Alameda Alliance for Health

Population Health Management (PHM)

2023 Evaluation

For Medi-Cal and Group Care lines of business

Presented to the Quality Improvement and Health Equity Committee
on 5/17/2024

Introduction

Alameda Alliance for Health (Alliance) conducts an annual comprehensive analysis of the impact of its Population Health Management (PHM) Strategy. The PHM Evaluation includes quantitative results for relevant clinical, utilization, and experience measures. Quantitative and qualitative analysis is conducted on the results for evidence of program effectiveness and continuous improvement.

The PHM workgroup conducts this analysis to support Alliance members and promote an effective PHM Strategy. Representation from various departments at the Alliance comprises the workgroup, including Population Health and Equity, Case Management, Access and Availability, Utilization Management, Analytics, Quality Improvement, Long Term Services and Supports, and Pharmacy. The workgroup meets weekly and analyzes progress on goals on a quarterly basis. Facilitators, barriers, and solutions are discussed and implemented. On a semi-annual basis, the workgroup presents the progress on goals to a PHM committee that includes the chief medical officer, medical directors, and other Alliance staff.

The Alliance uses the results of the PHM Evaluation as well as the PHM Assessment to review and update PHM programs, services, activities, and resources such as staffing ratios, clinical qualifications, job training, external resource needs and contacts, and cultural competency in order to meet member needs. The Alliance Quality Improvement and Case Management Program Descriptions also describe the process used to update PHM programs, activities, and resources.

2023 PHM Strategy Goals and Results

Managing Multiple Chronic Illnesses

The Alliance launched the Living Your Best Life Diabetes and Hypertension Disease Management program in November 2023 and continues efforts to increase member engagement. The goal for increased confidence in the program post-assessment was not met.

Living Your Best Life Diabetes and Hypertension Disease Management (Medi-Cal and Group Care)

The Disease Management program provides health coaching and case management services to increase confidence in self-management knowledge and behaviors and assist members in improving their health outcomes and wellness. Members are asked about their level of confidence on a 5-point Likert scale about their knowledge, attitude, and behaviors in self-managing their chronic conditions. This assessment is completed both at intake of the Disease Management referral and at the conclusion of two to three health coaching sessions. Members in the Disease Management program who are found to need more intensive case management services take the Complex Case Management post-assessment, which asks them if their confidence increased after receiving services.

Goal: At least 90% of members with diabetes and hypertension who complete the post-participation assessment by March 2024 will report increased confidence in disease self-management knowledge and behaviors. [Member experience]

- **Quantitative analysis:** Medi-Cal 80.48% (33/41), Group Care 100% (1/1)

	GOAL	Jul 2023	Oct 2023	Jan 2024	Apr 2024
Increased confidence	**90%**	Program not started	Program not started	MC: 50% (2/4)	MC: 80.48% (33/41)
				GC: N/A	GC: 100% (1/1)

- **Source**: Disease management health coaching assessments, Case Management Satisfaction Surveys
- **Met Goal:** The goal was not met for Medi-Cal. The goal was met for Group Care but with one member completing the survey.
- **Qualitative analysis:** Barriers to reaching the goal were discussed at the PHM workgroup meeting(see list of participants in the Introduction). The program began in January 2024, and program participation increased to a total of 42 participants by April 2024. The Manager of Population Health and Equity, Disease Management Health Educator, and Population Health and Equity Specialist analyzed the survey results and shared that members who did not report increased confidence in disease self-management knowledge and behaviors started the program with high levels of confidence. Members may have overestimated their confidence prior to engaging with the health coach and subsequently learned of other factors that would assist them in self-management of their conditions. The post-survey level of self-management confidence may have been more accurate, even if no increase was noted. These members did report that the information shared in the health coaching sessions was useful in the self-management of their diseases. More outreach to Group Care members is needed to increase engagement for this line of business.

