these individuals’ other health and social service needs as part of Whole Person Care, essentially doubling the impact of L.A. Care’s investment amount on our county’s resources. L.A. Care’s investment has already changed housing outcomes for 96 participants, with others in active housing search.

L.A. Care is beginning its evaluation, but because we invested in a proven local model (the L.A. County Housing for Health Program), we anticipate similar results found in their recent RAND¹ evaluation, which showed strong outcomes in several domains. With respect to housing outcomes, Housing for Health has a 96 percent retention rate (clients maintaining housing for at least 12 months). RAND also found that Housing for Health clients' use of public services, especially medical and mental health services, dropped substantially, including emergency room visits and inpatient care. Overall, the cost reductions from various public services more than covered a year's worth of supportive housing costs, with a net cost savings of 20 percent. Participants' self-reported mental health functioning improved after receiving housing, though self-reported physical health was largely unchanged.

Partnership

¹ RAND Website: RAND website: https://www.rand.org/pubs/research_reports/RR1694.html

1. Identifying Members Experiencing Homelessness in the Partnership Health Plan of California System

Homelessness, typically is not identified as part of the administration data of the Medi-Cal managed care system. Beneficiaries who are experiencing homelessness may only be identified at the managed care plan level, once their conditions have become problematic, or when a hospital discharge is delayed because a person doesn't have a safe place to go. Partnership Health Plan of California (PHC) sought to find a way to reliably identify members experiencing homelessness, in order to better coordinate and address their health care needs, and link them to available housing and other social service supports.

PHC, targeted members experiencing homelessness in our 14-county region which included: persons who are unable to provide a fixed address for Medi-Cal eligibility purposes, those diagnosed as homeless (generally in emergency room and hospital sites), and persons whose health conditions are likely the result of risks and vulnerabilities associated with living without adequate shelter. PHC sought to develop a uniform system for the identification of individuals experiencing homelessness by combining various available tools. Criteria used to identify members experiencing homelessness included: (1) Pattern recognition for keywords in a members residential address data. This included variations of words such as, "Homeless," "COTS," "General Delivery," "Shelter," "In Car," or "Under Bridge," etc. ("Logic was applied to ensure that actual residential addresses containing keywords, such as "Shelter Cove," etc., were not selected as identifiers). (2) Complete addresses of Homeless Shelters, Missions, and Homeless Resource Centers in PHC counties were cross-referenced with PHC member residential addresses to further identify members experiencing homelessness without explicit indicators in their address. (3) Members with an ICD-10 diagnosis of "Homelessness" within the past 12 months with or without the above criteria were also identified as experiencing homelessness.

We continue to use and refine the homeless members' data that resulted from this innovation. To date, it has been helpful in the targeting of the areas and providers most involved in the treatment of individuals experiencing homelessness, as well as an understanding of the general characteristics of the homeless members seen by providers. These data have informed our allocation and continued assessment of the use of the Housing Grant funds issued earlier this year as well as reviewing the work of the Intensive Outpatient Care Management (IOPCM) programs established in 10 of our 14 counties. Additionally, data on members experiencing homelessness in conjunction with claims data and CAIR records were used to assist in preparing and responding to the deadly Hepatitis A outbreak in October 2017, which primarily affected people experiencing homelessness. Local health officers from PHC's 14 counties were provided data on members experiencing homelessness, their Hepatitis A immunization status, and their primary care provider, and/or most recent point of contact in order to prepare for this outbreak. We believe this improved use of data and its practical applications (such as the Hepatitis A outbreak) are helping us better serve our members experiencing homelessness.

2. Analyzing Managed Care Plan Data to Strengthen and Support Local Public Health Strategies

A variety of sources, including the state Department of Public Health, the Robert Wood Johnson Foundation, and others, provide assessments of a variety of social and public health issues in the counties and communities served by PHC, yet there remain significant gaps in the information most useful for the development of strategies to effectively address certain public health and community needs. This can be seen in the area of addiction, where approaches to address one type of addiction (e.g., opiate abuse) are unlikely to be as effective with another type of addiction (e.g., methamphetamine abuse). PHC and its 14 member counties sought to build upon their successful collaborations on efforts to address public health needs by using PHC data. PHC, targeted members with addictions in our 14 county region.

