Illinois Department of Healthcare and Family Services

HEALTH EQUITY AND QUALITY SUBCOMMITTEE

Dec 8th, 2021

Virtual WebEx Meeting

10AM - 12PM

HE&Q SUBCOMMITTEE AGENDA

I. Call to Order

II. Roll Call of Committee Members

III. Introduction of HFS Staff

IV. Review and Approval of the Sep. 8th HE&Q Meeting Minutes

V. Update on Healthcare Transformation

VI. Community Health Workers, Perinatal Doula, and Evidence-based Home Visiting Services Feedback

VII. MCO Presentations (ten minutes each)

a. Use of Data to Identify SDOH and to Drive Equity

VIII. New Business/Announcements

a. Community-Safety Net Hospitals

b. Discussion of HFS Mandatory Ethics Training for Subcommittee Members

IX. Adjournment

HEALTH EQUITY AND QUALITY SUBCOMITTEE (HE&Q)

I. Call to Order ~ Howard Peters (Chair)

- *Chair presides over Subcommittee meetings and represents subcommittee at MAC meetings.*
- Nominations
- Discussion
- Selection

EXPECTATIONS OF SUBCOMMITTEE MEMBERS

- Attend all regularly scheduled meetings; when this is not possible, secure prior approval from Chair to send a non-voting substitute.
- Bring healthcare and social determinants of health knowledge and subject matter expertise to bear on the work of the subcommittee in support of Illinois' Medicaid Program.
- Drive meeting agendas and work products

HOUSEKEEPING

- Meeting basics
  - To ensure accurate records, please type name, organization, and email address into the chat.
  - If at all possible members are asked to attend meetings with their camera's turned on, however, if you call in, please email Kyle.Daniels@illinois.gov with a copy to Dawn.R.Wells@ Illinois.gov and Melisha.Bansa@Illinois.gov as soon as safely possible.
  - Mute audio except when speaking.
  - Please note that HFS staff may mute participants to minimize disruptive noise or feedback.
  - Patience, please – many subcommittee members and staff are new to MAC proceedings.

- HFS is committed to hosting meetings that are accessible and ADA compliant. Closed captioning will be provided. Please email Kyle.Daniels@illinois.gov with a copy to Dawn.R.Wells@ Illinois.gov and Melisha.Bansa@Illinois.gov in advance to report any requests or accommodations you may require or use the chat to alert us of challenges during a meeting.

- Minutes of the prior meeting will be circulated to subcommittee members in advance of each session. Once approved, they will be posted to the website.

HEALTH EQUITY AND QUALITY SUBCOMMITTEE AUTHORIZED BY THE MEDICAID ADVISORY COMMITTEE

The Health Equity and Quality subcommittee is established to advise the Medicaid Advisory Committee concerning strategies to improve customer outcomes by ensuring that populations covered under Healthcare and Family Services' Medical Assistance program have efficient, cost effective, and timely access to quality care that meets their need without discrimination based on race/ethnicity, gender, primary language, disability, sexual orientation, or socio-economic status.

This sub-committee shall:

1. Identify and Review evidence-based practices and programs that can improve patient care, population health outcomes by addressing strategies supporting the social determinants of health.
2. Examine barriers that impact customer access to care and utilization of health care services and recommend strategies to mitigate these barriers.
3. Recommend Improvements to quality metrics and indicators.
4. Assess streamlined approaches to identifying gaps in the delivery of services to Medicaid Customers.
5. Identify methods that can be modified or adapted to strengthen continuity of care.
6. Develop data informed recommendations to improve program implementation and evaluation metrics.
7. Recommend methods to improve provider participation and network adequacy.
8. Review and provide recommendations on how the Department can mitigate health disparities and the impact on communities disproportionately affect by COVID-19.
9. Consider and make recommendations on the definition of a "community" safety-net designation of certain hospitals
10. Make recommendations on the establishment of a regional partnership to bring additional specialty services to communities.
11. Review and make recommendations to address equity and healthcare transformation.

HEALTH EQUITY AND QUALITY SUBCOMITTEE (HE&Q)

II. Roll Call of Committee Members ~ Melishia Bansa
(Special Assistant to Director of HFS)

III. Introduction of HFS Staff ~ Howard Peters

IV. Review and Approval of the Sep. 8th HE&Q Meeting Minutes ~ Howard Peters

V. UPDATE ON HEALTHCARE TRANSFORMATION

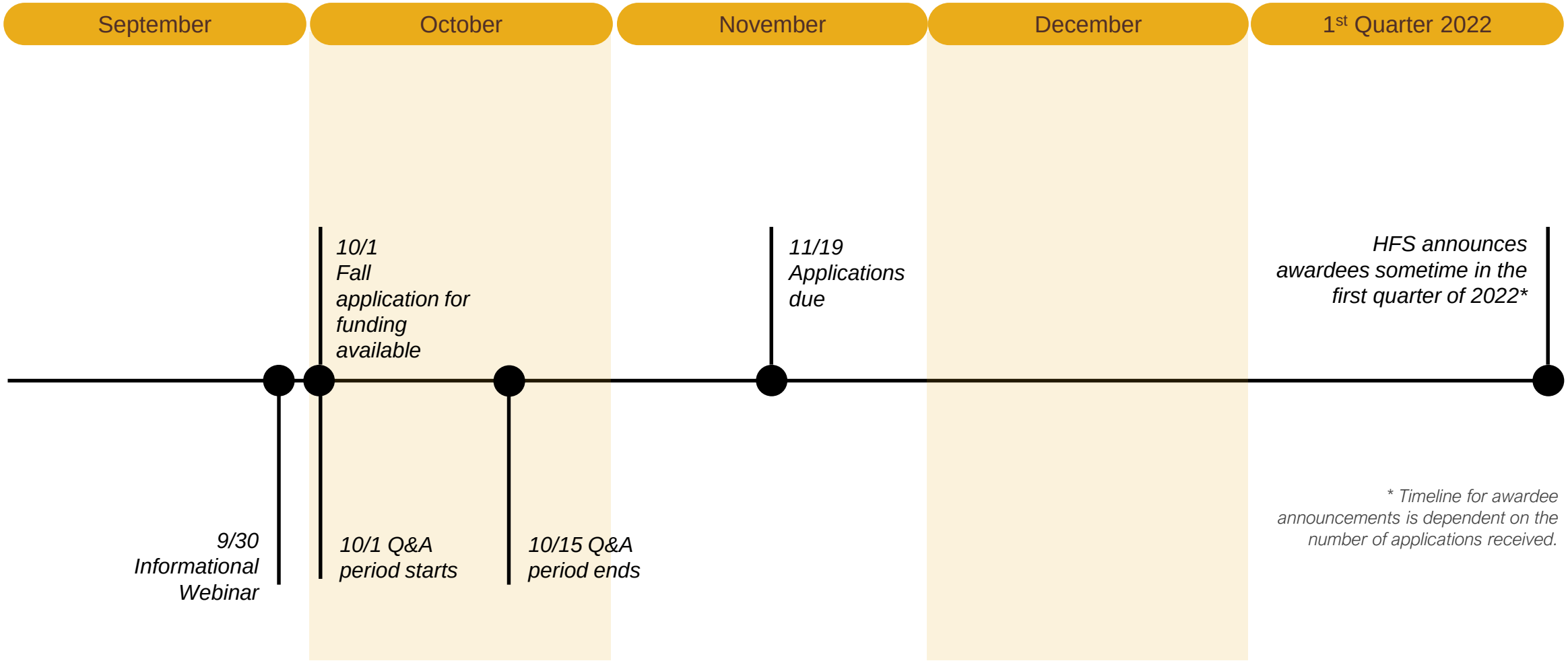
Presenter: Kimberly McCullough-Starks,
Deputy Director for Community Engagement - HFS

Healthcare Transformation Collaboratives Update

Application Period Closed: November 19, 2021
Public Comment Period Now Open: December 6-20, 2021
Awards Projected To Be Announced: Spring 2022

December 8, 2021

Application Key Dates



Stay connected

Register for HTC updates at HTC.Illinois.Gov

Questions

Answers

An HFS initiative

Healthcare Transformation Collaboratives

VI. COMMUNITY HEALTH WORKERS, PERINATAL DOULA, & EVIDENCE-BASED HOME VISITING SERVICES FEEDBACK

Presenter: Laura Phelan, Policy Director - HFS

- On November 10, HFS released a public comment notice requesting stakeholder feedback on the implementation of Community Health Workers (CHWs), perinatal doula services, and evidence-based home visiting services within the medical assistance program under Public Act 102-0004.

- Stakeholder feedback is being collected orally during today's meeting.

- Written comments are being collected through December 31, 2021 and may be sent to:
  - HFS.BPRA@illinois.gov, or
  - Illinois Department of Healthcare and Family Services, ATTN: Bureau of Program and Policy Coordination, 201 South Grand Avenue East, 2nd Floor, Springfield, IL 62763.

- Stakeholder feedback will help inform State Plan Amendments (SPAs) that will be submitted to the federal Centers for Medicare & Medicaid Services (CMS) in early CY 2022.
  - Federal CMS approval is required to receive federal matching dollars.

VI. COMMUNITY HEALTH WORKERS, PERINATAL DOULA, & EVIDENCE-BASED HOME VISITING SERVICES FEEDBACK

Stakeholder feedback could include:

- Provider type qualifications, including required training and/or certification,
- How to define CHW, doula, and home visiting services, including frequency of visits, components billed to Medicaid, and any maximum quantities or limitations,
- How to implement billing,
- How rates and a rate methodology should be developed, including background information that could be used to help justify the rates to federal CMS,
- How to implement these new services within a managed care framework, including how the new provider types may interact with MCO care coordinators,
- How doulas may interact with home visitors during the postpartum period,
- How to help existing providers learn about these new services and their importance,
- How to implement these new services in a way that promotes quality and coordination, advances equity, and qualifies for federal matching dollars, and
- Any other key implementation issues stakeholders want to raise

VII. MCO PRESENTATIONS (10 MINUTES EACH)

Facilitator: Melishia Bansa, Special Assistant to Director of HFS

a. **Use of Data to Identify SDOH and to Drive Equity**
   i. Aetna
   ii. Blue Cross Blue Shield of Illinois
   iii. CountyCare Health Plan
   iv. Meridianhealth
   v. Molina Healthcare

Leveraging Data to Identify SDOH and Promote Health Equity

Health Equity and Quality Subcommittee Meeting (HE&Q)

Dr. Lakshmi Emory, Chief Medical Officer
Mary Cooley, Health Services Officer
Angela Richmond, Director of Quality Management

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December 8, 2021

Data Driven Design:
Medical Management and Population Health Engagement[1]

Clinical, Claims, Financial, Operational, Consumer

Rules for Sorting and Categorizing Data

Thresholds and Filters

System-Level Goals and Programs

Communication and Activation Strategy

Person-Level Goals, Shared Decision Making and Coordination

Resource Allocation and Standing Orders

Programs and Services

Data → **Analytics and Reporting** → **Population Surveillance** → **Segmentation and Targeting** → **Outreach and Engagement** → **Care Planning** → **Clinical Strategy** → **Resource Managed Care Delivery**

Data Management

Care Coordination / Collaboration

DATA ATTRIBUTE EXAMPLES

Claims Based Data:
- Inpatient Utilization
- Emergency Department (ED) Utilization
- PCP and Specialists Visits
- Conditions
- Pharmacy Data

+

Socio-Economic Attributes:
- Age
- Gender
- Ethnicities
- Economics
- Unable to Engage

+

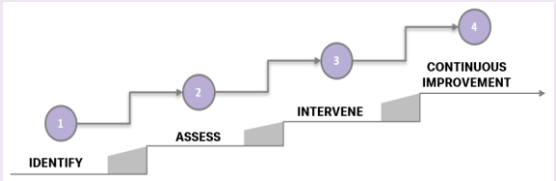
- Member self-reporting through health screenings and assessments: Social Determinants of Health (SDoH) including Housing, Physical Environment and Food Security
- Referrals from providers, practitioners, health and wellness programs, community supports, and caregivers

HYPERLOCAL TARGETING

- By products
- By providers and facilities
- By regions, counties and ZIP codes

Model of Care

Access, Equity, Person-Centeredness, Cultural Competence, Evidenced Based Medicine, Empowering the Member to Self-sufficiency



1) Reference: HIMSS Annual Conference | Session #301 on 2/20/17 | *A Universal Operating Model For Population Health Management*

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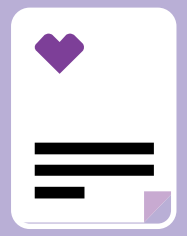
Example of Data Driven Design to Promote Health Equity

Sinai Chicago Medical Detox Unit at Holy Cross Hospital

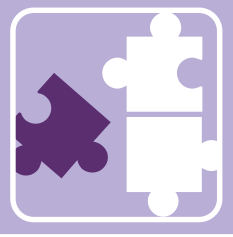
Adult Behavioral Health

Addressing Substance Use Disorder in Southwest Chicago



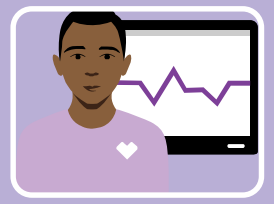
Program Summary

- Medical Detox Unit offers safe environment for withdrawal from drugs and/or alcohol under medical supervision
- Dedicated 20-bed unit at Holy Cross Hospital in Southwest Chicago
- Staff facilitates aftercare planning and links patient to resources for physical health, behavioral health, and other critical needs such as housing, safety, food access, and support systems



Progress to Date

- Medical Detox facility opened June 1, 2021
- 233 patients completed 3- to 5-day taper as of October 30, 2021, on track to outpace goal of 500 by February 2022
- Discharge Against Medical Advice rate 8.6% compared to 20% national baseline



Success Story

A young man who had been in recovery for many years relapsed. His aunt checked him into Holy Cross Medical Detox after she found him laying on the ground outside her place of employment. The patient was a $300/day heroin user, underweight, malnourished, and experiencing housing instability. He reported not feeling understood. The patient's aunt supported his transition into a residential program after a 5-day detox. She reports that he has gained weight and is thriving. The aunt now wants to apply for a job Holy Cross Medical Detox at after witnessing their care model.

