HEALTH EQUITY & QUALITY CARE SUBCOMMITTEE (HEQC) MEETING

NOVEMBER 17, 2022

VIRTUAL WebEx Meeting

1PM – 3PM

HFS
Illinois Department of
Healthcare and Family Services

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OUR VISION FOR THE FUTURE

We improve lives.

- We address social and structural determinants of health.
- We empower customers to maximize their health and well being.
- We provide consistent, responive service to our colleagues and customers.
- We make equity the foundation of everything we do.

This is possible because:

We value our staff as our greatest asset.

We do this by:

Fully staffing a diverse workforce whose skills and experiences strengthen HFS.

Ensuring all staff and systems work together.

Maintaining a positive workplace where strong teams contribute, grow and stay.

Providing exceptional training programs that develop and support all employees.

We are always improving.

We do this by:

Having specific and measurable goals and using analytics to improve outcomes.

Using technology and interagency collaboration to maximize efficiency and impact.

Learning from successes and failures.

We inspire public confidence.

We do this by:

Using research and analytics to drive policy and shape legislative initiatives.

Clearly communicating the impacts of our work.

Being responsible stewards of public resources.

Staying focused on our goals.

Welcome To Health Equity & Quality Care Subcommittee

The Health Equity and Quality Care 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 subcommittee shall:***
- 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.
- Examine barriers that impact customer access to care and utilization of health care services and recommend strategies to mitigate these barriers.
- Recommend Improvements to quality metrics and indicators.
- Assess streamlined approaches to identifying gaps in the delivery of services to Medicaid Customers.
- Identify methods that can be modified or adapted to strengthen continuity of care.
- Develop data informed recommendations to improve program implementation and evaluation metrics.
- Recommend methods to improve provider participation and network adequacy.
- Review and provide recommendations on how the Department can mitigate health disparities and the impact on communities disproportionately affect by COVID-19.
- Consider and make recommendations on the definition of a "community" safety-net designation of certain hospitals
- Make recommendations on the establishment of a regional partnership to bring additional specialty services to communities.
- Review and make recommendations to address equity and healthcare transformation.

House Keeping

- **Meeting basics**
  - Please note, this meeting is being recorded.
  - To ensure accurate records, please type your name, organization, and email address into the chat.
  - If possible, members are asked to attend meetings with their camera's turned on, however, if you called in, please note all meeting materials referenced today including this presentation deck will be made available to you on the MAC & Subcommittee website following this meeting. If you need assistance accessing this material, please email Melisha.Bansa@Illinois.gov & Kyle.Daniels@illinois.gov
  - If you have questions during the meeting, please contact the Host/Cohost. Patience please, a member of our team will get back to you between now and the next meeting.
  - Please Mute your audio throughout the duration of this WebEx meeting, except when speaking.
  - Please note that HFS staff may mute participants to minimize disruptive noise or feedback.
  - Patience, please – some committee members, staff, and participants are new to Health Equity and Quality Care Subcommittee proceedings.
  - If you are a presenter and whish to be granted presenter rights during your presentation, please use the chat function to contact the host.
- **HFS is committed to hosting meetings that are accessible and ADA compliant. Closed captioning will be provided. Please email Melisha.Bansa@Illinois.gov & Kyle.Daniels@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.**

Agenda

I. Call to order

II. Roll call of Subcommittee Members

III. Introduction of HFS staff

IV. Review and Approval of Meeting Minutes

V. Discussion on Quality of Care in Nursing Facilities and Rate Reform to Improve Quality

VI. MCOs Report Out: Use of DIA Data

VII. Public Comments

VIII. Additional Business: Old & New

IX. Adjournment

I. Call to Order

II. Roll Call of Subcommittee Members

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III. Introduction of HFS Staff

IV. Review and Approval of Meeting Minutes

- 2/25/2022
- 6/28/22

V. Discussions on Quality of Care In Nursing Facilities and Rate Reform to Improve Quality

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Illinois Nursing Facility Payment Reform's Impact on Quality

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Presenter: Andy Allison, Deputy Director, Strategic Planning & Analytics

Origins of nursing facility quality improvement efforts

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Objectives and principles for a new payment model -- from 2020-2021 stakeholder process

6 of 12 dealt directly with quality and performance

- Transparent, outcome driven, patient-centered model with increased accountability
- Directly tie funding/rates/incentives to demonstrable and sustained performance on key quality reporting metrics
- Documentation to support, review and validation of level of care coding and appropriateness, outliers, actual patient experiences, etc.
- Align regulation and payment incentives to the same goals
- Ensure appropriate incentives for community placement, including both uniform and MCO-specific incentives
- Build in flexibility to evolve as the industry evolves and establish ongoing channels of communication for new, proposed, or upcoming changes

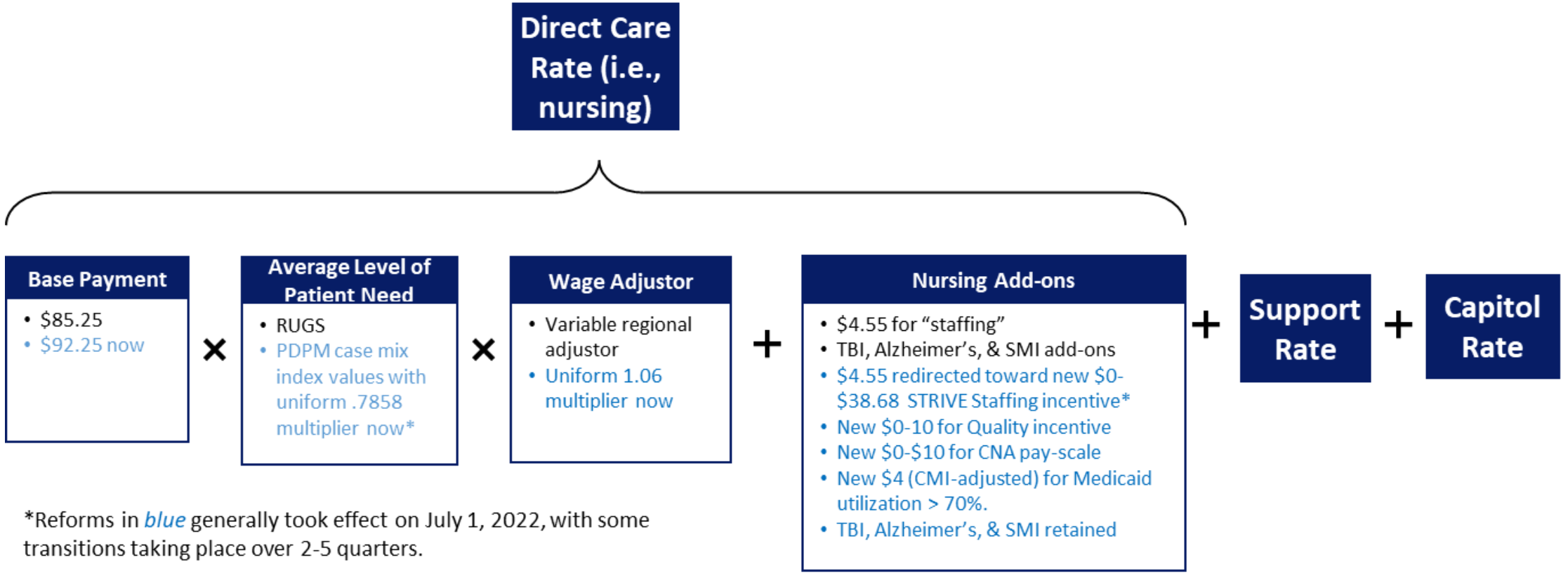
Performance incentives in other states

Examples highlighted in 2020-2021 stakeholder reform process

- California: $84M in payments of $2.37-$14.47 per Medicaid bed day (PMBD) for qualifying facilities (FY'19)
  - Based on performance v. a statewide benchmark and year-over-year improvement
  - Include a mix of long- and short-stay metrics are included, as is staff retention
- Colorado: payments of $1-4 PMBD based on performance
  - Quality of life (enhanced dining and personal care, end of life program, connection and meaning, etc.)
  - Quality of care (vaccination data, reducing avoidable hospitalizations, nationally reported quality measures scores, etc.)
- Maryland: $6 M per year is distributed via P4P
  - 85% of funds distributed to the highest-scoring facilities (at a 2-1 ratio for highest v. lowest-scoring facilities)
  - 15% distributed to facilities whose scores improved (also at 2-1 ratio for highest v. lowest-improving)
- Michigan: payments of up to $5.50 PMBD (2017) based on facilities' STAR Quality rating
  - facilities with an average rating below 2.5 must file a corrective action plan to be eligible for payment
  - initiative payments are decreased for facilities that do not submit resident satisfaction survey data

Adopted reforms focused on performance improvement

Reforms are focused on accuracy, staffing and quality



*Reforms in *blue* generally took effect on July 1, 2022, with some transitions taking place over 2-5 quarters.