The identification of persons with specific addictions is especially challenging as providers historically have not been reimbursed for addiction treatment for Medi-Cal beneficiaries. This means that PHC cannot rely on standardized use of diagnostic codes. Instead, PHC applied an analysis of the health care conditions most associated with specific addictions and the treatment “proxies” likely to be part of the care for the addicted individuals. By analyzing claims and related data, PHC provided data on the likely number of members addicted to methamphetamine, suffering from alcoholism, and experiencing other addictions, with an associated measure of the number of these being treated for co-occurring mental health or physical health conditions. These data have been used to identify pilot projects to test strategies such as: contingency management for methamphetamine addiction; support for medication assisted treatment for alcoholism; and others currently supported by PHC resources.

Santa Clara Family Health Plan

Gaps in care reminder at all member touchpoints

Santa Clara Family Health Plan (SCFHP) members have many disparities which contribute to their health status. They may not know when or which preventative health services and/or chronic disease screenings are recommended. SCFHP customer service representatives will perform gaps in care reminders on incoming calls to the Customer Service Call Center. The gaps in care data will be integrated into the customer service platform (QNXT). All member facing teams (Customer Service, Case Management, Behavioral Health, Long Term Support Services, and Utilization Management) will be trained to review gaps in care in the customer service platform when receiving incoming or performing outgoing calls to members. Most importantly, the customer service representatives will remind beneficiaries to take actions on these gaps in care. Many plans have gaps in care coordination with their case management teams but it is innovative in a Medi-Cal MCP to have this information integrated with a call tracking software and to use the Customer Service Call Center to perform this work. SCFHP will be launching this initiative on Sept 17, 2018 and we anticipate seeing outcomes in our HEDIS 2019 results.

United Health Care

1. Fully Integrated Transportation Platform

During United Health Care’s (UHC’s) Physician and Customer Advisory Councils, transportation has been raised as a consistent pain point. The concerns include: transportation benefits are often an afterthought; services are not easy to use and are fragmented; and transportation is not integrated into care and treatment planning. While additional access has been added through use of additional modes such as ride sharing, the need for tighter coordination persists.

Transportation is an important benefit for all beneficiaries with diverse health needs, complex medical conditions, as well as low complexity health members seeking preventive care, or education services. Today, transportation requests are individual events that don’t capture and

store member needs and leverage those identified needs to support future visits or the member's ongoing treatment plan. UHC designed an integrated transportation platform, which allowed member transportation needs to be identified early and integrated into their treatment plan. Our integrated transportation platform created tighter connections between members, providers, and case managers to complement patient care plans.

This new platform was initiated on July 1, 2018. An example of the platform's impact: a member who requires bariatric livery transportation services previously experienced issues related to inconsistent requests that didn't always identify her unique livery needs. There were gaps in information between different schedulers resulting in: missed or late appointments, and frustration for the member, transportation vendors and providers. This was remedied by using a consistent member profile that captures this member's needs with links to the member's mobile application, online provider, and case manager scheduling tool. By centralizing the member's information and using technology to enable ordering, bariatric transportation was integrated and consistently available for all parties. Through the platform, discrepancies have been resolved for this member and she has attended 100% of her appointments on time. In the first month post implementation, over 12,000 member profiles have been created to support over 2,300 transports.

2. Accountable Care Organization/ Clinical Transformation Program

Leadership at several Federally Qualified Health Centers (FQHCs) informed our health plan leadership that they do not receive clinical support and actionable data to help them prioritize and impact the high risk/high cost Medi-Cal members who drive the majority of their assigned population health care costs. UHC targeted Medi-Cal members receiving care at three contracted FQHCs. We are implementing our organization's Accountable Care Organization (ACO)/Clinical Transformation Program with targeted FQHCs. It aligns incentives toward efficient care delivery and cost reduction, while providing ongoing actionable and timely data to achieve population health goals. The program provides unique support as FQHC leadership has confirmed this type of program does not exist with other Medi-Cal plans.

We've initiated the ACO model with the FQHCs including regular Joint Operating Committee meetings with our collective leadership teams to review baseline data and trended utilization data, as well as address process barriers and opportunities. This program is new as of July 2018, and utilization results for these ACOs are not yet available to compare across the rest of our population; however in similar markets, inpatient admissions per thousand, inpatient days per thousand, and ER visits per thousand are consistently lower for Medicaid members in an ACO, as compared to the non-ACO network. Our new ACOs have typically seen a utilization reduction for admits and ER between 5%-15% within the first year of implementation and we anticipate similar results with these FQHCs. A real world example of this relationship is the case of a homeless member discharged to the streets with ongoing needs for antibiotics and monitoring by the PCP. However, the discharge information also indicated the patient had diabetes. Through engagement with the clinical practice consultant, this information was provided to the PCP, allowing for immediate additional monitoring.