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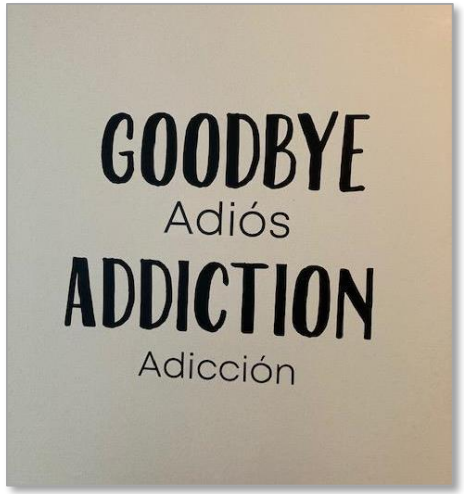
Example of Data Driven Design to Promote Health Equity

Adult Behavioral Health

Sinai Chicago Medical Detox Unit at Holy Cross Hospital

Addressing Substance Use Disorder in Southwest Chicago

Cultural Competence in the Wall Inspiration around the Medical Detox Unit



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Feedback
and
Questions
aetna

Blue Cross Blue Shield of Illinois

Health Equity and Quality Subcommittee Meeting

December 2021

SDOH & Health Inequity P4P Initiatives

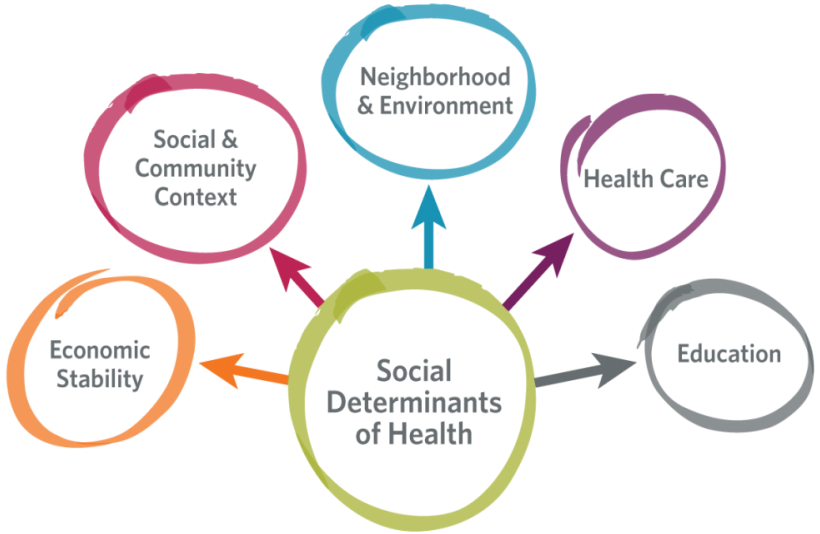
Care Coordination SDOH Fund

Purpose: *To support high-risk youth and adult members and families by providing basic necessities to address Social Determinants of Health. We are measuring the impact of funding SDoH needs on medical costs and health outcomes.*

The SDoH Fund program provides basic necessities to our members.

From January to October 2021:

- 1424 members have received assistance
- 850+ additional HRS/HRAs completed
- 380+ received assistance to attend an appointment after an acute behavioral health admission to promote improved health outcomes
- $63,000 spent to improve member access to basic needs and improve health outcomes.



SDOH & Health Inequity P4P Initiatives
Food Insecurity & Hunger Related to Health Outcomes

Top Box Foods Partnership: Targeting Hunger in Specific Neighborhoods

Purpose: *To address food insecurity for individuals at an increased risk of having or developing diabetes*

BCBSIL has expanded on a partnership that was started in 2020 with the American Diabetes Association and Top Box Foods. In the 3rd and 4th quarter of 2021, BCBSIL provided over 3,000 boxes of fresh produce and lean meats to some of our communities' most vulnerable individuals.

Sweet Potato Patch: Targeting High Risk Pregnant Women

Purpose: *To address food insecurity for high-risk pregnant women with the goal of reducing NICU admissions.*

Sweet Potato Patch focuses on improving infant and maternal health by providing meal delivery to women who are at high-risk. The meals provide the nutrients, lean meats, and vegetables needed to sustain a healthy pregnancy.

Currently, there are 50 women and 14 children in the program.

T. Castro Produce: Healthy Foods for the Whole Community

Purpose: *To bring fresh produce to communities in food deserts and neighborhoods with larger Medicaid recipient populations.*

Beginning in September, BCBSIL partnered with T. Castro to distribute a fresh and organic fruits and vegetables at monthly farmers' markets. A total of 35 events have been held in 2021.

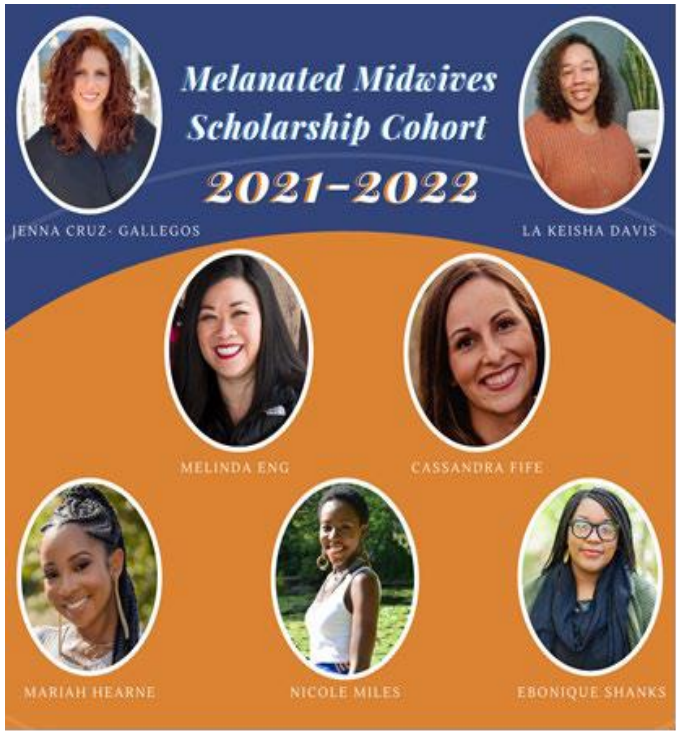
SDOH & Health Inequity P4P Initiatives:
Supporting Providers who focus on Medicaid & Underserved Populations

Purpose: *To partner with providers and community organizations who specifically target increasing Health Outcomes in black and brown communities by increasing the number of culturally diverse providers, addressing access to care, and educating on implicit bias.*

Maternal Health Partnerships

Melanated Midwives provides financial support to student midwives of color.

7 recipients received scholarships



Everthrive Illinois launched train-the-trainer seminars to address maternal mortality prevention.

18 service providers from two community-based organizations completed the training during the 3rd quarter.

A total of 91 social service providers at 7 organizations have participated in the trainings.

Social Determinants of Health & Health Equity Initiatives:

Telemedicine Infrastructure Grant

Purpose: *To expand virtual access to behavioral health care for underserved populations across the state of Illinois*

Grant Funding Utilization

Total Funding Distributed by BCBSIL:	Over $2M
Number of Participating Providers:	61
Grant Award Amount Range:	$9,000-$50,000 per provider

Outcomes

*From July 2020 to July 2021, over **625,000** telemedicine appointments were provided by participating providers to their Illinois patients – including almost **100,000** telemedicine visits for our BCBSIL Medicaid members.*

The grant enabled multiple BCBSIL Medicaid providers to lend telecommuting equipment to members who would otherwise not be able to receive services during the COVID-19 pandemic due to stay at home advisories and limited access to technology.

Summary of Received Items

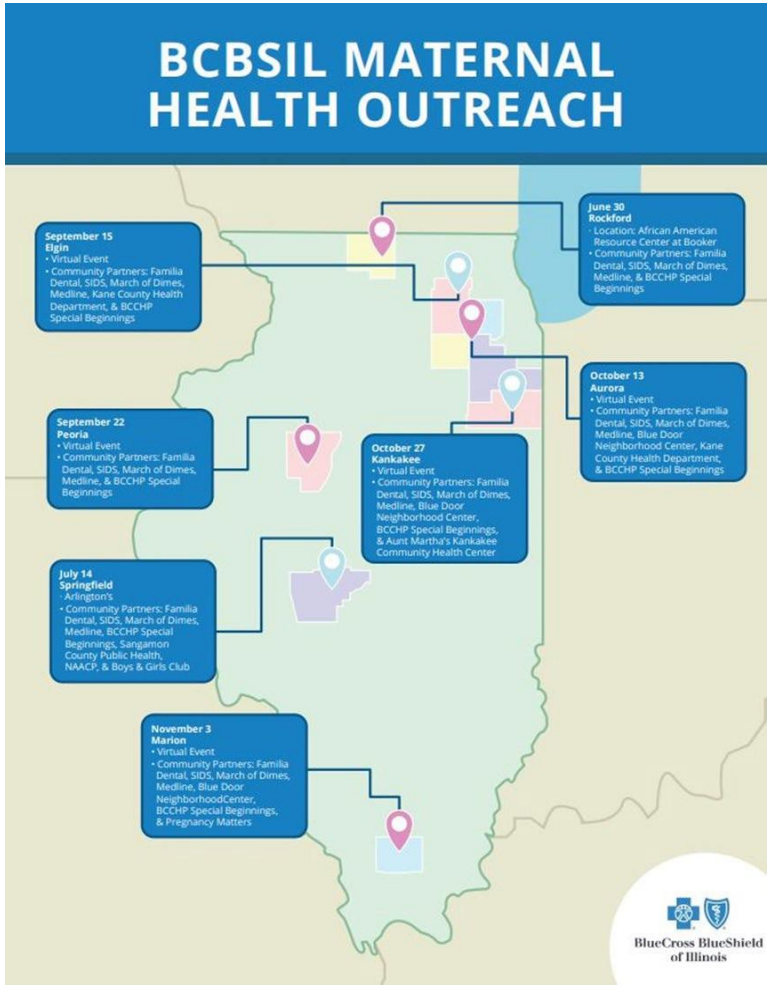
- 1,000+ computers and tablets for clinicians to conduct visits
- 75+ printers and scanners
- 400+ phones and headsets to increase efficiency of communication with clinicians / patients
- 120+ webcams
- 480+ HIPAA compliant telecommunication software licenses for 25+ organizations
- Training, technical support, data collection expertise, and consulting related to expanding telehealth programming for 20+ organizations
- Documentation platform and EHR software upgrades for 15+ organization
- Telecommunication room and building updates for 10+ organizations
- Wi-Fi and cellular network expansion for 29+ organizations

Blue Cross Maternal Health Outreach

Purpose: *To build partnerships with community organizations to host informational sessions and community baby showers to ensure positive health outcomes for both mothers and their babies.*

Community Baby Shower Overview:

- 7 locations, including participants from 11 counties, were served through this initiative.
- A total of 231 attendees were given access to educational maternal health resources, including 191 expectant mothers and 40 support people.



Feedback from Participants

"Everyone participating and all the helpful information made me feel a lot more confident and comfortable."

"Definitely learned a lot from the SIDS information. A lot of stuff I didn't know or even think of."

"Really appreciated the informative information and how helpful everyone was."

Social Determinants of Health & Health Equity Initiatives:

Vision Outreach Campaign

Purpose: *Outreach to members diagnosed with diabetes to educate them on annual health maintenance and assist with retinal eye exam appointment scheduling*

Program Overview

BCBSIL, in partnership with our vision provider, conducts targeted member outreach to help our members with diabetes complete annual retinal eye exams

Outcomes

Although the outreach campaign is ongoing, over the past 4 months over **300 appointments** have been scheduled

Process

1. We identify members diagnosed with diabetes and compile information about the date of their last eye exam and the vision provider last visited
2. Members who have not yet completed their eye exam for the current year are sent a letter with retinal eye exam education, the date of their last eye exam, the provider they visited, and offered assistance in scheduling an appointment
3. Members who receive a letter also receive a phone call during which they are offered immediate assistance in scheduling a visit

Social Determinants of Health & Health Equity Initiatives:

Clinical Data Exchange Efforts

Purpose: *To leverage Clinical Data Exchange Initiatives to support Health Equity Data Collection*

- Through our work with Athena and Epic, our Clinical Data Exchange team has developed a process to extract Race, Ethnicity, and Language indicators from medical records
- We are using this data from medical records to augment the Race, Ethnicity, and Language indicators received on the 834 enrollment file
- Initial efforts resulted in a **39% increase** in Race and Ethnicity indicators for IL Medicaid members with Athena medical records
- This information – along with additional indicators from medical records, such as smoking and alcohol use - will be incorporated into our population health efforts and clinical risk stratification model

We have implemented Epic Payer Platform partnerships with the following Illinois providers:

- Access Community Health
- Advocate Aurora Health
- DuPage/Edward Elmhurst
- OSF
- Northwestern Medicine
- NorthShore
- Northwest Community Hospital
- University of Illinois Hospital & Health Sciences System

The Epic Payer Platform is a secure, interconnected system of health information between BCBSIL and providers.