Note: Rates above represent amounts paid for each Medicaid consumer for each day in a facility, e.g., $0-$10 per day for the Quality incentive

Medicaid now ties over $500M (15%) to staffing and quality

Strategies

Reforms	Pay for staffing *levels*	Pay for rising wages	*Provoke* wage increases	*Direct* increases to experienced CNAs	Link payment to care & outcomes	Finance reforms	Reforms' impact on NFs[6] ($millions)
STRIVE staffing level incentive[3,4]	X	X			X		$ 359
CNA payscale subsidy		X	X	X	X		$ 85
Quality incentive					X		$ 70
PDPM adoption					X		$ -
Ownership transparency					X		$ -
Increased HFS oversight capacity					X		$ -
Rate increases[1]		X				X	$ 217
Re-directed "staffing" add-on						X	$ (65)
Increase and redesign assessment[2]						X	$ (205)
Objectives	Incent and support hiring at all levels & discourage under-staffing	Improve Medicaid cost coverage (e.g., post-pandemic)	Protect and expand CNA labor pool v. competing industries	Use wage scale to retain experienced CNAs and attract new CNAs	Enhance data and oversight and align profit motive with quality and equity	Ensure viability of reform package	Target inequities with unprecedented incentives

Description of HFS' new $70M quality incentive program

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Statutory description of $70M incentives

- Reforms include a new commitment of $70M per year in additional Medicaid payments linked (initially) to each nursing home's performance on the Federal "Long Stay Quality STAR" rating
- A facility's Medicaid payment will be increased in proportion to their Long Stay STAR rating and the number of Medicaid consumers served (measured in days)
  - beginning with an increase of ~$2 per Medicaid resident day for a STAR rating of 2
  - increasing to ~$8 per Medicaid resident day for a STAR rating of 5
- Quality incentive payments are based on most recent available quality data (from 3 quarters prior)

Source for initial quality measure: the long stay STAR rating

- Individual Long Stay quality measures and the composite Long Stay STAR rating are published quarterly on the Federal COMPARE website and are based on Federally-defined metrics
- Each Long Stay quality measure is assigned points based on the national distribution of performance on that measure
- There are 1,150 possible Long Stay points across 9 measures
- A facility's overall **Long Stay STAR rating** of 0-to-5 (best) is based on the sum of their scores for all 9 metrics in comparison to totals for other facilities across the country

Measures included in the Long Stay STAR rating

Long Stay quality measures worth 150 points

- Percent of residents whose need for help with activities of daily living has increased
- Percent of residents who received an antipsychotic medication
- Percent of residents whose ability to move independently worsened
- Number of hospitalizations per 1,000 resident days
- Number of outpatient emergency department (ED) visits per 1,000 resident days

Long Stay quality measures worth 100 points

- Percent of residents experiencing one or more falls with major injury
- Percent of high-risk residents with pressure ulcers
- Percent of residents with a urinary tract infection
- Percent of residents who have/had a catheter inserted and left in their bladder

Managing the $70M quality incentive program

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HFS publishes quality scores and incentives on its website

This screenshot is from HFS' August posting of 4Q 2022 quality incentives

Illinois Department of Healthcare and Family Services

October 1, 2022 Estimated Quarterly Quality Incentive Payment Calculation

Quality Star Data Period: https://data.cms.gov/ Provider Information File Published July 2022

Medicaid Resident Days per Annum Period: 1/1/2021 - 12/31/2021

	Calculation of Quality Tier Adjustment Factor (Floor Adjustment)				
Quality Tier	7/1/22 Payment Per Medicaid Day (Per Day Floor)	Total Medicaid Days	Total Quality Payments	Total Quality Payment Per Day	Quality Tier Adjustment Factor
5	$8.37	1,264,552	$10,654,975	$8.43	100.00%
4	$5.98	593,047	$3,569,246	$6.02	100.00%
3	$3.59	608,360	$2,196,846	$3.61	100.00%
2	$1.79	597,565	$1,078,933	$1.81	100.00%
1	$0.00	276,419	$0	$0.00	
0	$0.00	244	$0	$0.00	

										$ 17,500,000
			Quality Weight Calculation		Total Medicaid Days Calculation					
Provider Name	Medicaid Number	Medicare Number (CCN)	Quality Star Rating	Quality Weight	Medicaid FFS Days	Medicaid Managed Care Days (Non-MMAI)	Medicaid MMAI Days (estimated)	Total Medicaid Resident Days Per Annum	Estimated Medicaid Days for Calendar Quarter	Adjusted Quarterly Incentive Payment
ABBINGTON REHAB NURSING CENTER	6000020	146065	3	1.50	1,877	10,607	4,103	16,587	4,147	$ 14,973.91
ABINGTON OF GLENVIEW NURSING &	6012595	145683	3	1.50	3,863	5,403	1,252	10,518	2,630	$ 9,495.77
ACCOLADE HC OF PAXTON ON PELLS	6011571	145603	3	1.50	6,646	12,012	5,534	24,192	6,048	$ 21,839.83
ACCOLADE HEALTHCARE DANVILLE	6000210	145243	3	1.50	2,079	12,228	1,265	15,572	3,893	$ 14,058.03
ACCOLADE HEALTHCARE OF PONTIAC	6004642	146010	1	0.00	3,106	15,726	837	19,669	4,917	$ -
ACCOLADE PAXTON SENIOR LIVING	6004675	145449	3	1.50	3,948	5,482	2,838	12,268	3,067	$ 11,075.55
ADDOLORATA VILLA	6000046	145724	5	3.50	2,983	4,171	4,175	11,329	2,832	$ 23,863.80
AHVA CARE OF WINFIELD	6005334	146168	3	1.50	4,370	18,634	12,791	35,795	8,949	$ 32,314.50
ALDEN COURTS OF SHOREWOOD, INC	6016869	146183	5	3.50	767	2,084	1,363	4,214	1,054	$ 8,877.35
ALDEN COURTS OF WATERFORD, LLC	6015507	146182	3	1.50	2,820	3,056	1,683	7,559	1,890	$ 6,824.39

Statutory authority to update measures

- HFS “may add, remove, or change quality metrics and make associated changes to the quality payment methodology”
  - *“The Department shall review quality metrics used for payment of the quality pool and make recommendations for any associated changes to the methodology for distributing quality pool payments in consultation with associations representing long-term care providers, consumer advocates, organizations representing workers of long-term care facilities, and payors.”*
  - *“The Department may establish, by rule, changes to the methodology for distributing quality pool payments.”*

Potential principles for managing the quality incentive program

From HFS' 2021 report and recommendations to the legislature

- Quality metrics would evolve over time to reflect state performance priorities, but also allowing nursing facilities sufficient time to respond and recoup anticipated investments
- Incentives should initially be based on mature metrics that have well understood score distributions to reduce initial uncertainty over the impact of the full package of rate reforms
- Newer metrics should be added over time to capture Medicaid program priorities, including:
  - Staffing continuity
  - Staffing turnover (now being reported by Federal CMS)
- Update included measures annually as with the Medicaid Managed Care program
- Maintain a level of continuity to offer facilities meaningful gain from their QI investments
- Publish annual report on NF performance, including QI metrics

Matching financial incentives to the characteristics of each measure

From HFS' 2021 report and recommendations to the legislature

- Potentially adjust quality awards for nationally normed metrics
  - to reflect improvement in state v. national performance
  - to reward well-performing but low-ranking NFs
- Using state-normed measure scoring temporarily
  - new items where competition is intended
  - shorter, more intensive quality improvement initiatives associated with known performance gaps
  - items targeted for statewide improvement across the performance spectrum
- Potentially adjust base level rewards (upward) to accommodate the zero-sum nature of ranked performance metrics

Discussions on Quality of Care In Nursing Facilities and Rate Reform to Improve Quality

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Presenter: Mark McCurdy, Chief, Long-Term Care

ANY QUESTIONS?

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VI. MCOs Report Out: Use of Disproportionately Impacted Areas Data (DIA)

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Aetna

Health Equity & Quality Subcommittee Meeting

Mary Cooley | Health Services Officer, Aetna Better Health of Illinois

November 17th, 2022

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Session Outline

Our Approach to DIA Analysis

- Utilizing Data to Inform Our Strategy
- Leveraging Dashboards to Monitor DIA Performance

Sample Analyses

- DIA Hotspot Example
- Pharmacy Programs
- Community Outreach Initiatives
- Value-based Solutions & Health Equity
- Maternal and Behavioral Health Interventional Capabilities

Our Approach to DIA Analysis

Utilizing Data to Inform Our Strategy

Leveraging data analytics to garner hyperlocal insights into health equity and SSDOH trends across the ABHIL landscape to identify disproportionately impacted communities for focused interventions

Surveillance

- Ingesting our advanced data capabilities to track and monitor outcomes in DIA zip codes.
- Data Sources:
  1. HEDIS Data
  2. Data from Claims
     - Utilization (i.e., IP, ED, Specialists & PCP visits)
     - Rx Initiation therapy and adherence
  4. Care Management Data
  5. Comparative data from:
     - SociallyDetermined
     - Metopio

Identification

- Utilizing surveillance tools to identify members in who are disproportionately impacted for focused interventions
- DIAs/hot-spots are identified for focused interventions when they display a pattern of metric underperformance or unfavorable utilization trends

Intervention

- Curating customized interventions for focused communities to improve health equity across DIA zip codes
- Leveraging community-based events, provider partnerships, CBOs, and care management to connect residents with appropriate resources

Evaluation

- Continuous monitoring of DIAs for improvement in health equity metrics
- Monitoring of DIAs for improved health equity outcomes
- Adjust interventions appropriately to ensure members are receiving adequate support and care