Managing Members with Emerging Risk

In this focus area, the Black (African American) Breast Cancer Screening QI Project was successful in reaching its screening goal, employing educational flyers, outreach calls, mobile mammography, and member incentives. The Maternal Mental Health program has developed clinical guidelines for providers, internal workflows, and a member outreach flyer but was delayed in implementing member education mailings. Prenatal screenings increased, but the postpartum depression screening goal was not met.

Maternal Mental Health (Medi-Cal and Group Care)

The Alliance maternal mental health clinical guidelines require its providers to screen for depression during both the prenatal and postpartum periods. Screenings aim to support members at risk for perinatal depression during pregnancy and in the first year after birth. The screening is the first step in educating women about the risk, signs, and symptoms of depression and is designed to promote quality and cost-effective outcomes. After completion of the screening, all members are offered or referred to the appropriate services. The corresponding HEDIS measures for these screenings are PND-E for prenatal and PDS-E for postpartum.

Goal: Improve HEDIS prenatal (PND-E) and postpartum (PDS-E) depression screening rates by 2 percentage points from MY2022 (as of April 2023) to MY2023 (as of April 2024). [Clinical measure]

- Medi-Cal prenatal depression screening (PND-E): 40.86% to 42.86%.
- Medi-Cal postpartum depression screening (PDS-E): 25.47% to 27.47%.
- Group Care PND-E: 35.29% to 37.29%.
- Group Care PDS-E: 15.38% to 17.38%.

- **Quantitative analysis:** PND-E: Medi-Cal 48.74% (560/1,149), Group Care 60.00% (3/5); PDS-E: Medi-Cal 21.88% (286/1,307), Group Care 0.00% (0/8) for Community Health Center Network (CHCN) as of April 2024

	GOAL	Jul 2023	Oct 2023	Jan 2024	Apr 2024
PND-E	**MC: 42.86%** **GC: 37.29%**	MC: 50.41% (243/482) GC: 0% (0/2)	MC: 48.15% (390/810) GC: 0% (0/2)	MC: 45.91% (488/1,063) GC: 0% (0/5)	MC: 48.74% (560/1,149) GC: 60% (3/5)
PDS-E	**MC: 27.47%** **GC: 17.38%**	MC: 18.98% (194/1,022) GC: 0% (0/8)	MC: 18.63% (252/1,353) GC: 0% (0/8)	MC: 19.57% (257/1,313) GC: 0% (0/8)	MC: 21.88% (286/1,307) GC: 0% (0/8)

- **Source**: HEDIS dashboard
- **Met Goal:** The goal was met for both Medi-Cal and Group Care lines of business for PND-E. The goal was not met for PDS-E for either line of business. (Note: denominators are small for Group Care.)
- **Qualitative analysis:** Barriers to reaching the PDS-E goal were discussed at the PHM workgroup meeting, with input from the Analytics Manager,

Manager of Case Management, and Manager of Population Health and Equity. The Alliance Analytics Manager and CHCN quality improvement and analytics staff indicated that tools and reporting for depression screening vary across clinics and may not be accurately tracked. For example, CHCN only provides PHQ-9 and PHQ-2 screening data, which does not capture all types of depression screenings completed. More investigation is needed to learn why prenatal depression screening rates are consistently higher than postpartum rates; perhaps a different screening tool is more frequently used for postpartum than prenatal. Local WIC (Women, Infants & Children Supplemental Nutrition Program) programs also provide perinatal depression screening, but those are not documented in a way that the Alliance can capture the data. Other barriers identified by care management teams regarding completion of depression screenings include stigma associated with mental health conditions which lead to reluctance for members to participate in screenings, lack of member education, inability to recognize symptoms, and provider hesitance to screen due to a perceived lack of mental health services available to perinatal members. Outreach components of the Maternal Mental Health program were delayed in the materials development and approval processes.

Black (African American) Breast Cancer Screening QI Project (Equity focus, Medi-Cal and Group Care)

Black (African American) women are identified as a potentially high-risk group because breast cancer is often diagnosed at later stages and is more aggressive in African American women ((CDC), 2023). Although White women are more likely to get breast cancer, Black women are more likely to die from the disease. In the Alliance member population, Black (African American) women HEDIS breast cancer screening (BCS) rates were significantly below the minimum performance level, the 50th percentile across plans.