Utilization of ICD-10 Z Codes to Collect SDoH Data

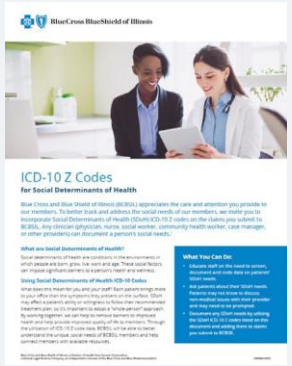
- Z Codes ranging from Z55 – Z65 are ICD-10 encounter reason codes used to document SDoH data
- We monitor Z Code claims on a monthly basis to identify top SDoH needs and inform potential member interventions

Illinois Medicaid Members – Top 10 Codes by Unique Member (2021 YTD)			
Z-Code	**Description**	**Unique Members**	**Claim Instances**
Z59.0	Homelessness	1,051	2,817
Z56.0	Unemployment, unspecified	903	1,464
Z62.810	Personal history of physical and sexual abuse in childhood	594	922
Z63.4	Disappearance and death of family member	579	1,071
Z63.8	Other specified problems related to primary support group	500	745
Z62.811	Personal history of psychological abuse in childhood	318	431
Z63.9	Problem related to primary support group, unspecified	243	407
Z63.79	Other stressful life events affecting family and household	225	369
Z55.9	Problems related to education and literacy, unspecified	220	330
Z62.820	Parent-biological child conflict	203	523

Note: The above table represents Z Code claims from January 2021 – August 2021.

Provider Education

We distributed a provider tip sheet on Z Codes to educate providers on SDoH and adding Z Codes to claims submitted to BCBSIL. The tip sheet is also available on our provider website.



Z Code Pilot

In 2021, we launched a pilot program with a few select providers to understand if **reimbursement for Z Codes would help drive provider adoption**. Providers were given funding to support their efforts around screening for SDoH and submitting Z Codes. We are monitoring the number of social needs screenings conducted and the volume of Z Codes submitted each month.

SDoH Assessments & Tracking

BCBSIL implemented an SDOH platform in August with over 200 engaged users, 575 searches, 30 screenings, and over 40 referrals.

Types of Referrals:

- Behavioral Health
- Financial Support
- Foods
- Goods
- Health
- Housing
- Social Supports

How We Use Data to Inform

Identify opportunity

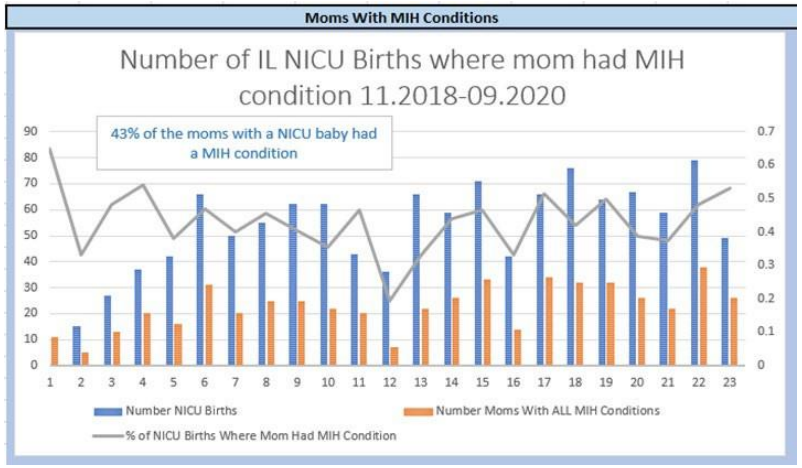
Conduct comprehensive analysis

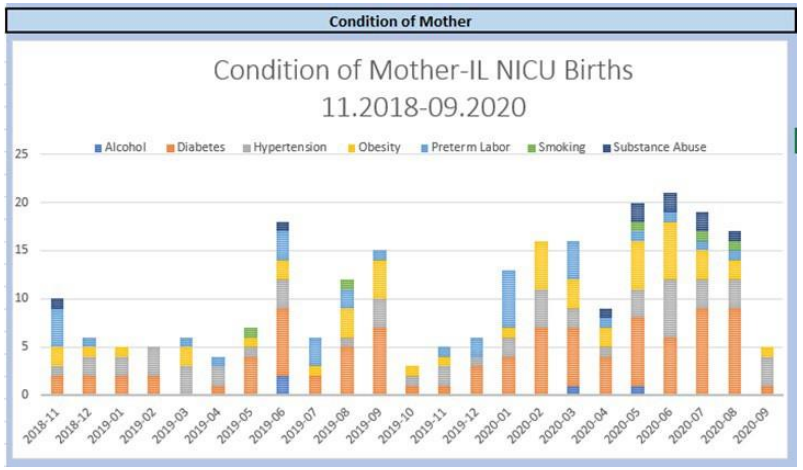
Identify target population

Identify partner to deliver food to at-risk members

Launch with Sweet Potato Patch

Using population data obtained from utilization, special beginnings care coordination, and leveraging the insights gained from a NM Maternal Infant Health pilot, the IL NICU births were examined to detect any similarities between the populations and high-risk conditions of the NICU mothers.





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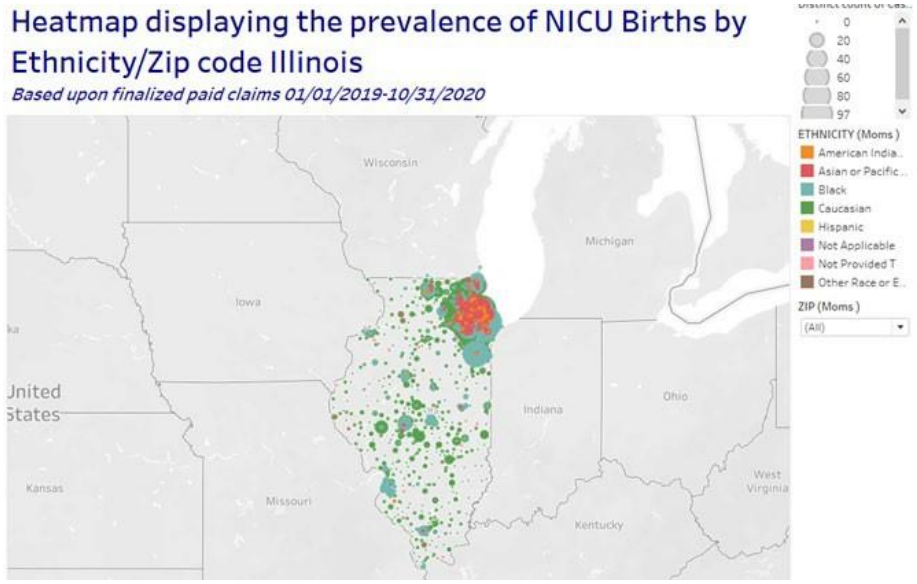


The Clinical Operations team worked to understand the social and economic demographics for communities with disproportionately high NICU rates.

NICU births for African American women by ZIP		
Zip	Neighborhood	Count
60901	Kankakee	69
60628	Roseland	91
60620	Auburn Gresham	67
60619	Chatham	56

How We Use Data to Inform

Identify opportunity

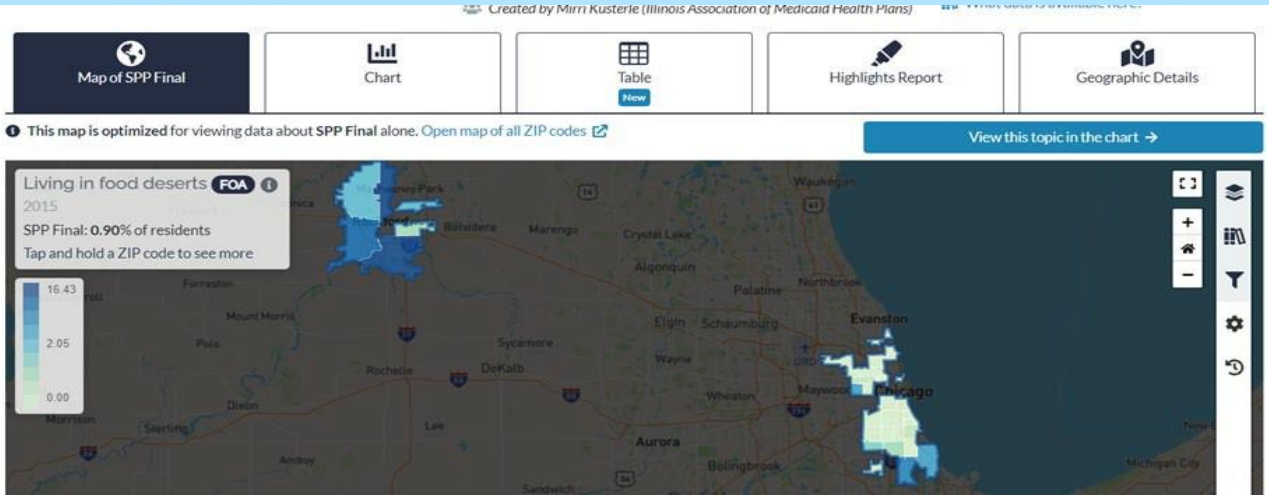
Conduct comprehensive analysis

Identify target population

Identify partner to deliver food to at-risk members

Launch with Sweet Potato Patch

Through the analysis, the team identified that communities with higher NICU rates aligned with identified food deserts. A target list of high-risk members living in food deserts was created.



How We Use Data to Inform

Using all data sources, we created a universe intended for targeted outreach to members with the highest density of:

- % of population living in a food desert
- Density of ethnic disparity
- Disadvantaged zip codes
- Exhibiting MIH at-risk indicators

Questions?

CountyCare Provider Collaboration within DIA Zip Codes and Updates

Kathy Shanahan, Director of Population Health & Performance Improvement

CountyCare HEALTH PLAN
AN ILLINOIS MEDICAID HEALTH PLAN

CountyCare/Provider Collaboration

- Share HEDIS Pillar performance data with Provider Groups
- 4 measures -Drill by DIA zip codes compared to Provider Group rates for 4 Measures
  - AAP Access to Preventive Health Services
  - BCS Breast Cancer Screening
  - CCS Cervical Cancer Screening
  - CBP Controlling Blood Pressure by DIA zip codes
- DIAs zip code drill down
  - Focus by volume (# of members) in each DIA zip code
  - Difference in rate from provider group's overall rates and DIA zip code rates

Provider Group A : AAP,BCS, CBP & CCS Rates for Disproportionately Impacted Areas (DIAs)

AAP- PCP Visit					Diff from
Zip Codes	0	1	Total	Rate	Rate
	11682	13082	24764	**52.8%**	
60619	1065	857	1922	44.6%	-8.2%
60628	693	542	1235	43.9%	-8.9%
60649	521	543	1064	51.0%	-1.8%
60620	402	489	891	54.9%	2.1%
60827	398	474	872	54.4%	1.5%
60426	393	473	866	54.6%	1.8%
60616	410	416	826	50.4%	-2.5%
60629	312	426	738	57.7%	4.9%
60621	303	432	735	58.8%	5.9%
60617	354	356	710	50.1%	-2.7%
60653	372	328	700	46.9%	-6.0%
60632	336	336	672	50.0%	-2.8%
60636	323	323	646	50.0%	-2.8%
60637	255	368	623	59.1%	6.2%

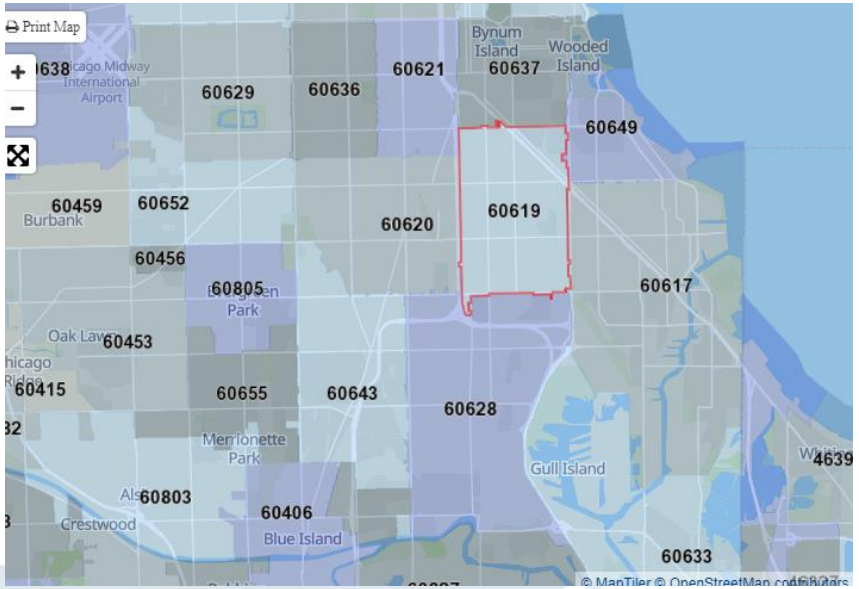
BCS - Breast CA Screen					Diff from
Zip Codes	0	1	Total	Rate	Rate
	1299	773	2072	**37.3%**	
60619	69	37	106	34.9%	-2.4%
60616	66	36	102	35.3%	-2.0%
60649	58	33	91	36.3%	-1.0%
60621	50	37	87	42.5%	5.2%
60628	60	19	79	24.1%	-13.3%
60426	32	42	74	56.8%	19.4%
60620	53	21	74	28.4%	-8.9%
60827	43	26	69	37.7%	0.4%
60637	43	22	65	33.8%	-3.5%
60629	38	26	64	40.6%	3.3%
60609	31	24	55	43.6%	6.3%
60617	37	15	52	28.8%	-8.5%
60653	33	19	52	36.5%	-0.8%
60636	27	22	49	44.9%	7.6%