Proactive

Utilizing Data to Inform Our Strategy

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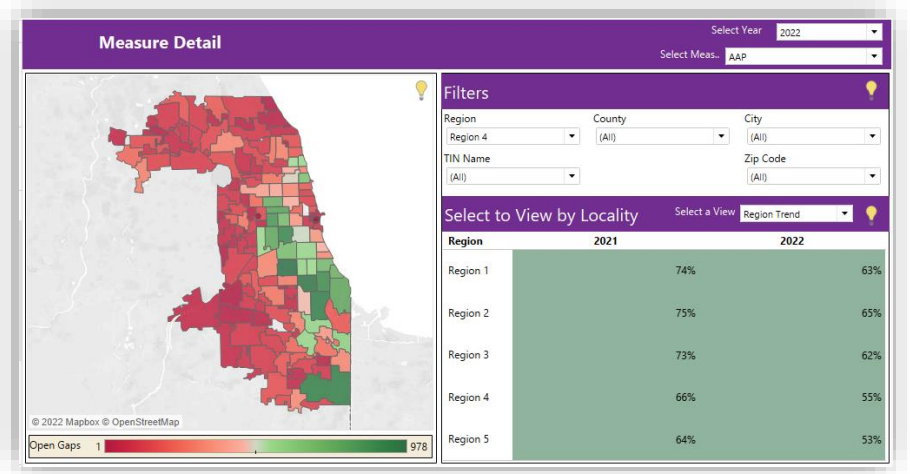
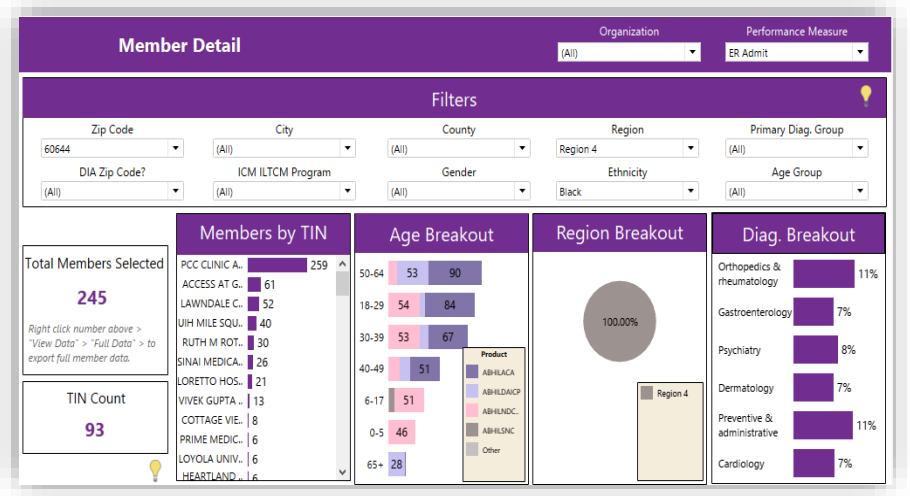
Our Approach to DIA Analysis

Leveraging Dashboards to Monitor DIA Performance



Note: Drilling in on select HEDIS measure across Region 4 zip codes



Note: Demographic breakdown of ED Admits in a select zip code

Dashboard Overview

- Our dashboards allow deep-dive analysis across numerous data sources including quality, utilization, and member demographics.
- Afford ABHIL the opportunity to identify hyperlocal analysis for focused intervention.
- Leveraging CVS' health equity dashboard for benchmarking and disparities in performance metrics.

The Building Blocks of Our Dashboards:

Hot-Spotting	Breakdown population from Region down to zip-code and DIA/Non-DIA localities to identify areas of opportunity
Quality Performance	Monitor trends in P4P and P4R quality measures period-over-period
Member Demographics	Ability to breakout membership by product, gender, ethnicity, age, in care management, etc.

Sample Analyses

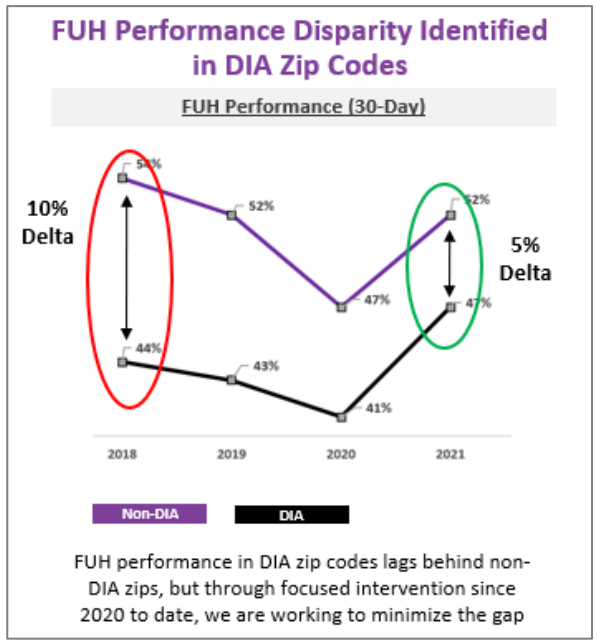
Health Equity Analysis: DIA Hotspot Example

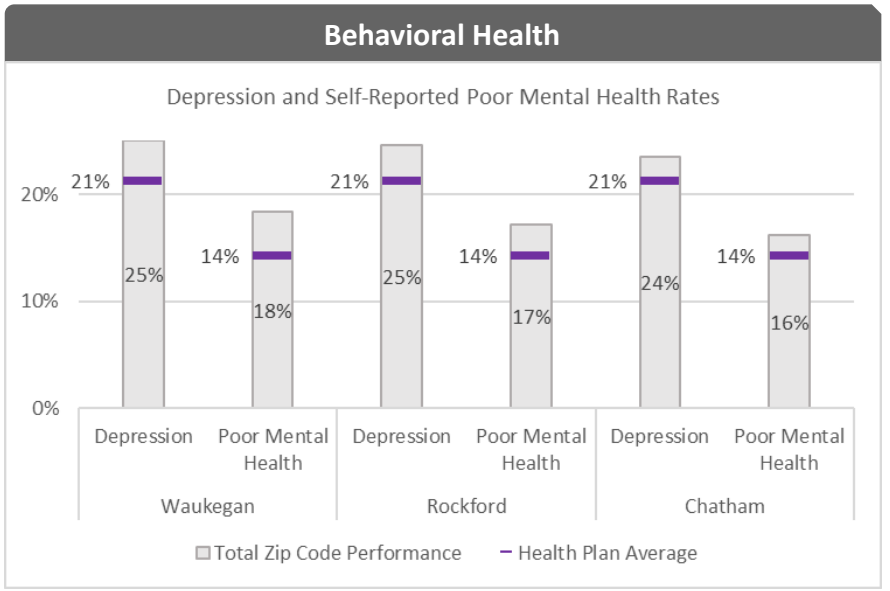
Disproportionately impacted areas (DIA) exist in Illinois where communities experience barriers to care and social & structural determinants of health (SSDOH) resources

Overview

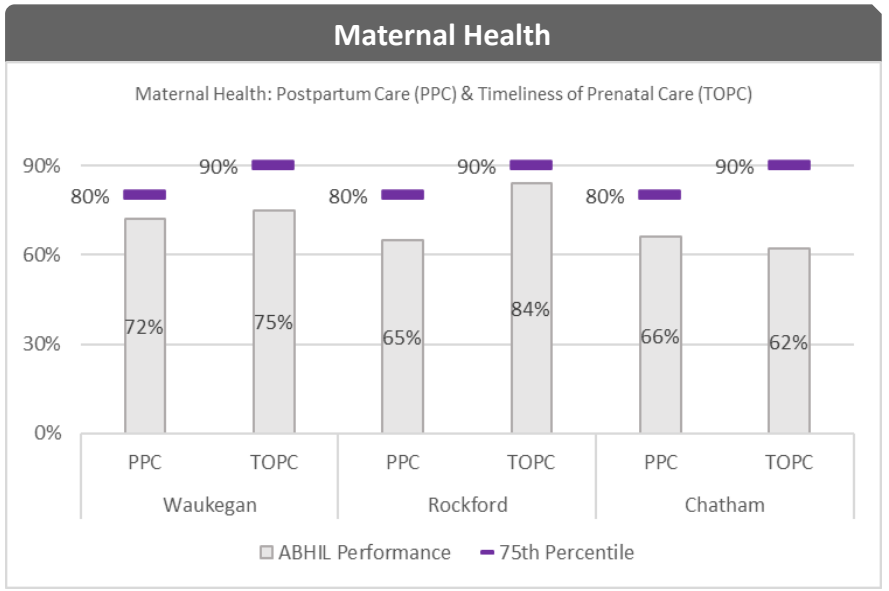
- Utilized population health tools to conduct a **hyperlocal analysis** and identify **DIAs** for focused outreach strategies during Q2 2022.
- Identified DIA localities exhibit the following characteristics:
  - Significant volume of ABHIL **membership**
  - Deficient **behavioral health**, **maternal health**, and **access to care** quality measures
  - Experiencing **SSDOH disparities** such as economic insecurity and food insecurity
- Within each of the identified DIAs, ABHIL leveraged CVS pharmacies, provider partners, community events, community-based organizations, and care management to **address the gaps in care** and promote **health equity**.

Identified DIAs			
Zip Code	City	Region	Members (#)
60085	Waukegan	5	4,334
61101	Rockford	1	3,024
60619	Chatham	4	2,994





Note: (1) Behavioral health metrics retrieved from SSDOH data source, Metopio



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DIA Hotspot Example: Pharmacy Programs

Leveraging CVS Resources to Address Health Equity and Improve Health Outcomes

Over-The-Counter Health Solution (OTCHS)

- Members receive a **monthly $25 benefit** to obtain items as needed from a catalog of **OTC** and **personal care products** for ABHIL members.
- Processed over **48,000** unique orders State-wide, totaling **150K+ items** for ABHIIL members in 2022.
- Updated product catalog to include diapers and other **baby and maternal care items** beginning in 2023.
- Received recommendation to expand catalogue from Apogee Health during quarterly JOC

Pharmacy Advisor Counseling (PAC) Program

- Real-time data engine that identifies and prioritizes members with **chronic conditions** for **communications** regarding potential non-adherence to improve **adherence** and ultimately long-term **health outcomes**.
- PAC Program has had over **200K** interventions State-wide YTD and contributed to the improvement of medication adherence rates for **depression**, **ADHD**, and other **behavioral health conditions**.
- **Multimodal** approach to **engagement** includes: IVR, text, call center, retail, and email

OTCHS Utilization in Identified DIAs

Zip Code	In-Store Orders	Shipped Orders	Total Orders	Total Items	Avg. Items per Order
Waukegan (60085)	2	192	194	667	3.4
Chatham (60619)	62	153	215	626	2.9
Rockford (61101)	56	276	332	1,062	3.2
Total	120	621	741	2,355	3.2