Goal: Increase Breast Cancer Screening (BCS) rates for Black (African American) women ages 50-74 by 3 percentage points from MY2022 (as of April 2023) to MY2023. [Clinical measure]

- Medi-Cal: 48.30% to 51.30%.
- Group Care: 59.76% to 62.76%.

- **Quantitative analysis:** Medi-Cal 51.42% (1,086/2,112), Group Care 65.27% (109/167) as of April 2024

	GOAL	Jul 2023	Oct 2023	Jan 2024	Apr 2024

BCS	**MC: 51.30%** **GC: 62.76%**	MC: 40.65% (1,156/2,844) GC: 53.72% (101/188)	MC: 45.48% (1,211/2,663) GC: 60% (105/175)	MC: 51.44% (1,087/2,113) GC: 64.07% (107/167)	MC: 51.42% (1,086/2,112) GC: 65.27% (109/167)

- **Source**: HEDIS dashboard
- **Met Goal:** Yes for both Medi-Cal and Group Care
- **Qualitative analysis:** The Quality Improvement Manager and Specialist reported success with conducting outreach calls following an educational flyer campaign and providing mobile mammography with member incentives in partnership with a clinic. The denominator for the measure also decreased following the removal of members with other insurance, which contributed to higher rates of completion. This program was effective and will continue in 2024.

Keeping Members Healthy

The goals in this focus area were partially met. For the Black (African American) Well-Child Visit QI Project, one of the three HEDIS measures reached the goal. The W30 measures improved due to incentive programs, provider education, and elimination of members with other primary insurance from the denominator. The non-utilizer outreach project involved three outreach attempts to over 3,000 members 0-6 years old as well as over 4,000 members 50 years and older. There were challenges in launching the project and reaching members to connect them to primary care.

Black (African American) Well-Child Visit QI Project (Equity focus, Medi-Cal)

Well-child visits and recommended vaccinations are essential in helping make sure infants, children, and adolescents stay healthy and prevent disease outbreaks. Vaccine-preventable diseases can be extremely contagious, especially for babies. Well-child visits are important for tracking growth and developmental milestones and identifying and addressing concerns early. Alliance rates showed inequities experienced by Black (African American) members as compared to other racial/ethnic groups.

Goal: HEDIS well-child visit (W30) and immunization (CIS-10) rates will increase for Black (African American) members by 3 percentage points from MY2022 (as of April 2023) to MY2023. [Utilization and clinical measures]

- Well-Child Visits in the first 15 months of life (W30-6+): 30.54% to 33.54% (pending DHCS approval of Performance Improvement Project).
- Well-Child Visits in the first 15-30 months of life (W30-2+): 58.25% to 61.25%.
- Childhood Immunization Status (CIS-10): 24.20% to 27.20% (administrative rates).

- **Quantitative analysis:** W30-6+ 40.59% (41/101), W30-2+ 60.87% (210/345), CIS-10 17.85% (63/353) as of April 2024

	GOAL	Jul 2023	Oct 2023	Jan 2024	Apr 2024
W30-6+	**33.54%**	18.06% (28/155)	28.37% (40/141)	39.60% (40/101)	40.59% (41/101)
W30-2+	**61.25%**	56.81% (267/470)	59.34% (270/455)	60.98% (211/346)	60.87% (210/345)
CIS-10	**27.20%**	18.11% (86/475)	18.18% (82/451)	17.38% (61/351)	17.85% (63/353)