CBP- Controlling BP					Diff from
Zip Codes	0	1	Total	Rate	Rate
	3222	68	3290	**2.1%**	
60619	198	3	201	1.5%	-0.6%
60621	147	1	148	0.7%	-1.4%
60827	145	2	147	1.4%	-0.7%
60426	142	4	146	2.7%	0.7%
60628	142	3	145	2.1%	0.0%
60649	121	3	124	2.4%	0.4%
60620	110	1	111	0.9%	-1.2%
60629	94	2	96	2.1%	0.0%
60637	94	2	96	2.1%	0.0%
60617	75	8	83	9.6%	7.6%
60636	80	1	81	1.2%	-0.8%
60653	77	2	79	2.5%	0.5%
60616	69	4	73	5.5%	3.4%
60609	71	1	72	1.4%	-0.7%

CCS - Cervical CA Screening					Diff from
Zip Codes	0	1	Total	Rate	Rate
	6887	**5021**	**11908**	**42.2%**	
60619	521	285	806	35.4%	-6.8%
60628	330	205	535	38.3%	-3.8%
60620	275	227	502	45.2%	3.1%
60649	314	183	497	36.8%	-5.3%
60827	254	231	485	47.6%	5.5%
60616	295	152	447	34.0%	-8.2%
60621	225	194	419	46.3%	4.1%
60426	200	196	396	49.5%	7.3%
60637	202	165	367	45.0%	2.8%
60629	186	173	359	48.2%	6.0%
60653	202	149	351	42.5%	0.3%
60617	195	142	337	42.1%	0.0%
60636	177	156	333	46.8%	4.7%
60632	183	118	301	39.2%	-3.0%

CountyCare HEALTH PLAN

Provider Group A : Targeted Outreach



- Provider Group A targeted outreach to zip codes:
  - 60619 (Neighborhoods: Avalon Park, Burnside, Calumet Heights, Chatham, Grand Crossing, Roseland, Longwood Manor, Park Manor, West Chatham
  - 60628 (Neighborhoods: Calumet Heights, Morgan Park, Roseland, West Pullman, Longwood Manor, Washington Heights, Fernwood, Brainerd

Provider Group A : Interventions by DIA zip codes 60619 & 60628

Identify which PCP members have seen within the past 3 years

The most recent AAP codes (up to three) and dates of service if found for members from 2018 until the present.

The rendering provider name, or provider who saw the member

- Member outreach to 1,749 member's living in zip codes 60619 and 60628 with **1 gap in care**
  - Start Date: 08/16/2021
  - 3 phone calls to member
  - Assistance with scheduling mammogram and/or PCP appointment
  - Follow-up phone call after appointment to ensure appointment completed
    - Assistance with rescheduling appointment as needed

Outreach Summary members with 1 Care Gap

1749 Members in file
262 (15%) No phone #

1485 Members outreached – 3 Attempts
597 (40%) Conversation and/or voicemail
9(<1%) Declined
888 (60%) No answer or member not available

CountyCare HEALTH PLAN

Provider Group A : Interventions by DIA zip codes

- Member outreach to 609 member's living in zip codes 60619 and 60628 with **2+ gaps** in care AND **offer transportation via Uber**
  - Start Date: 09/07/2021
  - 3 phone calls to member
  - Assistance with scheduling mammogram and/or PCP appointment
  - Offered transportation via Uber
  - Follow-up phone call after appointment to ensure appointment c
    - Assistance with rescheduling appointment as needed

Outreach Summary members with 2 + Care Gaps 507 Calls

# Unique Member Calls	% from 507 Population	Last Call Resolution
141	27.8%	Answering Machine - Left Message
102	20.1%	Conversation with member, discussed care gaps and UBER opportunity
170	33.5%	Call Attempts- No answer
3	0.6%	Member requested to be added to Do Not Call list
86	17.0%	Invalid Phone number

- 6 members accepted UBER ride
- 10/15/21 - 1st scheduled appt
- # of members accepting an appt is lower than expected
- Members have expressed appreciation for the UBER offer but did not have transportation as a barrier.
- Besides assistance with PCP visit, CCS, BCS, additional specialty referrals, medical and psychosocial care needs addressed

CountyCare HEALTH PLAN

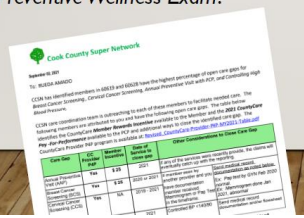
Provider Group A – Provider Newsletter

HFS EQUITY MEASURE STRATEGY

IN PARTNERSHIP WITH CC QUALITY TEAM

Members in 60619 and 60628 zip codes have the highest rate of non-compliance for:

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Controlling High Blood Pressure*
- *Annual Preventive Wellness Exam.*



Phase I

- Outreach 1749 members having one identified care gap - complete

Care Gap Reports

- All measures (delivered May)
- Equity Measures (September)
  - Includes list of members, phone numbers, highlights P4P opportunity and Member Rewards

HFS EQUITY MEASURE STRATEGY

IN PARTNERSHIP WITH CC QUALITY TEAM

More about the UBER opportunity

If a member would like to arrange an Uber they would need to provide the CCSN rep with their cell phone number, address and appointment date two business days prior to their appointment.

- The member must be able to have the Uber application installed on their cellular phone (Credit card needed for install, but will not be charged for ride).
- The member will receive a text from CCSN including active link to the Uber application with pick up and drop off information included.
- The member will confirm pick up and drop off address information once they receive the text
- The day of the appointment the member will open the Uber application and the pick up and drop information will be provided for them and they will confirm (call) the Uber ride ONE hour prior to their appointment time and when they are ready to go to their appointment if it is a walk in clinic.
- For the pick up from the appointment they will also open the Uber application and select their drop off address based on the addresses already populated in the Uber application for this ride.

Step 1: Members with 1 care gap (1749) will be part of a phone campaign, assisted with scheduling m

Step 2: Members with 2,3 or 4 care gaps (609) will be a phone campaign AND will offer UBER ride to and from scheduled appointment for *initially*

CountyCare HEALTH PLAN

Provider Group A : Interventions Phase II

HFS Equity Measure Strategy

IN partnership with CC Quality Team

Members in 60619 and 60628 zip codes have the highest rate of non-compliance for:

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Controlling High Blood Pressure*
- *Annual Preventive Wellness Exam.*

Phase II

- Outreach to 609 members having 2 or more care gaps and offer UBER ride to/from appointment to 100 members meeting UBER requirements.

Results of UBER Opportunity

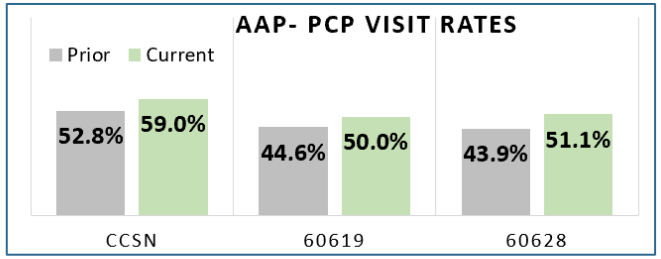
- Members were appreciative of offer, but did not have transportation as a barrier.
- Most members reported having recently seen or have scheduled visits with providers
- 9 Members accepted the UBER transportation opportunity and were scheduled
  - 2 members rescheduled their appointments
  - 1 successful appointment, others future dated

CountyCare HEALTH PLAN

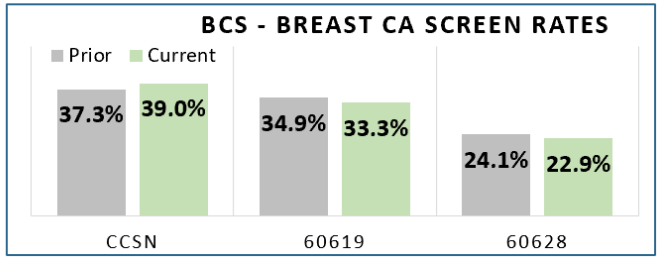
CCSN – Disproportionately Impacted Areas (DIAs)

Zip Codes 60619 and 60628 – July to October 2021 Rate Comparison

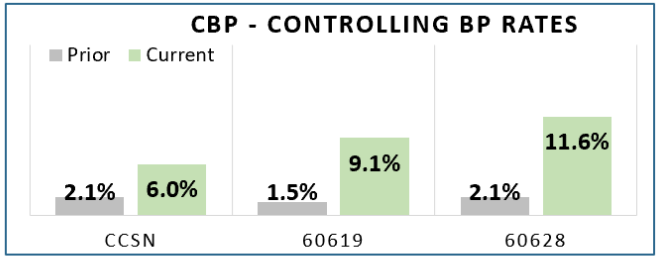
AAP- PCP Visit	Noncompliant		Compliant		Denominator		Rate		Diff from CCSN	
Zip Codes	Prior	Current	Prior	Current	Prior	Current	Prior	Current	Prior	Current
CCSN	*11,682*	***9,901***	*13,082*	***14,258***	*24,764*	***24,159***	*52.8%*	***59.0%***		
60619	1,065	**908**	857	**907**	1,922	**1,815**	44.6%	**50.0%**	-8.2%	**-9.0%**
60628	693	**576**	542	**601**	1,235	**1,177**	43.9%	**51.1%**	-8.9%	**-8.0%**



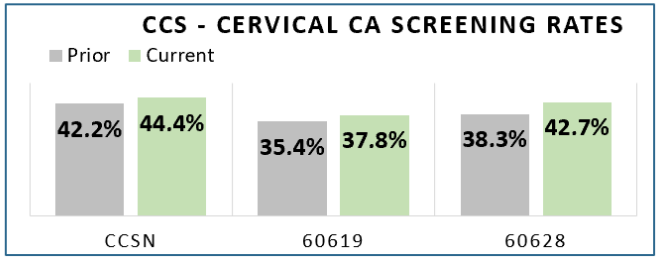
BCS - Breast CA Screen	Noncompliant		Compliant		Denominator		Rate		Diff from CCSN	
Zip Codes	Prior	Current	Prior	Current	Prior	Current	Prior	Current	Prior	Current
CCSN	*1,299*	***1,168***	*773*	***748***	*2,072*	***1,916***	*37.3%*	***39.0%***		
60619	69	**60**	37	**30**	106	**90**	34.9%	**33.3%**	-2.4%	**-5.7%**
60628	60	**54**	19	**16**	79	**70**	24.1%	**22.9%**	-13.3%	**-16.2%**



CBP - Controlling BP	Noncompliant		Compliant		Denominator		Rate		Diff from CCSN	
Zip Codes	Prior	Current	Prior	Current	Prior	Current	Prior	Current	Prior	Current
CCSN	*3,222*	***2,928***	*68*	***186***	*3,290*	***3,114***	*2.1%*	***6.0%***		
60619	198	**160**	3	**16**	201	**176**	1.5%	**9.1%**	-0.6%	**3.1%**
60628	142	**122**	3	**16**	145	**138**	2.1%	**11.6%**	0.0%	**5.6%**



CCS - Cervical CA Screening	Noncompliant		Compliant		Denominator		Rate		Diff from CCSN	
Zip Codes	Prior	Current	Prior	Current	Prior	Current	Prior	Current	Prior	Current
CCSN	*6,887*	***6,368***	*5,021*	***5,079***	*11,908*	***11,447***	*42.2%*	***44.4%***		
60619	521	**469**	285	**285**	806	**754**	35.4%	**37.8%**	-6.8%	**-6.6%**
60628	330	**291**	205	**217**	535	**508**	38.3%	**42.7%**	-3.8%	**-1.7%**



Provider Group B: BCS & CCS Rates for Disproportionately Impacted Areas (DIAs) with Mammography Site Designation

Breast Cancer Screening						
Mbr DIA Zip	MAMMO SITE	Community Name(s)	BCS		% Difference	
					Group B Rate	CountyCare Rate
			Denom	Rate	41.2%	43.8%
60637	PROV	Greater Grand Crossing, Hyde Park, Washington Park, Woodlawn	154	35.1%	-6.11%	-8.77%
60619		Avalon Park, Greater Grand Crossing	152	42.1%	0.94%	-1.72%
60620		Beverly	142	52.1%	10.94%	8.28%
60649		Jackson Park Highlands, Woodlawn	134	52.2%	11.07%	8.41%
60621	PROV	Englewood, Park Manor	126	36.5%	-4.66%	-7.32%
60644	PRIETO	Austin	118	29.7%	-11.51%	-14.17%
60651	STROG	West Humboldt Park, North Austin, Austin	110	33.6%	-7.53%	-10.19%
60636		Englewood	107	36.4%	-4.72%	-7.38%
60612	STROG	Medical District, East Garfield Park, Lawndale	100	30.0%	-11.17%	-13.83%
60628		Cottage Grove Heights, Longwood Manor	99	52.5%	11.36%	8.70%
60653	PROV	North Kenwood, Bronzeville	98	39.8%	-1.37%	-4.03%
60623	STROG	Little Village, Lawndale	92	35.9%	-5.30%	-7.96%
60411		Chicago Heights	85	43.5%	2.36%	-0.30%
60629		Chicago Lawn, Ashburn, Gage Park	85	43.5%	2.36%	-0.30%
60609	PROV	Back of the Yards, Bronzeville	81	40.7%	-0.43%	-3.09%
60624	STROG	East Garfield Park, Lawndale	79	31.6%	-9.52%	-12.18%