PAC Program Interventions in Identified DIAs

DIA	PAC Interventions
Waukegan (60085)	486
Chatham (60619)	561
Rockford (61101)	762
Total Interventions	1,809

IL State-wide Medication Adherence Rate

Chronic Condition	FY21	FY22	YoY Change
ADHD	54.2%	55.2%	1.0%
DEPRESSION	58.4%	59.7%	1.2%
OTHER BEHAVIORAL HEALTH	62.1%	62.8%	0.7%

Note: (1) CVS Pharmacies medication adherence rates are reported at the State-level and cannot be further reduced to specific zip codes

Health Equity

2022 Community Outreach Initiatives

Aetna has participated in **321** community-based health equity outreach events across **40** IL counties during **CY 2022**

Waukegan

Laundry Days

- Events in Q1 & Q2 '22 provided laundry services, health screenings, education, and snacks.
- Hosted 5 additional events in 2021
- CBOs in attendance: Waukegan Housing Authority, Oak Street Health, Waukegan Public Library, and United Way

Outcome(s)

- 244 attendees
- 43 blood pressure screenings

Rockford

Love Rockford

- Free community health fair which included food, haircuts, and health services for attendees
- 14 CBOs were in attendance, including: National Alliance on Mental Illness, OSF St. Anthony's Medical Center, and Opioid Response Team

Outcome(s)

- 100 attendees

Chatham

Fresh Foods Market

- Provided attendees access to free, healthy foods, health resources, and information on CBOs and the services they offer to the community.
- CBOs included: Kindness Campaign, ACCESS, and Hope in Action

Outcome(s)

- 415 attendees

- ABHIL leverages community-based events as a vehicle to improve **member engagement** and **distribute resources** to communities experiencing health disparities
- **Additional events** planned in the identified DIAs include: (1) National Night Out, (2) Back to School Bash, and (3) Virtual Baby Showers

2022 Health Equity Community Outreach Initiatives

Some of the positive feedback we have received from our community includes:

"How did you think to do this? We can't believe our laundry is free today."

"I'm really glad we heard about this event. Times are tough & we appreciate any help that we can get for our large family. This food is very unexpected too. Thank you!"

"Thanks for having these activity books & crayons for the kids. This gives them something fun to do & keep busy while I wash."

"My kids have been loving this little seating area. I can't believe they can choose a book to take home. This is so great for our family!"

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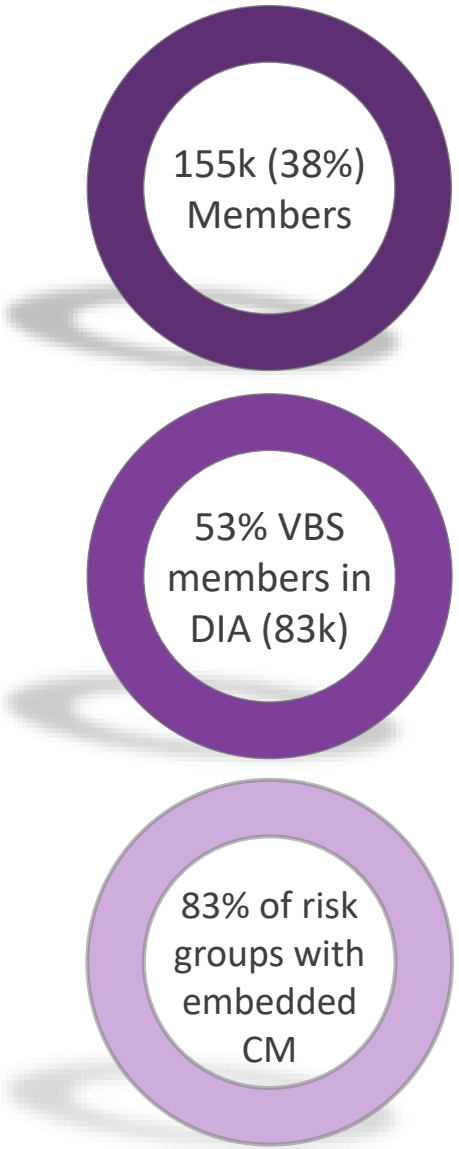
Value-Based Solutions and Health Equity



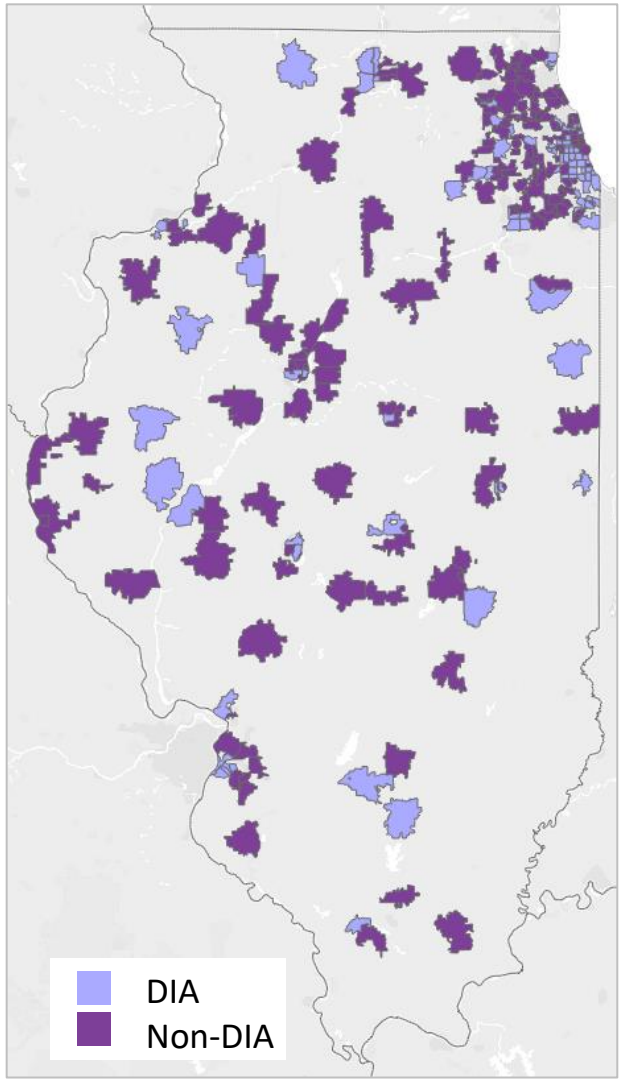
2021 & Current State

- **Triple aim clinical strategy** (Quality, CM, and Pharmacy) **supports provider health equity initiatives** by proactively managing referrals, reducing unnecessary utilization, and improving HEDIS gap closure.
    - Implemented **field CHW** for SW Chicago **provider with 88% of assigned members living in DIA**; CHW is **engaging difficult-to-reach members**, many of whom have >2 SDOH risk factors, and linking them to needed PH, BH, and CBO services

2021 Outcomes

- FQHC providers in risk models reduce utilization*, particularly in DIA areas
    - ED Visits /1000: 2.4% overall reduction; **8.3% for DIA**
    - Admits /1000: 6.9% overall reduction; **10.7% for DIA**
    - Days /1000: 17.8% overall reduction; **19.9% for DIA**
    - Readmits /1000: 11.9% overall reduction; **23.3% for DIA**

VBS Provider Footprint by ZIP



** Compared to non-value-based groups*

nois

Strategic Initiatives: Behavioral Health

Spotlight on Interventional Capabilities

Addressing Behavioral Health Disparities in Disproportionately Impacted Areas

Interventions Deployed to Close Behavioral Health Disparities

Access and Availability to Behavioral Health Care

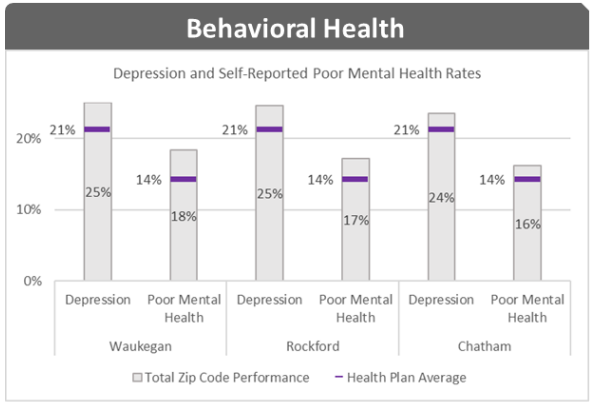
- Increased embedded Care Managers within inpatient and outpatient provider facilities
- Community Health Workers (CHW) F2F deployment to support engagement and advocacy in care access and navigation.
- Promote/expand the utilization of telehealth & telepsychiatry when appropriate for member's needs
- Engagement in CM upon initiation of MAT therapy (POD).