- **Source**: HEDIS dashboard
- **Met Goal:** Goal was met for W30-6+. Goal was not met for W30-2+ and CIS-10.
- **Qualitative analysis:** The Quality Improvement Manager and Specialist reported that rates increased between October 2023 and January 2024 because members with other insurance were excluded from the denominator. The HEDIS crunch member incentives provided at the end of the year to participating clinics also help to increase well-child visits. Barriers to reaching the W30-2+ and CIS-10 goals were discussed at the PHM workgroup meeting, with input from the Quality Improvement Manager, Senior Director of Quality Improvement, and Access and Availability Manager. Appointment availability is a barrier for families completing well-child visits. Network partners have reported staffing challenges while the demand for appointments has increased as the Alliance member population has expanded. Alliance care coordination efforts and member surveys have found that appointments may not be available quickly, or available at convenient times. The data also showed that the second flu shot is a challenge for the CIS-10 measure. Members receive the first shot but do not get the second shot in the appropriate timeframe or at all. This may be due as well to appointment availability, or lack of provider or member knowledge regarding flu vaccine completion. Black families may experience additional inequities that make access to appointments challenging, including factors related to social determinants of health, such as challenges with transportation or childcare. Black members also may be distrustful of the necessity of recommended preventive care services due to historical racism in health care provision. A focus group conducted by the Alliance with Black families during the COVID-19 pandemic revealed distrust of medical advice regarding the COVID-10 vaccine that may also extend to other vaccines. The Alliance conducted a survey with Black families to better understand these

barriers and is currently analyzing the results. The Alliance will continue our efforts to address inequities in well-care for Black (African American) child and adolescent members in 2024.

Non-utilizer Outreach QI Project (Medi-Cal and Group Care)

Non-utilization of services refers to members who are not receiving health care services from the Alliance. This could be due to many factors like member choice but could also signal barriers like access to care. Encouraging members to play a more active role in their care is crucial for staying healthy and prevention and management of health conditions. The Alliance conducts outreach to educate members on the importance of regular care and connect members a primary care provider.

Goal 1: Outreach to at least 20% of non-utilizers in 2022 ages 50 years and above by June 2023 and connect 2% to primary care services. [Utilization measure]

- **Quantitative analysis:** Outreached to 12.25% (4,264/34,801) for Medi-Cal and 9.73% (89/915) for Group Care. Connected 2.30% (98/4,264) to primary care services for Medi-Cal and 4.49% (4/89) for Group Care.

	GOAL	Jul 2023	Oct 2023	Jan 2024	Apr 2024
Outreach	**20%**	MC: 12.25% (4,264/34,801) GC: 9.73% (89/915)	Program ended	Program ended	Program ended
Connected	**2%**	N/A	MC: 2.30% (98/4,264) GC: 4.49% (4/89)	Program ended	Program ended

- **Source**: Non-utilizer outreach pilot results
- **Met Goal:** Goal was met for Connection to Primary Care Services. Goal was not met for outreach.
- **Qualitative analysis:** Barriers to reaching the outreach goal were discussed at the PHM workgroup meeting. The Quality Improvement Manager and Specialist reported that the outreach campaign was late in starting due to challenges with the vendor contract and script approvals by the State. During the outreach implementation, there was a high percentage of incorrect or missing phone numbers. The Alliance receives member telephone numbers from monthly State enrollment data. If these members have had little contact with the plan, the Alliance does not have the opportunity to update

member contact information. In addition, feedback from the outreach coordinators reported that a significant number of members had a different primary insurance. As a Medi-Cal plan, the Alliance would be the payer of last resort. Although they appeared on the Alliance non-utilizer list, they may have received care paid by their primary insurance. Lastly, outreach was conducted with a non-local area code, which might have contributed to the high rate of members not answering the outreach calls. Members may have believed it was a spam call not from their health plan. Outreach activities including member outreach call campaign and assistance with scheduling appointments helped meet this goal. This program will continue for 2024.

Goal 2: Outreach to at least 20% of non-utilizers in 2022 ages six and under by June 2023 and connect 2% to primary care services. [Utilization measure]

- **Quantitative analysis:** Outreached to 100% (3,334/3,334). Connected 1.26% (42/3,334) to primary care services. All were Medi-Cal members.