Cervical Cancer Screening						
Mbr DIA Zip	MAMMO SITE	Community Name(s)	CCS		% Difference	
					Group B Rate	CountyCare Rate
			Denom	Rate	30.7%	46.9%
60637	PROV	Greater Grand Crossing, Hyde Park, Washington Park, Woodlawn	654	30.7%	0.00%	-16.16%
60411		Chicago Heights	507	32.0%	1.22%	-14.94%
60619		Avalon Park, Greater Grand Crossing	405	34.1%	3.34%	-12.82%
60636		Englewood	400	26.8%	-3.98%	-20.14%
60620		Beverly	394	30.5%	-0.27%	-16.43%
60649		Jackson Park Highlands, Woodlawn	347	35.4%	4.72%	-11.44%
60621	PROV	Englewood, Park Manor	332	34.0%	3.31%	-12.85%
60644	PRIETO	Austin	321	30.2%	-0.51%	-16.67%
60651	STROG	West Humboldt Park, North Austin, Austin	319	30.7%	-0.01%	-16.17%
60623	STROG	Little Village, Lawndale	313	21.1%	-9.64%	-25.80%
60629		Chicago Lawn, Ashburn, Gage Park	254	30.3%	-0.42%	-16.58%
60628		Cottage Grove Heights, Longwood Manor	246	27.6%	-3.09%	-19.25%
60624	STROG	East Garfield Park, Lawndale	232	32.3%	1.60%	-14.56%
60617		East Chicago, Calumet Heights	226	32.7%	2.01%	-14.15%
60653	PROV	North Kenwood, Bronzeville	225	32.9%	2.16%	-14.00%
60612	STROG	Medical District, East Garfield Park, Lawndale	218	31.7%	0.92%	-15.24%

Provider Group B: AAP & CBP Rates for Disproportionately Impacted Areas (DIAs) with Mammography Site Designation

Cook County Health Membership in Disproportionately Impacted Area (DIA) Zip Codes

MAMMO SITE Designations: ARL HTS (Arlington Heights), BLUE ISL (Blue Island), PRIETO (Dr. Jorge Prieto Hlth Ctr), PROV (Provident Hospital), STROG (Stroger Hospital)

Top 10 DIA Zip Codes based on AAP Denominator Counts Are Color-Matched Across All Measure Tables

Adult Access to Preventative/Ambulatory Services

Mbr DIA Zip	MAMMO SITE	Community Name(s)	AAP		% Difference	
					CCH Rate	CountyCare Rate
			Den	Rate	####	60.2%
60637	PROV	Greater Grand Crossing, Hyde Park, Washington Park, Woodlawn	1442	46.4%	-7.82%	-13.78%
60411		Chicago Heights	1160	45.9%	-8.26%	-14.22%
60636		Englewood	1017	48.2%	-6.03%	-11.99%
60619		Avalon Park, Greater Grand Crossing	901	61.2%	6.94%	0.98%
60620		Beverly	893	59.1%	4.92%	-1.04%
60623	STROG	Little Village, Lawndale	874	45.0%	-2.32%	-8.28%
60644	PRIETO	Austin	814	54.4%	-9.24%	-15.20%
60621	PROV	Englewood, Park Manor	774	56.6%	0.21%	-5.75%
60651	STROG	West Humboldt Park, North Austin, Austin	769	51.9%	8.64%	2.68%
60649		Jackson Park Highlands, Woodlawn	724	62.8%	2.38%	-3.58%
60628		Cottage Grove Heights, Longwood Manor	599	61.4%	7.23%	1.27%
60624	STROG	East Garfield Park, Lawndale	570	49.6%	-4.56%	-10.52%

Controlling High Blood Pressure

Mbr DIA Zip	MAMMO SITE	Community Name(s)	CBP		% Difference	
					CCH Rate	CountyCare Rate
			Den	Rate	####	8.90%
60637	PROV	Greater Grand Crossing, Hyde Park, Washington Park, Woodlawn	256	0.00%	-0.59%	-8.90%
60619		Avalon Park, Greater Grand Crossing	243	0.00%	-0.59%	-8.90%
60620		Beverly	223	0.00%	-0.59%	-8.90%
60649		Jackson Park Highlands, Woodlawn	199	0.00%	-0.59%	-8.90%
60644	PRIETO	Austin	196	1.02%	0.43%	-7.88%
60636		Englewood	189	0.00%	-0.59%	-8.90%
60628		Cottage Grove Heights, Longwood Manor	189	1.06%	0.47%	-7.84%
60621	PROV	Englewood, Park Manor	181	0.55%	-0.04%	-8.35%
60411		Chicago Heights	164	1.22%	0.63%	-7.68%
60617		East Chicago, Calumet Heights	142	1.41%	0.82%	-7.49%
60624	STROG	East Garfield Park, Lawndale	139	2.16%	1.57%	-6.74%
60651	STROG	West Humboldt Park, North Austin, Austin	132	0.76%	0.17%	-8.14%

CountyCare HEALTH PLAN

Provider Group B : Interventions for DIA zip codes

- **Host Health Extravaganza**
- **Partner with Provider Group B to identify mammography screening for 5 sites (Stroger, Provident, Blue Island, Arlington Heights, and Prieto)**
  - Health Extravaganza scheduled October 23, 2021 at Provident
  - Bundle measures to close care gaps
    - Services offered with mammogram: Pap smear, PCP visit with blood pressure check, COVID vaccination
  - Member engagement
  - Member transportation –CCH Fleet, Bus passes
  - Member education
  - CountyCare staff engagement (Volunteers)
- **Data, Marketing, and Partnerships**
  - Review DIA zip code list by poor compliance, volume and geography
  - Develop communication/ outreach strategy
  - Member incentive for AAP, BCS, and COVID vaccination
  - Target Gift Cards on site
  - Give-a-ways: CountyCare keychains, hand sanitizer, pens, Kleenex
  - Volunteer t-shirts
  - Breakfast and Lunch

CountyCare HEALTH PLAN

HealthCare Extravaganza Results

Successes

- Gaps closed
- Member interaction
- CountyCare staff engagement with members
- Increase Health Equity for disparate population in 4 zip codes
- Promotion of CountyCare HealthPlan
- Multidisciplinary Collaboration with Provident Staff
- Member Comments:
  - Liked to be able to get all services done at once
  - Been waiting 6 months for a mammogram and then CountyCare called
  - Glad that services are offered on a Saturday because it is hard to come during the week

Gaps Completed

- Mammograms 22/34
- Pap Smears 14/29
- PCP Visits 13/ 27
- COVID Vaccination 6

Volunteers

- CountyCare Staff at event 8
- CountyCare Outreach staff 5
- Provident Mammograms 5
- Provident Providers 10
- Nurses 2
- MA/Clerks 5

CountyCare HEALTH PLAN

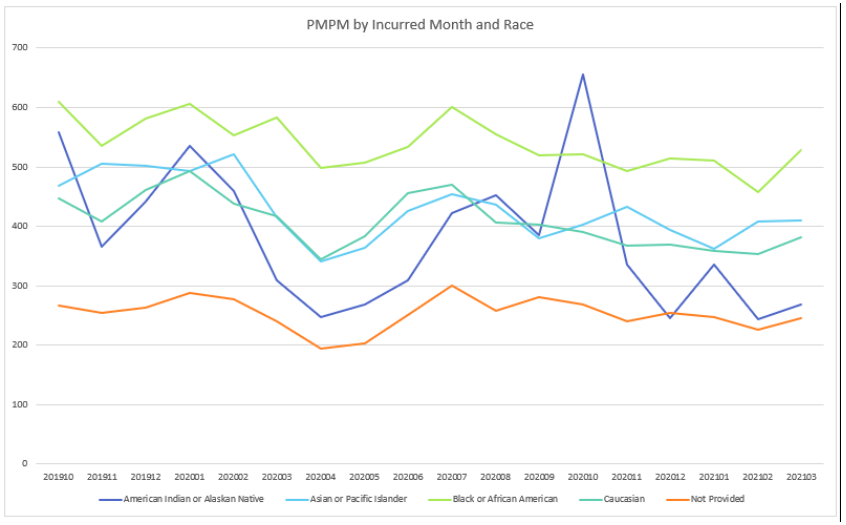
SDOH Data used to Drive Health Equity

Yvonne Collins, MD,
Chief Medical Officer

CountyCare HEALTH PLAN

Racial Disparity Dash

PMPM by Race & Region



- Reporting period: October 2019-March 2021
- Black or African American members have the highest overall PMPM ($537 across the 18-month reporting period), which is 34% higher than the average overall PMPM across all members ($401)
- Members residing in Central Chicago have the highest overall PMPM ($530, 32% higher than average PMPM)
  - The high overall PMPM is mainly driven by the medical PMPM ($431), which is 38% higher than the population average medical PMPM ($313)
- Members residing in the South Suburbs have the lowest PCP visits per 1,000 (1,351), which is 20% lower than the population average (1,689)
- South Chicago has the highest average ED visits per 1,000 (648), which is 22% higher than the population average (530)

Claims Summary by Region

Row Labels	Sum of Ed Visits per 1000	Sum of PCP Visits per 1000	Med Total	Med PMPM	Rx Total	Rx PMPM	Overall PMPM	Current Members	% of Current Membership
West Chicago	550	1842	$ 372,126,990	$ 296	$ 94,674,923	$ 75	$ 371	81,438	20%
South Chicago	648	1520	$ 322,215,889	$ 365	$ 87,751,224	$ 99	$ 465	58,445	14%
Far Southeast Chicago	574	1429	$ 234,405,235	$ 318	$ 64,054,159	$ 87	$ 405	48,580	12%
Far North Chicago	418	1976	$ 213,492,466	$ 357	$ 68,333,898	$ 114	$ 471	40,850	10%
South Suburbs	595	1351	$ 160,688,149	$ 281	$ 44,316,910	$ 77	$ 358	39,401	10%
North Chicago	464	1905	$ 150,114,092	$ 292	$ 51,746,496	$ 101	$ 393	34,209	8%
Southwest Chicago	450	1793	$ 136,987,793	$ 255	$ 38,945,280	$ 72	$ 327	35,336	9%
Central Chicago	493	1742	$ 104,229,188	$ 431	$ 23,971,704	$ 99	$ 530	16,152	4%
West Suburbs	538	1749	$ 82,044,922	$ 277	$ 26,267,445	$ 89	$ 366	19,971	5%
North Suburbs	393	1823	$ 80,114,179	$ 291	$ 23,884,810	$ 87	$ 378	19,351	5%
Southwest Suburbs	426	1606	$ 62,990,135	$ 297	$ 17,339,180	$ 82	$ 379	14,316	4%
Grand Total	**528**	**1697**	**$ 1,919,409,040**	**$ 313**	**$ 541,286,027**	**$ 88**	**$ 402**	**408,049**	**100%**

Racial Disparity Dash

Inpatient/CM by Race & Region

IP Claims Summary by Race

Row Labels	Admits per 1000	Average Length of Stay	IP Med Spend Total	IP Med PMPM	Current Members	% of Current Membership
Black or African American	191	5.50	$ 241,609,574	$ 161	154,965	38%
Not Provided	103	5.01	$ 136,047,629	$ 93	142,401	35%
Caucasian	133	5.12	$ 99,216,041	$ 105	101,073	25%
Asian or Pacific Islander	91	4.71	$ 7,642,056	$ 68	12,740	3%
American Indian or Alaskan Native	182	4.90	$ 630,657	$ 102	492	0%
Hispanic	316	8.00	$ 15,040	$ 198	2	0%
Grand Total	**143**	**5.28**	**$ 485,160,996**	**$ 121**	**411,673**	**100%**

IP Claims Summary by Region

Row Labels	Admits per 1000	Average Length of Stay	Med Total	Med Total PMP	Current Members	% of Current Membership
West Chicago	136	5.19	$ 140,289,158	$ 119	81,438	20%
South Chicago	163	5.31	$ 122,312,450	$ 148	58,445	14%
Far Southeast Chicago	141	5.21	$ 85,352,222	$ 123	48,580	12%
Far North Chicago	134	5.42	$ 64,332,595	$ 115	40,850	10%
South Suburbs	127	5.17	$ 56,528,394	$ 106	39,401	10%
Southwest Chicago	121	4.74	$ 51,150,538	$ 101	35,336	9%
North Chicago	125	5.30	$ 48,105,663	$ 100	34,209	8%
Central Chicago	153	6.07	$ 36,913,496	$ 163	16,152	4%
West Suburbs	128	5.20	$ 26,573,725	$ 96	19,971	5%
Southwest Suburbs	132	6.82	$ 20,348,522	$ 102	14,316	4%
North Suburbs	110	5.28	$ 19,145,135	$ 74	19,351	5%
Grand Total	**136**	**5.30**	**$ 671,051,899**	**$ 117**	**408,049**	**100%**

Inpatient Summary (October 2019 - March 2021)

- Aside from Hispanic members, Black or African American members have the highest average length of stay (5.51 days, 4% larger than population average of 5.31) and IP medical PMPM ($156, 33% higher than population average of $117)
- Members who reside in the Southwest Suburbs have the highest average length of stay (6.82 days, 29% higher than population average of 5.30)

Care Management Summary (September 2021 membership)