Promote Partnerships

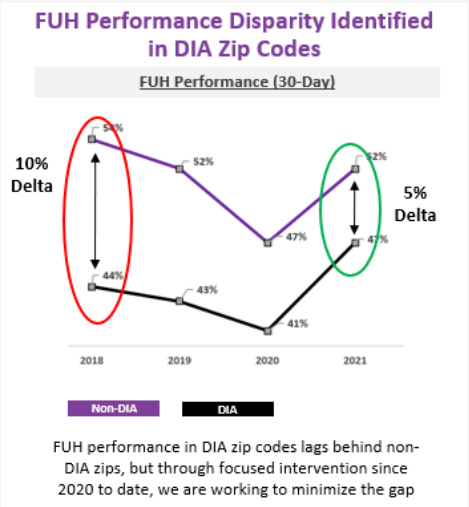
- *Community Mental Health Clinics (CMHC):* Partnerships to increase FUH and post-discharge stabilization
- *Mobile Crisis Response (MCR) grants:* Supported training, enhanced technology, and coping skills tools
- *Monthly MCR Huddles:* Discuss members status, needs, barriers, and care plans for screened members
    - *(1)* 76% reduction in crisis claims; *(2)* 72 less admits per 1000 compared to Non-MCR Huddle Groups
- *Expand Telepsychiatry:* Leverage MyOwnDoctor and other ABH tele-psychiatry resources to support psychiatric access to care.
- *Southland Care Coordination Partners (SCCP):* Engage members post discharge to complete FUH via telemedicine and connect back to health plan for ongoing Case Management
    - *(1)* 30 Day FUH: Increased from 37% Q1 '22 to 88% Q2 '22; *(2)* 7 Day FUH: Increased from 35% Q1 '22 to 81% Q2 '22

Expand Member Engagement and Resources

- Utilization of ABHIL innovative resources such as Pyx Health, Mood Fit app and Finit Health
- Promote Increased utilization of facilities with observation units
- Promote wellness checks for high risk members, proactively and post hospitalization.
- Participation in family support programs such as the Family Leadership Council (FLC)



Note: (1) Behavioral health metrics retrieved from SSDOH data source, Metopio



Strategic Initiatives: Maternal Health

Spotlight on Interventional Capabilities

Addressing Maternal Health Disparities in Disproportionately Impacted Areas

Interventions Deployed to Close Maternal Health Disparities

Access and Availability to Healthcare

- Identify access issues; work cross functionally with Networking/Contracting, Operations, Marketing
- Leverage Care Management to support members experiencing access barriers
- Leverage home visiting program, birthing centers, Doula and Family Case management programs

Maternity Matters Program*

- Utilize ongoing Case Management program to address SDOH barriers (including transportation)
- Leverage claims data for early identification of pregnant members
- High risk CM for all PG women living on the SS of Chicago

Member/Provider Outreach*

- Utilize ABHIL Engagement Hub for member outreach
- Increased focus on Next Best Actions (NBAs) national campaign
- Implementation of mPulse IVR member outreach Campaign
- Notification of Pregnancy (NOP) campaign Blitz to Provider partners

Incentive Programs

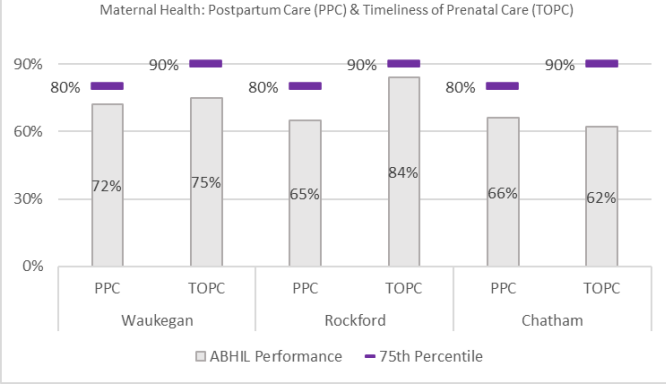
- Align maternity incentives structure with HEDIS specifications
- Update Marketing materials for providers & members to socialize ABHIL incentive program

Health Equity*

- Implementation of ABHIL SSDOH work plan as is relates to maternal health

* Interventions targeted at identified DIA populations

Maternal Health (Goal: Higher rates)



Note: (1) ABHIL performance 2022 YTD; **(2)** Higher PPC & TOPC quality measures are an indication of better maternal health care

Maternal Health: Deep-Dive Analysis

	Waukegan (60085)		Rockford (61101)		Chatham (60619)	
Maternal Health: Compliance Metrics	Members (#)	Members (%)	Members (#)	Members (%)	Members (#)	Members (%)
Timeliness of Prenatal Care (TOPC)						
Total Population	**57**	**100%**	**49**	**100%**	**29**	**100%**
Compliant Members	**43**	**75%**	**41**	**84%**	**18**	**62%**
Non-Compliant Members (Reason)	**14**	**25%**	**8**	**16%**	**11**	**38%**
Late Visit	9	16%	5	10%	6	21%
Specialty Issue	3	5%	2	4%	2	7%
No Visit	2	4%	1	2%	3	10%
Postpartum Care (PPC)						
Total Population	**57**	**100%**	**49**	**100%**	**29**	**100%**
Compliant Members	**41**	**72%**	**32**	**65%**	**19**	**66%**
Non-Compliant Members	**16**	**28%**	**17**	**35%**	**10**	**34%**
Early Visit	6	11%	4	8%	6	21%
Late Visit	1	2%	2	4%	0	0%
No Visit	9	16%	11	22%	4	14%

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Aetna Better Health® of Illinois

ANY QUESTIONS?

Blue Cross
Blue Shield of Illinois

Driving Health Equity

Presented By

Blue Cross Blue Shield of Illinois

Terri Pokraka

Quality Improvement Director

How are we driving Health Equity differently?

Data-driven approach

- **Stratification** of claims & care gaps by race, gender, ethnicity & zip code to define target populations and to **inform predictive model**
- **Low – to Moderate** member engagement for community events
- **Prioritization** of DIA Zip Codes, Southside & West Side for member engagement
- **Muti-faceted** & enhanced **family centered** outreach
- **Deeper Focus** on member engagement & empowerment in health education programming and community events

Co-Design community-based interventions

- **Strategic** community-based interventions & **partnerships mitigate disparities** outlined in conditions in our Health Equity Plan,
- **Deeper Integration & shared strategic focus** with Blue Door Neighborhood Center, Community-Based Organizations and BEP vendors to address structural and **social determinants of health.**
- Enhanced Intervention **timelines, calendars and engagement models** focused on health equity

Provider Engagement

- **Transformation Collaborative** engagement plan & timeline with goals to reduce health disparities & improve health outcomes
- Alignment of **value-based care plan** to Health Equity plan
- Grants & micro funding **to increase access** to care and build capacity

Quality Improvement Success Measures

Comprehensive quality improvement & measurement methodology which includes:

- **Improved health outcomes** within Health Equity control groups
- Increased PCP & preventive care access
- Reduction of ER and/or preventable costs
- HEDIS/ Care Gap Closure for high-risk members
- Improved feelings of member empowerment, satisfaction & health literacy

Data driven infrastructure

Driving Illinois Medicaid Health Equity

Intervention Framework & Checklist

- ❑ Approach work with **humility & cultural competency** – acknowledging **structural systems** that drive inequities
- ❑ Understand individual, communal & economic **costs of health disparity**
- ❑ Targeted member control group – with indicators & stratification for **(R.E.A.L) data, disability status & zip code**
- ❑ Methodology to **track outcomes & measure quality improvement** of interventions
- ❑ **Co-Design community-based interventions** with hyper-local approach in partnership with Blue Door Neighborhood Centers, BEP Vendors, Community Based Organizations and/or other key partners
- ❑ Demonstrable improvement in **health outcomes** for the members & communities we serve

Operational Pillars

Maternal Health

- Reduce maternal mortality rates and improve birth outcomes for groups that have been historically & intentionally disenfranchised
- Demonstrate identification and resolution of SDOH needs i.e. food as medicine

Behavioral Health

- Population Health approach to improve health outcomes
- Increase access to preventive care, peer services, community-based organizations

Chronic Conditions

- Whole person care approach to improve health outcomes for groups that have higher instances of disparities with chronic conditions such as asthma, sickle-cell, diabetes, or hypertension

Provider Engagement

- Ensure value-based care program to incentivize the reduction of health disparities

Community Partnerships

- Integration of Blue Door Neighborhood Centers, Community Based Organizations, BEP vendors to address structural and social determinants of health

Data driven infrastructure

Health Equity Creative Programming Model
"Closing the Data/Service Loop" Approach

DATA

PLACE MATTERS
- Geographic Region
- Zip Code
- DIAs

HE/SSDOH Health Literacy Focus
- Asthma
- Hypertension
- Diabetes
- Behavioral Health
- Maternal and Infant Health

HEDIS
- WCV
- W30
- CIS
- CCS
- BCS

- BCBSIL Priorities
- Monthly Health Observance
- Project sWish
- Transformation Collaborative
- Community Based Organization

Program/Event/ Engagement

Care Coordination
- BP Cuff
- Prescription Refill
- Glucometer/Lancet
- Disease Management Education

Member Benefits
- Member Card
- New Primary Care Physician
- Transportation

HEDIS Gap Closure Coordination

Social Needs

Redetermination

Care Coordination Team

Member Services/CSST

HEDIS Team

CSST 2.0

BCBSIL

REDUCE DISPARITIES

SUCCESS MEASURES:
ENGAGE-EDUCATE-EMPOWER
- Number of BCBSIL members attended
- Number of BCBSIL members connected to care re: Asthma, DM, HTN, BH, M&CH
- Number of BCBSIL members social needs collected and addressed
- Number of BCBSIL members for updated demographics (Redetermination)

ANY QUESTIONS?

HFS
Illinois Department of
Healthcare and Family Services

CountyCare

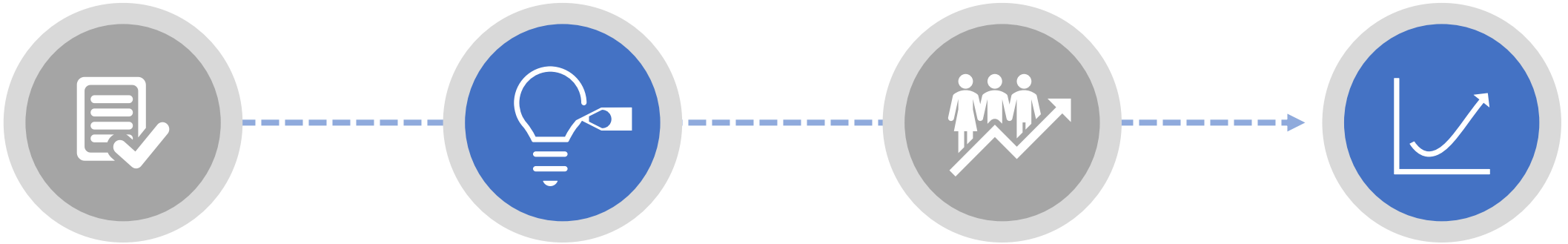
Use of Disproportionately Impacted Area (DIA) Data for Health Equity & Performance Improvement

Health Equity & Quality Subcommittee
11/17/2022

CountyCare
A MEDICAID HEALTH PLAN

Equity & Performance Improvement

- CountyCare has prioritized use of DIA data, race/ethnicity and other demographic data to better understand the needs of members.
- Data segmentation and analysis is used by performance improvement workgroups for strategic, targeted initiatives addressing disproportionately impacted populations.