	GOAL	Jul 2023	Oct 2023	Jan 2024	Apr 2024
Outreach	**20%**	100% (3,334/3,334)	Program ended	Program ended	Program ended
Connected	**2%**	N/A	1.26% (42/3,334)	Program ended	Program ended

- **Source**: Non-utilizer outreach pilot results
- **Met Goal:** Goal was met for outreach. Goal was not met for connection to primary care services.
- **Qualitative analysis:** Although the outreach goal was met, it resulted in fewer than anticipated members connecting to services. Barriers to reaching the goal were discussed at the PHM workgroup meeting, with input from the Director of Population Health and Equity, Quality Improvement Manager and Quality Improvement Specialist. Like with the adults, there was a high percentage of incorrect or missing numbers as well as a high no response rate. One issue the outreach vendor found was that children often had other primary health insurance or were already being seen at Kaiser. Similar to challenges encountered for child well-visits, network partners have reported staffing challenges, while simultaneously the Alliance member population has expanded. This has resulted in fewer appointments being available. Alliance care coordination efforts and member surveys have also revealed that appointments may not be available quickly, or available at convenient times.

Patient safety or outcomes across settings

Follow-up after Emergency Department (ED) visits related to substance use (FUA) and Transitional Care Services care manager contact have both improved and reached the goal. Following up with members after ED visits for mental illness (FUM) or hospital discharges continues to be challenging with receiving data and successfully reaching the member over the phone.

Follow-up after ED Visit for Mental Illness and Substance Use QI Project (Medi-Cal)

Many members go to emergency departments for urgent mental health problems. Getting follow-up mental health care after leaving the ED can improve health and prevent the need for future ED visits. Care management staff help members get follow-up care and resources that can improve their health and quality of life. Follow-up care after being seen in the ED with mental illness has shown a decrease in repeat ED visits, better physical and mental function, and increased compliance with follow-up instructions.

Goal 1: Follow-up After ED Visits for Mental Illness (FUM) - 30 days HEDIS rate for Medi-Cal members will increase from 49.03% in MY2022 to 54.51% in MY2023 (pending DHCS approval of Performance Improvement Project). [Clinical measure]

- **Quantitative analysis:** 51.10% (856/1,675) as of April 2024

	GOAL	Jul 2023	Oct 2023	Jan 2024	Apr 2024
FUM	**54.51%**	23.53% (196/833)	27.09% (366/1,351)	30.92% (513/1,659)	51.10% (856/1,675)

- **Source**: HEDIS dashboard
- **Met Goal:** No
- **Qualitative analysis:** The Quality Improvement Manager and Specialist reported an increase for FUA from January to April 2024 because of data received from Alameda County Behavioral Health; however, this was still short of the stated goal. Providers are experiencing challenges identifying members for follow-up through accurate data feeds. ADT feeds have been found to be unreliable because the diagnosis is often unrelated to mental illness or substance use. Alliance Quality Analytics staff also discovered issues with visit coding and receiving claims from all hospital EDs and Alameda County Behavioral Health. Another barrier for FUM is that Bridge program navigators who assist patients in the ED in Alameda County only assist with FUA.

Goal 2: Follow-up After ED Visits for Substance Use (FUA) – 30 days HEDIS rate for Medi-Cal members will increase from 29.82% in MY2022 to 31.31% in MY2023 (pending DHCS approval of Performance Improvement Project). [Clinical measure]

- **Quantitative analysis:** 38.01% (677/1,781) as of April 2024

	GOAL	Jul 2023	Oct 2023	Jan 2024	Apr 2024
FUA	**31.31%**	31.15% (290/931)	29.89% (452/1,512)	30.60% (541/1,768)	38.01% (677/1,781)

- **Source**: HEDIS dashboard
- **Met Goal:** Yes
- **Qualitative analysis:** The Quality Improvement Manager and Specialist reported an increase for FUA from January to April 2024 because of data received from Alameda County Behavioral Health. As noted in the FUM analysis, Bridge program navigators assist patients in the ED in Alameda County for FUA. This intervention was effective in reaching the goal. No additional programs for FUA are needed in 2024.

Transitional Care Services (Medi-Cal and Group Care)

Case Management staff promote continuity of care for members who have been discharged from the hospital or transfer from one setting or level of care to another. Staff outreach to members identified as high-risk for frequent hospitalization and/or emergency services and address medical or non-medical barriers that could cause a readmission. They coordinate follow-up with appropriate providers and connect members to plan or community resources.