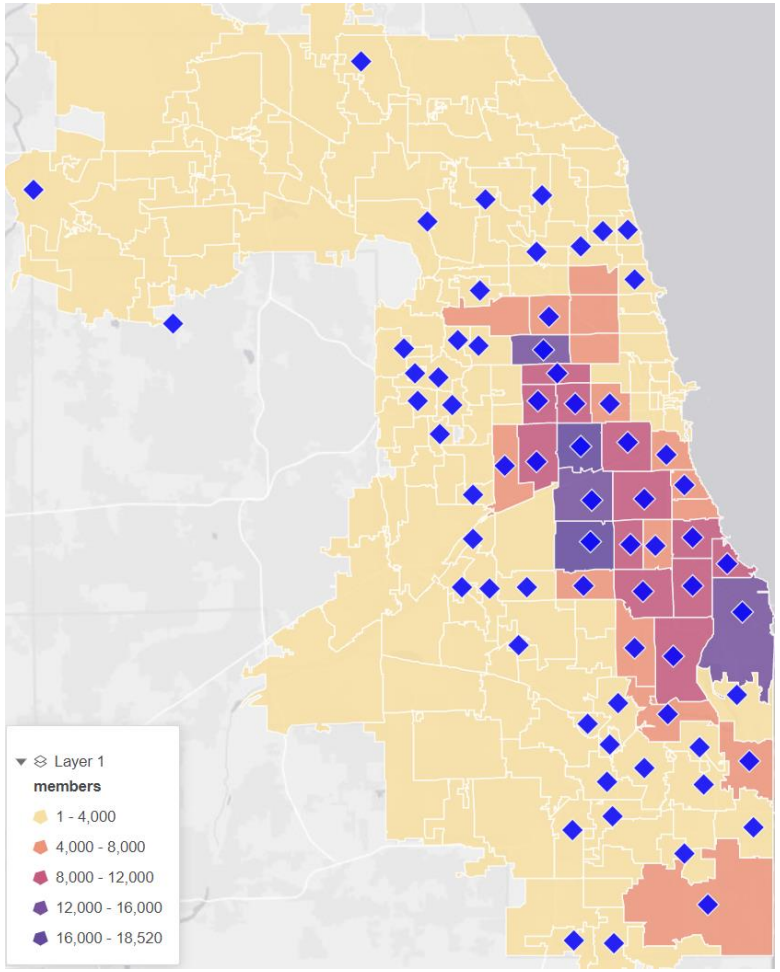
- Members residing in the North Suburbs have the lowest screening completion rate (51%), which is 23% lower than the population average (66%)
- Members residing in the Southwest Suburbs have the lowest high-risk care plan completion rate (49%), which is 13% lower than the population average care plan completion rate (56%)

CM Summary by Region

Row Labels	Total Members	High Risk Members	% High Risk	% Screening Completed (All Members)	% CPC (High Risk)	% HRA (High Risk)	% High Risk Recent CM
West Chicago	81,438	3,065	4%	74%	59%	71%	62%
South Chicago	58,445	2,504	4%	67%	62%	73%	69%
Far Southeast Chicago	48,580	1,809	4%	68%	59%	70%	66%
Far North Chicago	40,850	1,509	4%	61%	50%	62%	60%
South Suburbs	39,401	1,393	4%	60%	60%	70%	70%
Southwest Chicago	35,336	970	3%	74%	58%	70%	65%
North Chicago	34,209	1,250	4%	69%	50%	64%	56%
West Suburbs	19,971	765	4%	61%	52%	61%	60%
North Suburbs	19,351	545	3%	52%	52%	67%	67%
Central Chicago	16,152	654	4%	66%	54%	63%	62%
Southwest Suburbs	14,316	464	3%	59%	50%	64%	63%
Grand Total	**408,049**	**14,928**	**4%**	**67%**	**57%**	**68%**	**64%**

Membership by DIA Zip

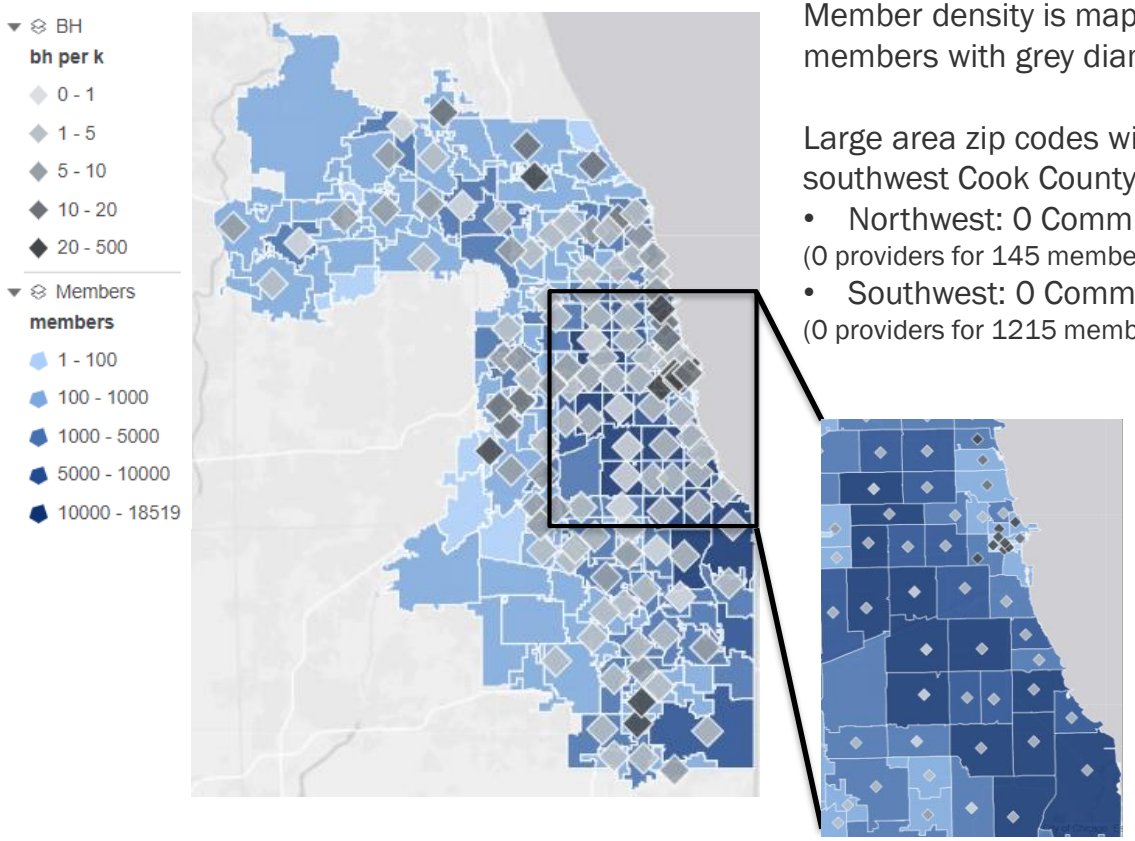
Disproportionately-Impacted Areas (DIA)



- The shaded zip code areas represent CountyCare's membership while the diamond markers represent 68 DIA zip codes that CountyCare members reside in
- Out of CountyCare's current membership, 325K members live in disproportionately-impacted zip codes, which is **80% of CountyCare's current membership** of 411K for September 2021

Access to Care

Mapping Community BH Provider and Member Density by Zip Code



Member density is mapped in blue and Community BH providers* per 1000 members with grey diamonds. All service locations are represented.

Large area zip codes without any Community BH providers in northwest and southwest Cook County indicates a potential opportunity

- Northwest: 0 Community BH providers per 1000 members

(0 providers for 145 members in 60010)

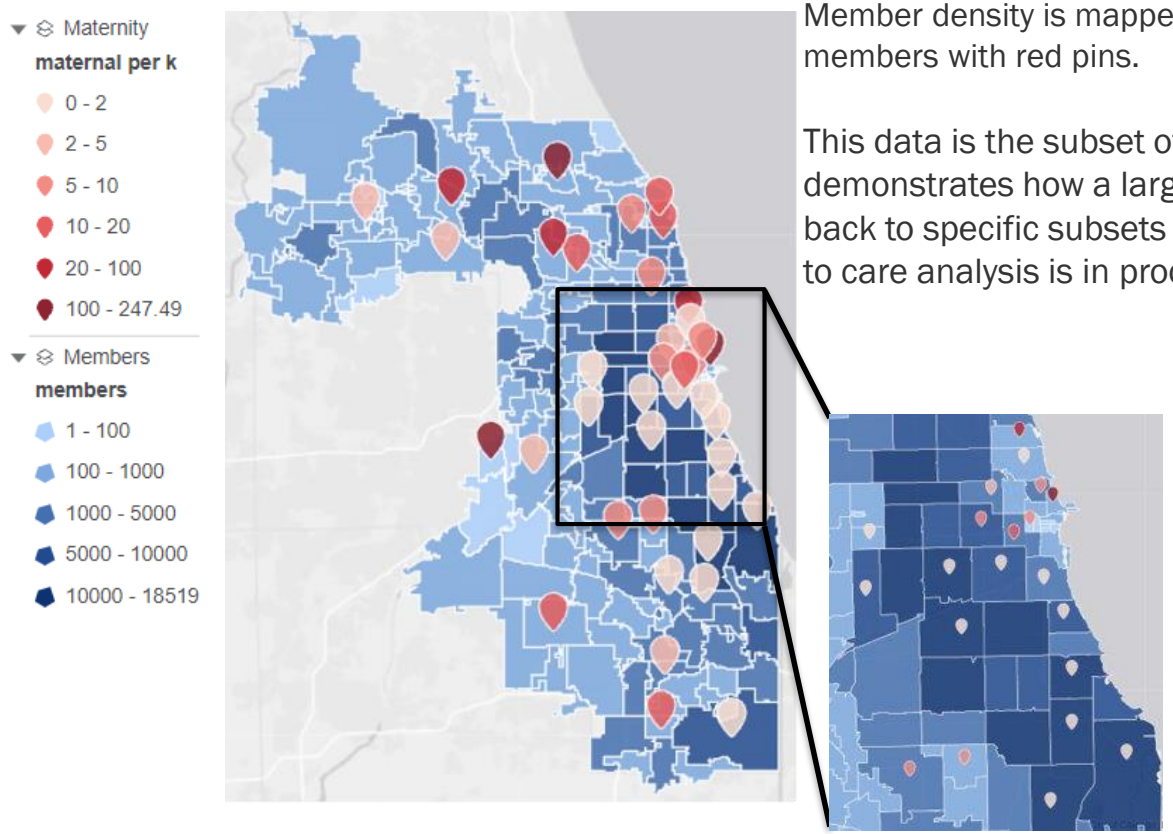
- Southwest: 0 Community BH providers per 1000 members

(0 providers for 1215 members in 60439, 60462, 60464, 60467, 60480, 60527)

*CMHCs, BHCs and SUPR Providers

Access to Care

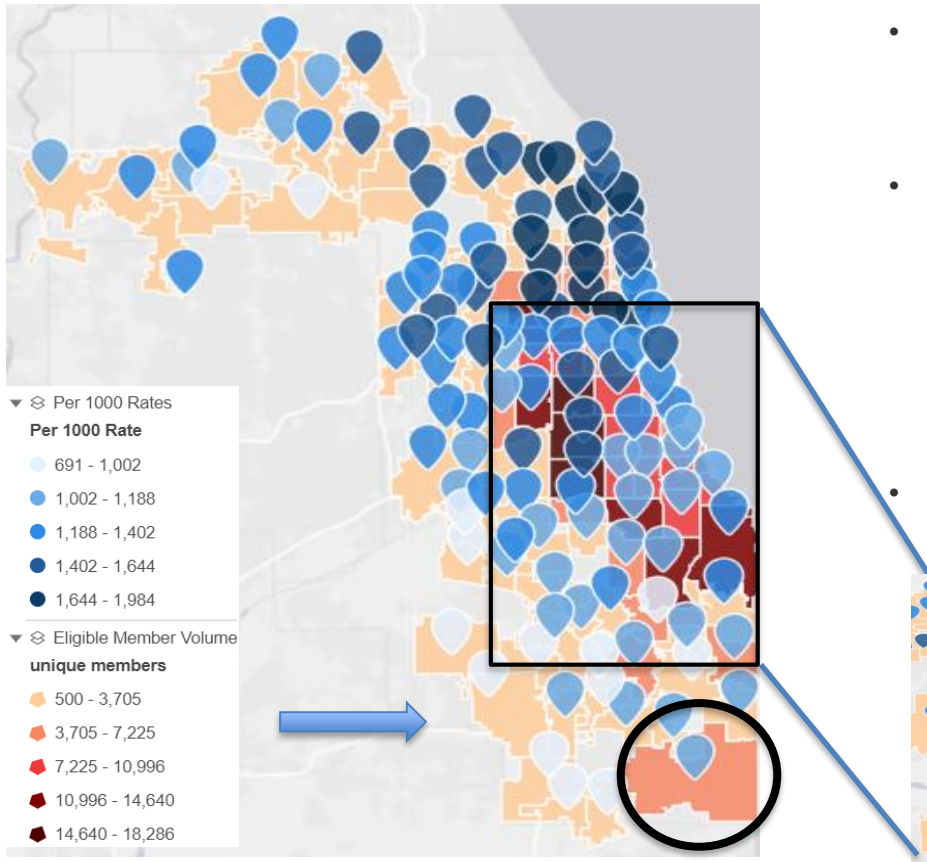
Mapping MFM Provider and Member Density by Zip Code



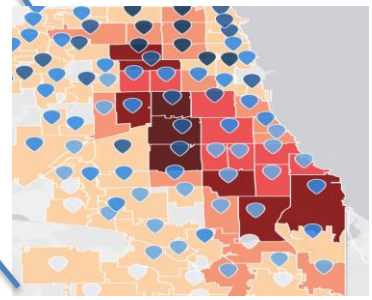
Member density is mapped in blue and maternity providers per 1000 members with red pins.

This data is the subset of Maternal Fetal Medicine specialists, and demonstrates how a larger provider access point dataset can be peeled back to specific subsets of providers. Comprehensive maternity access to care analysis is in process.