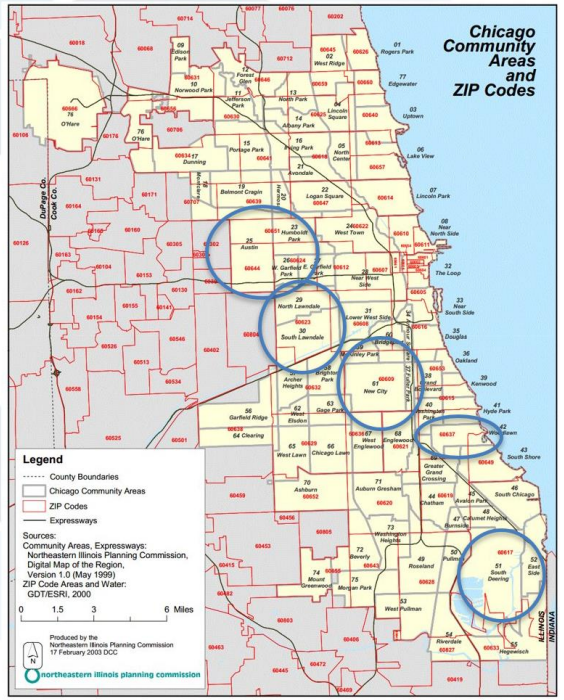


Population Analysis & Segmentation

CountyCare has completed segmented analysis on performance measures to identify trends in barriers, behaviors and/or characteristics of sub-populations.

Near South CC Region	
Total Prenatal Members	234
Prenatal Members in DIA Zips	227
% of Regional Prenatal Members in DIA Zips	97.01%
% of Timely Prenatal Care in Region	64.53%
West CC Region	
Total Prenatal Members	250
Prenatal Members in DIA Zips	228
% of Regional Prenatal Members in DIA Zips	91.20%
% of Timely Prenatal Care in Region	62.80%
Far South CC Region	
Total Prenatal Members	220
Prenatal Members in DIA Zips	170
% of Regional Prenatal Members in DIA Zips	77.27%
% of Timely Prenatal Care in Region	65.89%
North CC Region	
Total Prenatal Members	347
Prenatal Members in DIA Zips	130
% of Regional Prenatal Members in DIA Zips	37.46%
% of Timely Prenatal Care in Region	69.45%

Childhood Immunization Status (CIS) Analysis



Zip Code	Numerator	Denominator	Rate
60609	89	258	34.50%
60617	58	285	20.35%
60623	153	404	37.87%
60629	205	506	40.51%
60632	195	391	49.87%
60637	35	233	15.02%
60639	138	309	44.66%
60644	44	237	18.57%
60651	87	262	33.21%
60804	123	285	43.16%

Key findings:

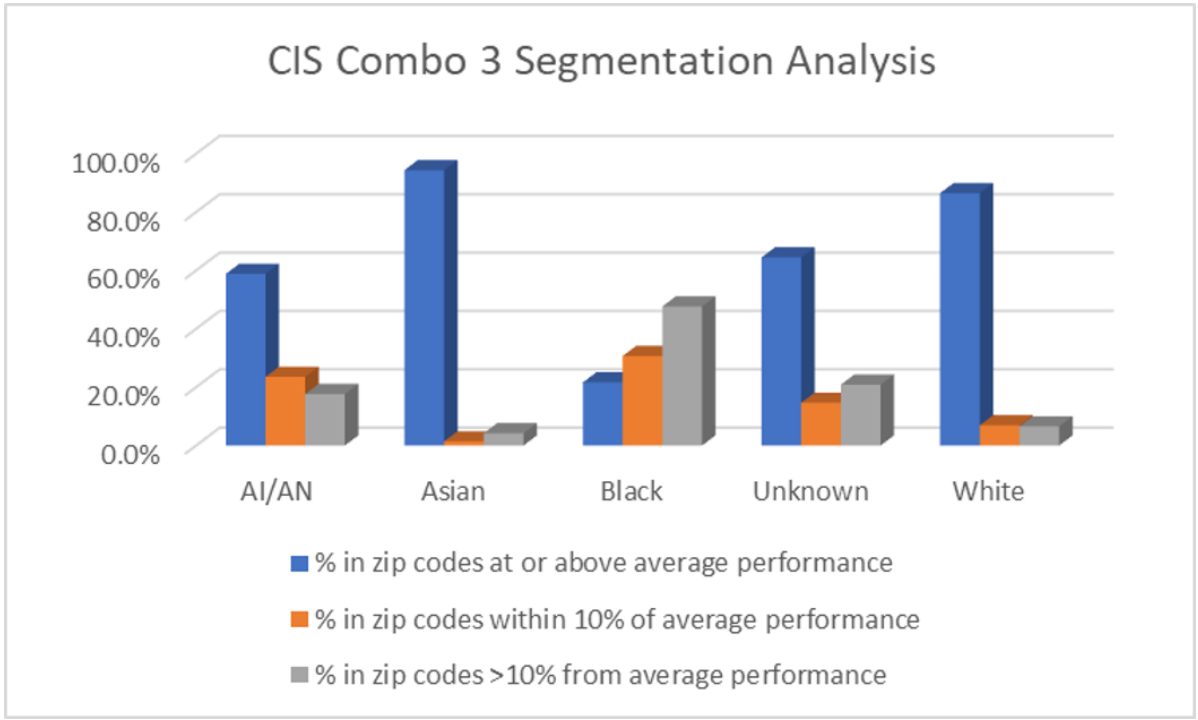
Lowest performance rates for zip codes in South and West communities

Population Analysis & Segmentation

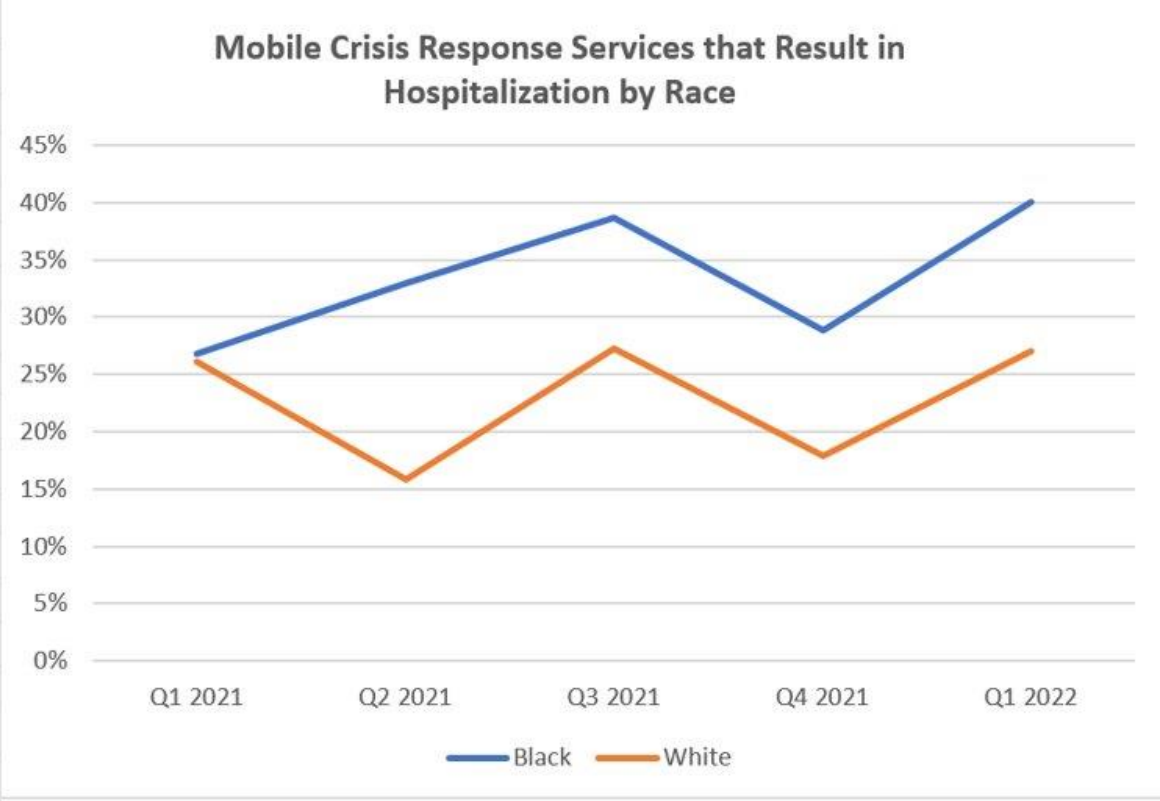
Combo 3 Performance Segmentation Analysis