Goal: Increase the percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7 days post-discharge from 14.6% for Medi-Cal and 9.8% for Group Care in August 2023 by 1 percentage point in March 2024. [Clinical measure]

- **Quantitative analysis:** Medi-Cal 24.7% (1,793/7,269), Group Care 22.9% (24/105)

	GOAL	Jul 2023	Oct 2023	Jan 2024	Apr 2024
Care manager contact	**MC: 15.6%** **GC: 10.8%**	New goal for August	MC: 18.8% (1,135/6,025) GC: 15.1% (13/86)	Data not available	MC: 24.7% (1,793/7,269) GC: 22.9% (24/105)

- **Source**: Transitional Care Services records
- **Met Goal:** Yes for both Medi-Cal and Group Care
- **Qualitative analysis:** The Manager of Case Management and the Business Intelligence Analyst who runs the data attributed the increase from October 2023 to March 2024 to better tracking of care manager contact through TruCare, the Alliance record system, starting in January. The Case Management team has also been checking the discharge status for TCS members daily to help meet this goal. This program has been effective in meeting the goal set for 2023. The Alliance will aim to continue improving this rate in 2024.

PHM Overall Strategy Effectiveness

On review of the 2023 Population Health Strategy outcomes, the Alliance noted success with launching multiple programs to reach more members in each of the focus areas to offer support and facilitate access to primary care services. There are opportunities for improvement in reaching members and learning how to create more effective interventions and capture more accurate data to improve outcomes.

Successes of the PHM Program included launching a disease management program for diabetes and hypertension, non-utilizer outreach to young children and older adults, and the Transitional Care Services program involving care managers contacting high-risk members after hospital discharge. The Alliance continued to work on quality improvement projects to target health disparities for Black (African American) members with lower rates of breast cancer screening and well-child visits. Goals were reached for breast cancer screening, the well-child visit measure in the first 15 months, and follow-up after ED visits for substance use.

Challenges included delays in the launch of programs; while it was a success that the diabetes and hypertension disease management program and non-utilizer outreach project were launched in 2023, being launched behind schedule meant less engagement for the programs. The member outreach strategy for the maternal mental health program was not implemented in 2023. Programs involving outreach to members have also faced barriers in reaching members because of challenges in timely and accurate data on who to outreach to, missing or incorrect phone numbers, and high no-response rates. Receiving complete data was a challenge for accurately measuring the rates of perinatal depression screenings and follow-up after ED visits for mental illness and substance use. Well-child visits and breast cancer screening for Black members continues to be a persistent disparity with rates below the DHCS minimum performance levels of 50th percentile among health plans.

Opportunities for Improvement

On review of the evaluation results, opportunities include:

- Increased engagement and partnerships with members, community organizations, and providers to understand and address barriers for Black (African American) members and members with ED visits for mental illness or substance use.
- More member education around the importance of breast cancer screenings and child preventive services.
- Beginning outreach with members before they leave the ED or hospital.
- Connections across Alliance and county programs to use successful member touches to promote other needed services and close gaps in care.
- Exploring ways to improve data for ED visits related to mental illness or substance use, members with no utilization, and perinatal depression screenings.

Actions Based on Opportunities

Actions based on opportunities are listed below:

1. Preventive Care - The Alliance will partner with a community organization to conduct a survey with Black families to learn more about barriers for well-child visits. The Alliance also plans to participate in church and clinic health fairs to educate and incentivize preventive services. There will be a second round of non-utilizer outreach calls with a modified methodology.
2. Maternal Mental Health – A member outreach mailing on perinatal depression will begin in 2024. The Alliance will also work to coordinate perinatal support across the organization and promote utilization of doula services to provide more support to members at risk for perinatal depression.
3. Follow-up after ED Visits – For follow-up after ED visits related to mental illness, the Alliance will explore ways to improve data on the visits and follow-up and to conduct member outreach using navigators in the ED, community health workers, and/or Alliance staff.