PCP Visits

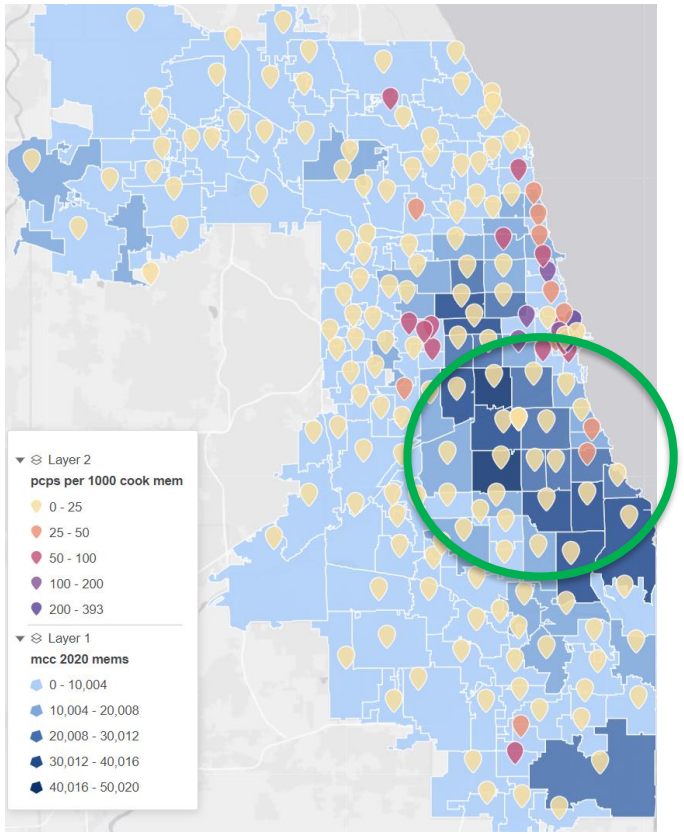


- The map shows per 1000 PCP Visit rates during 202004-202103 for zip codes where the eligible member population is greater than 500 unique members
- The greatest opportunity for improvement is in the **Southern part of Cook County**. This impacts 68K unique members.
  - Average per 1000 PCP Visit rate is 1046.
  - **Zip Code (60411)** in Southern Cook County would be a high impact area for intervention and comprises of 6,766 unique members with an average per 1000 PCP Visit rate of 1033.
- The areas with the highest member density (darker red) had an average per 1000 PCP rate of 1303



Access to Care

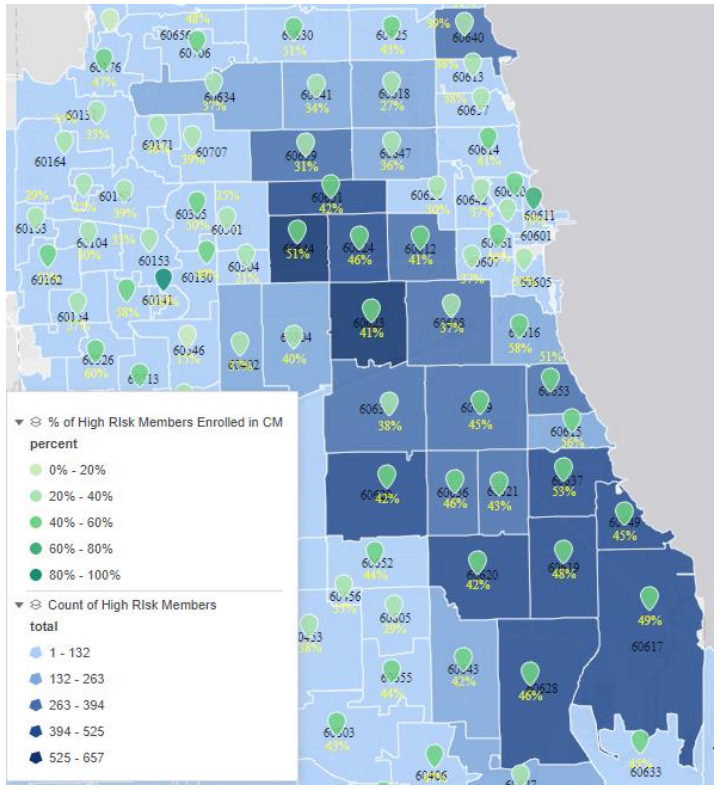
CountyCare PCPs Per 1000 Cook County Medicaid Members



- The blue represents Cook County Medicaid member density by Cook County zip code while the markers indicate the CountyCare PCPs Per 1000 Cook County Medicaid Member rate
- From a membership growth perspective, the **south and southwest areas of Chicago** would have the highest opportunity in contracting more PCPs into CountyCare's network given the high Cook County Medicaid membership concentration in this region
  - These areas represent about 600K Cook County Medicaid members, which is roughly less than half of the total Cook County Medicaid population

Care Management

CM Enrollment Rates for High Risk Members



	Enrolled in CM	High Risk Members	CM Enrolled %
Total CC Average:	6,619	15,320	43%
Average within High Density Zip Codes:	3,806	8,449	45%
Opportunities for Improvement (Total):	**1,472**	**3,681**	**40%**
60639	110	356	31%
60608	119	319	37%
60632	113	294	38%
60612	139	342	41%
60623	241	592	41%
60620	204	487	42%
60629	179	427	42%
60651	211	497	42%
60621	156	367	43%

- Map visualizes high-risk member population density (blue) and CM enrollment rates with high-risk members (green).
- Areas of opportunity identified by finding zip codes with high density of high-risk membership with lower-than-average CM enrollment.
- Using July 2021 CM data, ACCESS enrollment is not accurately portrayed this month.

Health Equity Efforts: COVID Vaccination Campaign

1 in 3 CountyCare members are vaccinated

Vaccination Phase	Count of Membership	Percent of Total Membership (407k)	Percent of Vaccine-Eligible Membership (294k)
1st of 2 doses only:	19,093	4.69%	6.47%
Fully Vaccinated:	122,092	29.96%	41.39%

Member Counts by Residential Area (*DIA= Disproportionately Impacted Area):	
Residential Area	# of Members with at Least 1 Dose
DIA Cook County	105,579
non-DIA Cook County	35,192
Other	414
Total	141,185

- 47.87% of vaccine-eligible CountyCare members have received at least 1 dose of the vaccine
- At the July 2021 QBR we reported 79,339 members with at least one dose, which increased by 44% to 141,185 members with at least one dose

Data as of 10/1/2021
"Vaccine-eligible membership" is 12 y/o+

CountyCare Partnership with Chicago Public Schools

COVID-19 Vaccinations

- Targeting school-aged members living in 606 zip codes
  - Text messages sent to remind CPS families about importance of getting vaccinated and locations near their home.
  - Members are directed to COVID-19 Vaccination clinics, events and CPS School-based Health Centers.

- Cook County Health and CPS Partnership
  - Linking CPS students/families to nearest CCH clinic for testing and vaccinations
    - Develop PCP relationship
    - Liaison between CPS principles and clinic managers
  - Staffing of CCH providers within CPS school-based clinics
    - Scheduled to align with timing of parents/guardian being present

Next Steps for Further Analysis SDOH Data

Current Initiatives

- Creation of Health Equity Dashboard
- Review of how to utilize Metopio data (initial analysis around food insecurity and rental assistance based on DIA zip codes)
- SDoH Dashboard (Metopio, Z-Codes)
  - Other areas COVID 19 Vulnerability, High School graduation rate, Poverty rate, social vulnerability index, households with no internet
- Z code Analysis in conjunction with the Flexible Housing Pool
- Member Demographic Initiative
- Development of a Housing Strategy for the Health Plan (Eviction Diversion, street outreach, Bridge/supportive housing, employment navigation)
- Development of a Food Insecurity Strategy for the Health Plan (Dietary support, food based incentives, disease focused meal planning)
- New Century Health Clinically Focused Health Equity Initiatives

Next Steps for Further Analysis SDOH Data

Future State

- mPulse Data Feeds for Member Language
- Potential data feeds from EMR flat files
- Exploring and potentially leveraging Identifi indicators (e.g. MEH - Members Experiencing Homelessness)
- Other areas COVID 19 Vulnerability, High School graduation rate, Poverty rate, social vulnerability index, households with no internet
- Merging SDoH with existing reporting
- Z code Analysis
- Creating custom SDoH scores using a combination of publicly available data and Evolent data
- CME race & ethnicity feeds
- Tying SDoH to resources for all members

meridianhealth

Establishing Health Equity

Targeted initiatives to address health disproportionality

December 2021

Defining Health Inequity

Health inequities are systematic differences in the health outcomes of different population groups. In order to achieve health equity, resources must be allocated based on the needs of those disproportionately impacted.

To address health disproportionality, Meridian is:

- Stratifying HEDIS measure reporting for age, race, gender, and geography (including Disproportionately Impacted Area (DIA) zip codes) based on the 834 enrollment files received from HFS
- Customizing vendor relationships to cater initiatives for disproportionately impacted population needs
- Identifying and partnering with key providers and community resources to provide additional resources to disproportionately impacted populations
- Utilizing internal resources to collect and apply SDoH data to improve health outcomes

Health Inequity Example: Maternal Health Program

Meridian Health Equity Analysis:

2021 HEDIS Health Disparities by Demographic Category		
Measure	**Geography** (DIA Zip Codes vs. Non-DIA Zip Codes)	**Race** (Black vs. Caucasian)
PPC - Prenatal	3.63%	7.91%
PPC - Postpartum	2.73%	9.73%

In an effort to improve Maternal Health Inequity we targeted **East St. Louis** which is **97.7% Black or African American** and partnered with two BEP vendors to work to ***reduce the inequality and improve the lives of our community***

Members are eligible if they are:

- Prenatal Patient
- African American
- First or Second Trimester
- Singleton Pregnancy
- Resident of selected counties

- Chicago-based, BEP, food business whose mission is to increase healthy food access to residents in urban food deserts
- Delivers farm-to-table healthy meals directly to residents

Promote healthy pregnancy and address disparities in birth outcomes among African American prenatal patients through increased healthy food access and consumption

Evaluation: Early stages of data collection, which includes completing a post-test with each participant after delivery, gathering participant clinical data and birth outcome data, and conducting interviews with participants and staff

“I gained a better relationship with my physician through participating. I was grateful for meals, and was also encouraged to attend regular OB visits with my doctor. I thank this program for having meals readily available to me during and after pregnancy. I was able to stop depending on fast food and junk food snacking.”

- Health inequity maternal health program participant

Future State – Meridian's New SDOH Model:

Overview

- The goal of the model is to identify members who have potentially unmet SDOH needs
- Once eligible members are identified, targeted outreach can help to meet those needs, improving health outcomes
- This model can also be applied at the population level, identifying potential community-wide issues and neighborhoods with particularly high potential need (This can be used to direct community outreach and partnerships)

Process

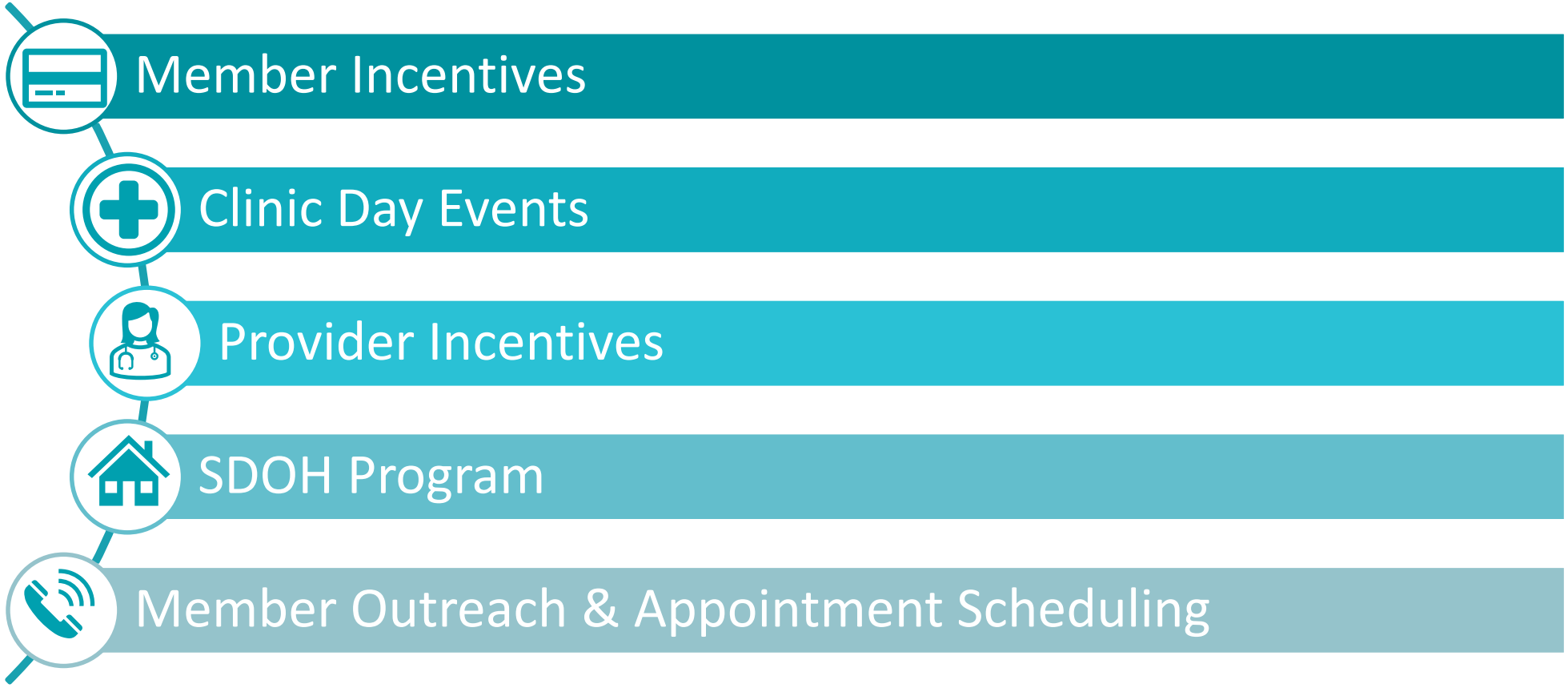
- The model draws on hundreds of measures of social, environmental, and economic conditions, at both the individual and neighborhood levels
- Using state of the art machine learning methods, each member is assigned an easily interpretable score that indicates their overall health risk from potentially unmet SDOH needs (Higher scores indicate a larger risk of adverse health outcomes or a deterioration in overall health)
- The model does not consider any purely medical information, like claims or prescription history, which allows the score to solely reflect socioeconomic risk factors