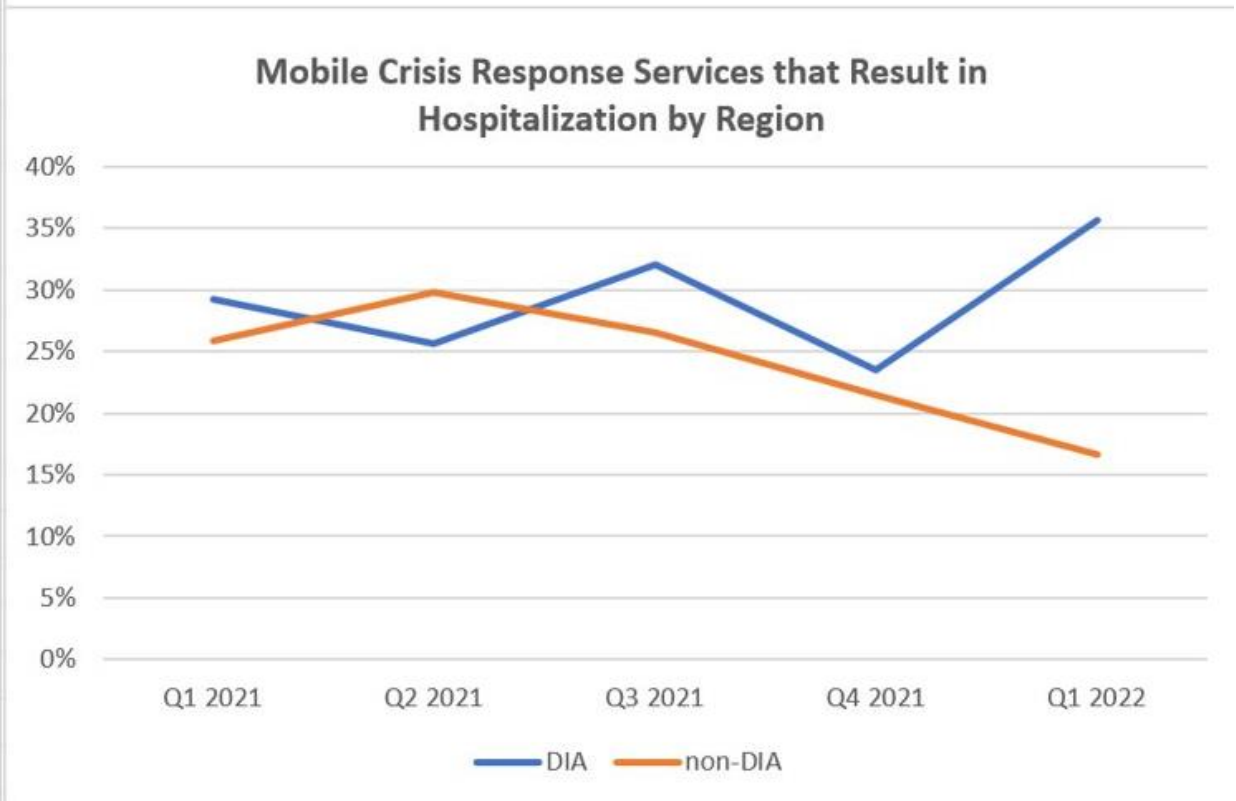
Zip Codes by Race Group by Performance Relative to Average

	AI/AN	Asian	Black	Unknown	White
People in zip codes at or above average performance	20	134	686	2588	2472
People in zip codes within 10% of average performance	8	2	972	588	198
People in zip codes >10% from average performance	6	6	1510	838	188
Total	34	142	3168	4014	2858
% in zip codes at or above average performance	58.8%	94.4%	21.7%	64.5%	86.5%
% in zip codes within 10% of average performance	23.5%	1.4%	30.7%	14.6%	6.9%
% in zip codes >10% from average performance	17.6%	4.2%	47.7%	20.9%	6.6%



Population Analysis & Segmentation





Identification of Opportunities

Geography

Specific regions (South and West regions of Cook County) with DIA zip codes are most highly impacted.

Race/Ethnicity

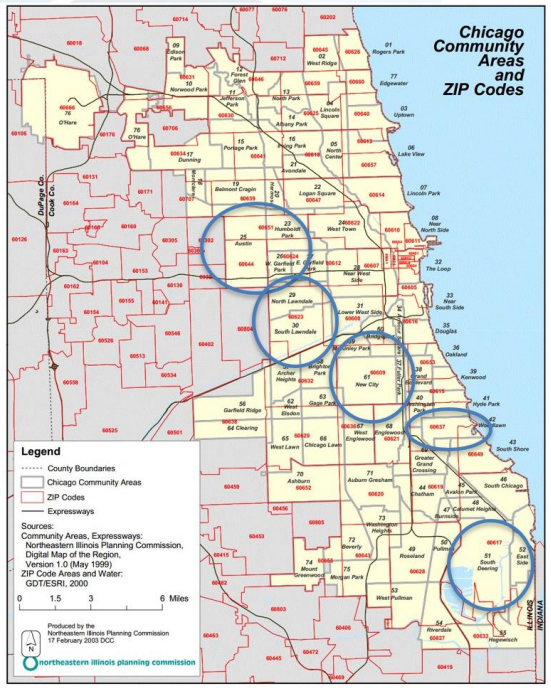
Race/Ethnicity data improving; Black/African-American members showing most barriers to care and services.

Age

Trends by age group were also identified by measure.

Performance Improvement

Childhood Immunization Status (CIS) Analysis



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60804	123	285	43.16%

Key findings:

Lowest performance rates for zip codes in South and West communities

CountyCare developed a diaper bag pilot program. A provider partner serving members in highly impacted DIA zip codes was identified to participate in this pilot program.

The pilot is currently underway. Participant engagement (contacts, care plan updates, medical visit completion) is being measured and outcomes (completion of services, clinical outcomes) is also being tracked. Evaluation expected in Q1 2023.

CELEBRATING 10 YEARS COUNTYCARE

Performance Improvement

- Provident Health Fair

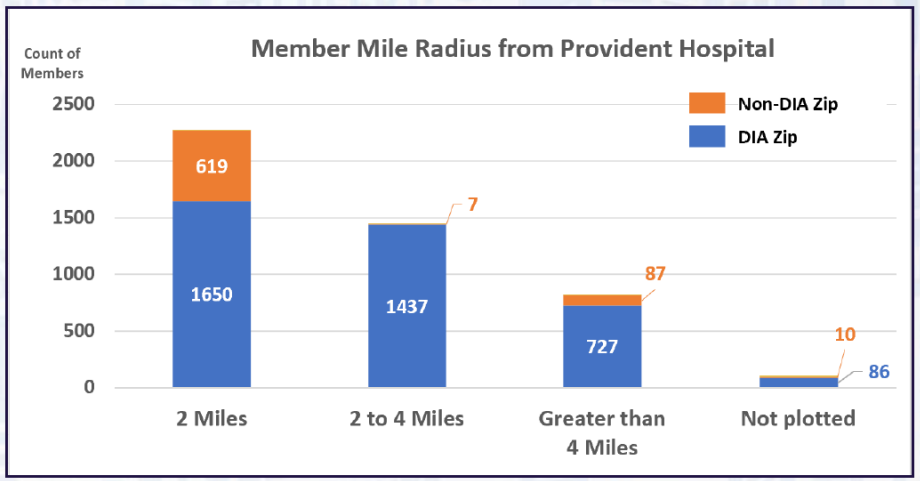
HEDIS Measure Performance Report: CountyCare Health Plan

Dates of Service through August 15, 2022

		Admin				Percentile				
Meas Abbr	Measure Name	Total Num	Denom	Needed Mbrs to Target	Current Rate	Percentile 25th	Percentile 50th	Target Percentile 75th	Percentile 90th	CountyCare Rate
AAP	Adult Access to Preventative/Ambulatory Services	2620	4612	1161	56.81%	73.17%	78.30%	81.97%	84.78%	59.42%
BCS	Breast Cancer Screening	374	755	70	49.54%	48.07%	53.93%	58.70%	63.77%	48.12%
CBP	Controlling High Blood Pressure	352	1017	284	34.61%	50.61%	55.35%	62.53%	66.79%	21.14%
CCS	Cervical Cancer Screening	642	2086	686	30.78%	51.80%	59.12%	63.66%	67.99%	47.17%
CDC	CDC HbA1c Screen	418	621	117	67.31%	80.29%	82.97%	86.13%	88.08%	71.83%
CDC	CDC Eye Exam	246	621	114	39.61%	45.01%	51.36%	57.91%	63.02%	33.92%
KED	Kidney Health Evaluation for Patients With Diabetes	184	596	-	30.87%	-	-	-	-	31.28%

Members in DIA areas have lower compliance in BCS, HbA1c Screening, and KED measures.

		Compliance Rate Comparison		
Meas Abbr	Measure Name	Non-DIA Members	DIA Members	DIA to non-DIA Difference
AAP	Adult Access to Preventative/ Ambulatory Services	52.22%	57.66%	5.43%
BCS	Breast Cancer Screening	55.17%	48.80%	-6.37%
CBP	Controlling High Blood Pressure	33.61%	34.74%	1.13%
CCS	Cervical Cancer Screening	28.57%	31.17%	2.60%
CDC	CDC HbA1c Screen	77.46%	66.00%	-11.46%
CDC	CDC Eye Exam	38.03%	39.82%	1.79%
KED	Kidney Health Evaluation for Patients With Diabetes	43.06%	29.20%	-13.86%



Health Fair Call Outreach	
Measure	Members with Remaining Gaps
Adult Access to Preventative/Ambulatory Services	1992
Cervical Cancer Screening	1444
Controlling High Blood Pressure	665
Kidney Health Evaluation for Patients With Diabetes	412
Breast Cancer Screening	381
CDC Eye Exam	375
CDC HbA1c Screen	203

Measuring Impact & Results

Performance Improvement Workgroups are tracking impact and results for interventions. An example of impact and results for two interventions is shown below.

Provident Health Fair

5,478 members from 10 zip codes were identified within a 4-mile radius of Provident Hospital

Outreach was completed to identified members.