MAC Health Equity Subcommittee

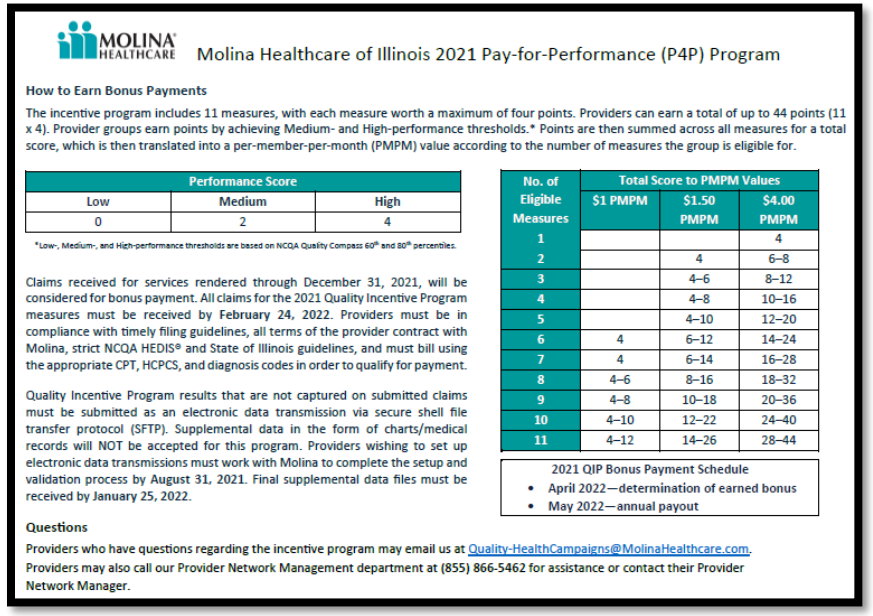
December 8, 2021

MOLINA® HEALTHCARE

Best Practices



Investing in Provider Partnerships



MOLINA HEALTHCARE

Molina Healthcare of Illinois 2021 Pay-for-Performance (P4P) Program

How to Earn Bonus Payments

The incentive program includes 11 measures, with each measure worth a maximum of four points. Providers can earn a total of up to 44 points (11 x 4). Provider groups earn points by achieving Medium- and High-performance thresholds.* Points are then summed across all measures for a total score, which is then translated into a per-member-per-month (PMPM) value according to the number of measures the group is eligible for.

Performance Score		
Low	Medium	High
0	2	4

*Low-, Medium-, and High-performance thresholds are based on NCQA Quality Compass 60th and 80th percentiles.

Claims received for services rendered through December 31, 2021, will be considered for bonus payment. All claims for the 2021 Quality Incentive Program measures must be received by **February 24, 2022**. Providers must be in compliance with timely filing guidelines, all terms of the provider contract with Molina, strict NCQA HEDIS® and State of Illinois guidelines, and must bill using the appropriate CPT, HCPCS, and diagnosis codes in order to qualify for payment.

Quality Incentive Program results that are not captured on submitted claims must be submitted as an electronic data transmission via secure shell file transfer protocol (SFTP). Supplemental data in the form of charts/medical records will NOT be accepted for this program. Providers wishing to set up electronic data transmissions must work with Molina to complete the setup and validation process by **August 31, 2021**. Final supplemental data files must be received by **January 25, 2022**.

No. of Eligible Measures	Total Score to PMPM Values		
	$1 PMPM	$1.50 PMPM	$4.00 PMPM
1			4
2		4	6–8
3		4–6	8–12
4		4–8	10–16
5		4–10	12–20
6	4	6–12	14–24
7	4	6–14	16–28
8	4–6	8–16	18–32
9	4–8	10–18	20–36
10	4–10	12–22	24–40
11	4–12	14–26	28–44

2021 QIP Bonus Payment Schedule
- April 2022—determination of earned bonus
- May 2022—annual payout

Questions

Providers who have questions regarding the incentive program may email us at Quality-HealthCampaigns@MolinaHealthcare.com. Providers may also call our Provider Network Management department at **(855) 866-5462** for assistance or contact their Provider Network Manager.

- Safety Net Hospital Follow Up Incentive:
  Bonus payments for successful 7-day visit completions for FUA-7 and FUH-7
- 2021 Provider Pay for Performance Program
- Women's Health and PPC Incentives
  BCS/CCS visits completed in October; Deliveries from 8/1-12/31
- FUH Referral Partnerships: Partner with providers for follow-up visit referrals after in-patient discharge
- Molina Clinic Days – Molina outreach to fill reserved appointments

MOLINA HEALTHCARE

Health Equity Efforts: Updates

Adult Behavioral Health

- Molina is partnering with provider in Winnebago County to provide a Behavioral Mobile Health Van

Maternal & Child Health

- Community outreach partnered with local organizations to do virtual and in-person events to discuss COVID-19, COVID vaccines and impacts to maternal health in African American/Black women
- Molina partnered with March of Dimes to provide 400 expectant mothers with a Drive

Child Behavioral Health

- Regular meetings with SASS providers to discuss continuum of care opportunities & improvements

Equity Inclusiveness

- Molina works to create an inclusive environment by working in diverse communities, utilizing BEP vendors and creating culturally appropriate events using vendors from communities we are serving.
- Partnership with WalMart clinics in two underserved areas of Chicago. Targeting local members who are not accessing primary care in zip codes 60620 and 60639.

Keeping People in Community

- Molina has created over 177 events that provide essential services to families across the state of IL (i.e., job fairs, food events, community gardens, baby showers, etc.)

Health Equity Efforts Update: Initiatives

Disease-Specific Case Management Program

Specialized case managers become expert in manageable disease states, including disease states that disproportionally impact vulnerable populations. Those case managers work directly with highest need members and offer internal consultations to other case managers.

Sickle Cell: 94 members engaged in 2021; 69% in DIA zip codes. 27% reduction in inpatient costs.

HIV/AIDS: 171 members engaged in 2021; 66% in DIA zip codes. 18% reduction in inpatient admits. 20% reduction in ED visits.

SUD/OUD: 222 members engaged in 2021; 46.4% in DIA zip codes. 53% reduction in inpatient costs. 57% increase in prescription costs (medication adherence)

SDOH Program

Connectors work directly with members with SDOH needs to support a variety of SDOH factors and consult with internal Case Managers.

Housing program including a dedicated Housing specialist. 13 successful housing outcomes supported in 2021.

69% of engaged members live in DIA zip codes

Change in Utilization Patterns for Members Engaged in DSCM

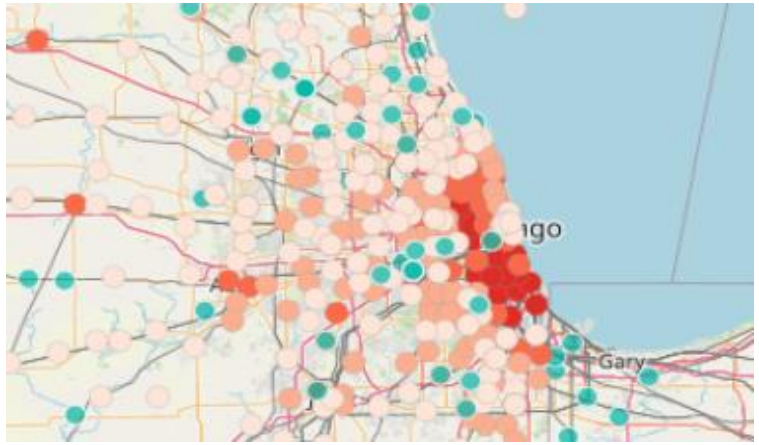
	% of Engaged in DIA Zip	IP Admits	IP Costs	ED Visits	ED Costs	Preventive Visits
Sickle Cell	69%	-15%	-27%	-2%	-7%	+6%
HIV/AIDS	66%	-18%	-10%	-20%	-16%	+4%
OUD/SUD	46%	-24%	-53%	-18%	-17%	+11%

MOLINA HEALTHCARE

Health Equity Efforts Update: Women's Health

Breast and Cervical Cancer Screening	October Women's Health Month Provider Incentive –Provider incentives for provider that refers for BCS/CCS visits completed in October
	Walmart Partnership targeting members with no CCS visit
	Member incentive campaign includes 32K members needing either/both their BCS/CCS services
Molina (Clinic) Day Events	Targeted provider groups in Central IL, Rockford, and Chicago's South and West Side neighborhoods with 34 Women's Health events during 2021
	Scheduled 130 appointments for across 34 events statewide

Cervical Cancer Screening – In Focus



Cook County CCS Rates

CCS-eligible Members	17,857
Members Noncompliant	10,444
Compliance Rate	41.51%
Black/African American CCS Rate – WalMart zips	36.83% (44.65% statewide)

Molina Day Events

	Breast Cancer Screening	Cervical Cancer Screening
Communities Targeted	3	3
Provider Partners	5	7
Events Hosted	12	22
Appointments Scheduled	78	52

MOLINA HEALTHCARE

Health Equity Efforts Updates: Language Services

Language Services by Language and Type

Language	Service	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Total
Arabic	Interpretation	21	25	14	13	17	19	23	20	11	163
	Translation	0	-	-	-	-	-	-	-	-	0
Cantonese	Interpretation	9	16	24	12	11	23	25	30	28	178
	Translation	0	-	-	-	-	-	-	-	-	0
French	Interpretation	7	17	7	7	7	8	7	6	26	92
	Translation	0	-	-	-	-	-	-	-	-	0
Hindi	Interpretation	4	1	4	6	7	3	4	5	5	39
	Translation	0	-	-	-	1	-	-	-	-	1
Korean	Interpretation	8	10	7	4	10	10	10	3	2	64
	Translation	0	-	-	1	2	-	-	1	-	4
Mandarin	Interpretation	5	4	11	17	14	11	15	15	18	110
	Translation	0	-	-	-	-	-	-	-	-	0
Polish	Interpretation	13	7	21	5	15	7	8	8	11	95
	Translation	0	-	-	-	-	-	-	-	-	0
Russian	Interpretation	6	6	8	5	12	10	8	13	6	74
	Translation	1	-	-	1	-	1	-	-	-	3
Spanish	Interpretation	518	480	604	472	553	731	925	955	988	6226
	Translation	1	4	6	4	1	3	5	4	-	28
Vietnamese	Interpretation	2	5	9	10	13	5	10	7	8	69
	Translation	0	-	-	-	-	-	-	-	-	0

Interpretation Services

- Molina uses an interpreter vendor to offer members interpretation services in over 250 languages, including American Sign Language (ASL) and teletypewriter (TTY)
- Central platform to easily order, manage and track the modes of language support. Which includes but is not limited to; telephone interpreting, video interpreting, onsite interpreting as well as written interpretations where needed
- Structured quality program that ensures the interpreters are performing to expectations of both the vendor and the organizations they support.
- All vendor staff are trained and certified in HIPAA compliance and provide support 24/7.

Translation Services

- Molina uses two vendors for translation services
- Communications, including materials requested by members, health education pieces, member letters, marketing materials and other plan materials are available in the requested language
- Molina Store available for call center agents to order commonly used translation materials for members.
- Ad-hoc requests come from Member Services team for translation
- Turnaround times for translation materials vary based on language and length of document. Most materials are completed within one week. All materials have been approved by HFS and reviewed for 6th grade reading level

Community Events Addressing SDOH

Our community engagement team has partnered with various community-based organizations across the state leading to various initiatives including:

- Food Distributions in East St. Louis, Rockford, East Moline, Waukegan, Springfield and Decatur
- Drive-Thru Baby Showers and Diaper Drives in South Shore and Austin
- Flu Clinics
- Winter Coat Drives
- Job Fairs

Drive Thru Food Distribution in East St. Louis

May 2021

Community Events Addressing SDOH

- Community Laundry Days and Vaccination Clinics in Roseland
- Cleaning Supplies Giveaway and Vaccination Clinics in Champaign
- Molina Community Garden in Englewood
- Building Micro Pantries in Champaign to Address Food Insecurity
- Housing Insecurity Donation Events in Cook County

Community Laundry Days and Vaccination Clinics in Roseland – May 2021

VIII. NEW BUSINESS/ANNOUNCEMENTS

Presenter: Howard Peters, HE&Q Chairman
Kimberly McCullough-Starks

A. Community-Safety Net Hospital Designation Recommendation
- **Assignment, Planning, and Next Steps**

VIII. NEW BUSINESS/ANNOUNCEMENTS (Contd.)

Presenter: Melishia Bansa, Special Assistant to Director of HFS

B. Discussion of HFS Mandatory Ethics Training For Committee & Subcommittee Members

i. Links to the mandatory trainings are provided below:

- Ethics Training Program for State Employees and Appointees 2021
- Harassment and Discrimination Prevention Training 2021
- Security Awareness Training
- HIPAA & Privacy Training

VIII. NEW BUSINESS/ANNOUNCEMENTS (Contd.)

ii. Completion Deadline: Dec 23, 2021

ii. For any questions or concerns please contact and (cc) the following:

a. Kiran Mehta, HFS Assistant Ethics Officer ~ Kiran.Mehta@Illinois.gov

b. Bureau of Training: Hfs.bureauoftraining@illinois.gov or their office at 217.557.9065

c. Melishia Bansa, Special Assistant to Director of HFS ~ Melishia.Bansa@Illinois.gov

IX. Adjournment

THANK YOU!