>100 members were scheduled to attend the Health Fair.

22 annual preventive visits (HEDIS AAP) were completed.

28 members received breast cancer screening (HEDIS BCS).

33 members completed Cervical Cancer Screening (HEDIS CCS).

Community Transitions

As of Q3 2022, 11 members have been successfully transitioned to the community.

100% of members transitioned reside in DIA zip codes (60707, 60640, 60639, 60623, 60619, 60478, 60466, 60164, 60077)

Intensive discharge planning process includes addressing of social determinants of health including food insecurity, transportation needs, and other identified needs.

CountyCare

A MEDICAID HEALTH PLAN

Questions?

Meridian

meridian

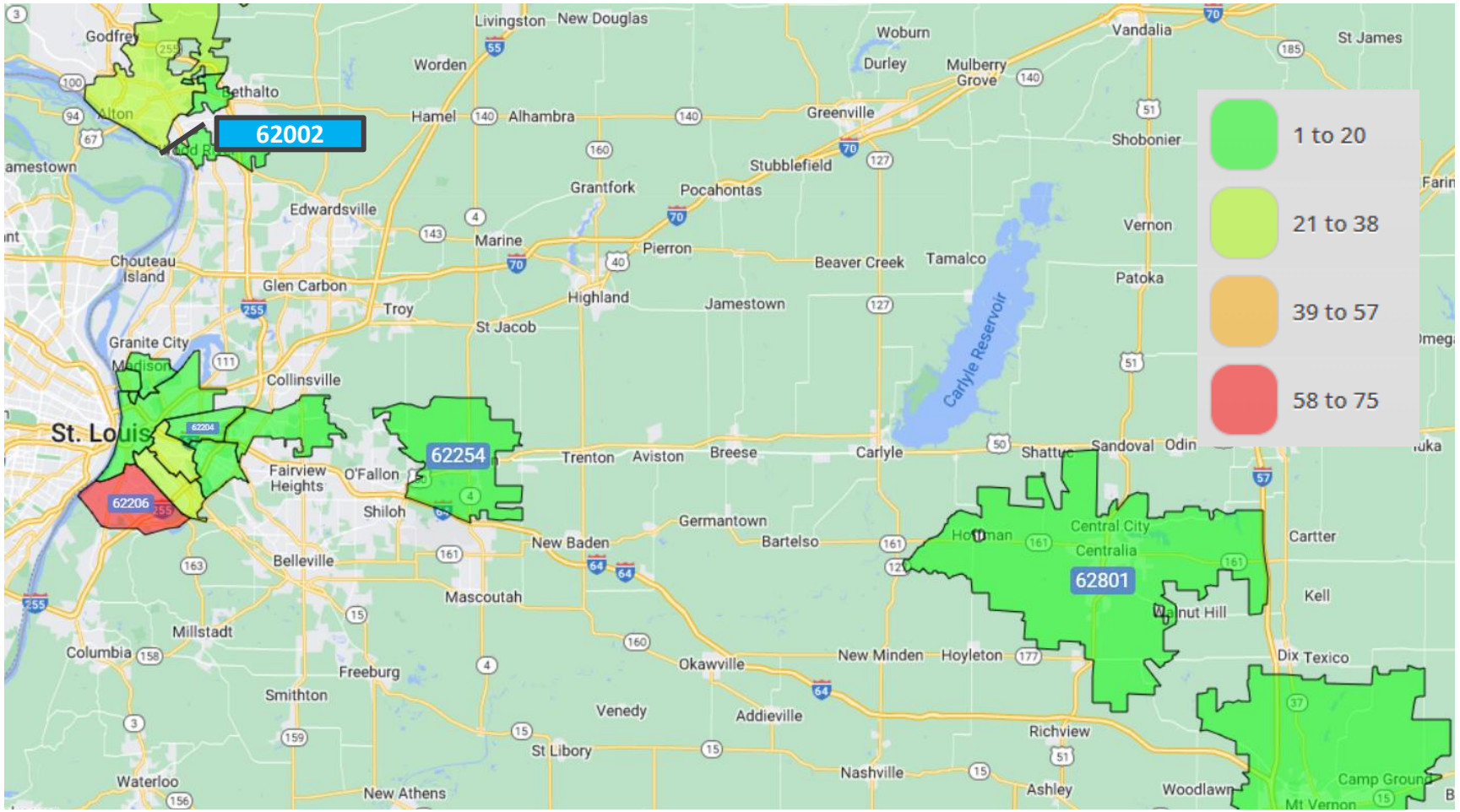
Meridian Use of DIA Data

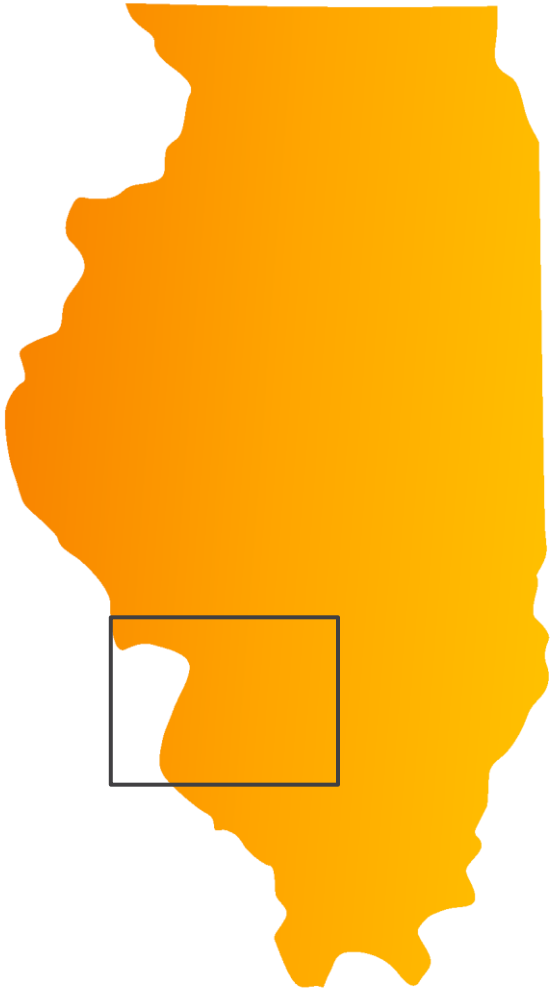
November 17, 2022

Health Disparities Analysis Overview

- **Rate Stratification:**
  - Race: Asian, Black, White, and Unknown/Other
  - Gender: Male members compared to female members
  - Zip Code: Disproportionately Impacted Area (DIA) zip codes compared to non-DIA zip codes
  - Demographic Data Source is 834
- **Rate Comparison**
  - Overall rate differences
  - Chi-square Statistical Test
    - P-value <0.05 used to identify significant gaps between the comparison groups
- **Prioritize measures/members with statistically significant differences in performance by Race, Gender, and Zip Code**

CIS Care Gaps among Black Members in DIA Zip Codes





Initiatives

Use Disproportionately Impacted Area (DIA) data for:

- **Member engagement**
  - Outreach, modality
  - Programs , member events
- **Provider partnerships**
  - Wellness events
- **Community stakeholders**
  - Community events
- **Community Health Workers (Community Health Service Representatives)**
  - Face to Face home visits
  - Follow-up with members who've identified a SDoH need on the screening tool
  - Engagement with organizations who have members who have shared they have Meridian
  - Our CHW's are place in Meridians service areas prioritized by high membership and DIA Zip Codes

Member Outreach: Phone

Phone outreach campaign to prenatal and postpartum members

- Completed in August 2022
- Targeted members who were Black English-speaking females residing in DIA zip codes
- Successfully reached 51 members (12%)
  - 623 members, 418 members with valid phone numbers
  - Call outcomes included:
    - 13 members recently completing the service
    - 4 members with scheduled appointments
    - 5 members assisted with scheduling appointment
    - 29 members appreciated the open care gap education being communicated to them

Member Outreach: Text Message

- Targeted CIS-Combo 10 non-compliant black members and members residing in DIA zip codes
- Sent in August 2022

To parent of guardian of Meridian Medicaid Plan member: On-time vaccines promote immunity for your child. See the CDC immunization schedule: <insert link> Call Meridian Member Services at 866-606-3700 (TTY: 711) to find a provider near you! Text HELP for assistance or STOP to opt-out. Msg&DataRatesMayApply

Member Outreach: Mailings

- Social support resources
  - Child Care
  - Clothing
  - Financial
  - Food
  - Housing
  - Job and Training
  - Transportation
  - Utility
- Mailed to 1,086 members in October 2022

Member Events

Baby Shower

- Meridian hosted its first Start Smart for Your Baby virtual baby shower March 2nd, 2022
- 63 new or expecting moms/dads attended the event
  - 44% of attendants resided in a DIA zip code
- Shared health education and information from community resources to promote healthy baby and maternal outcomes

Community Baby Shower

- Hosted community event with St Bernard Hospital Chicago, IL 60621 (DIA zip code)

Provider Partnerships

Wellness Events

- Invite members from surrounding area or empaneled to provider group
- Members able to complete services to close care gaps

- Family Christian Health Center Kidfest Back to School Event
  - 60426, Harvey, South Chicago (DIA zip code)
- Southern Illinois Healthcare Foundation's (SIHF) Back to School Wellness Event
  - 62002, Alton, Southwest Illinois (DIA zip code)
  - Over 70 child and adolescent members from the community completed well-child visits and closed care gaps

meridian

Provider Partnerships

- Local Health Departments (LHD's)
- Federally Qualified Health Centers (FQHCs)
- Free Clinics
- Safety Net Hospitals
- Other Hospitals and Clinics

Strategy and Next Steps

- Dashboard development
- Continue to focus upcoming interventions on identified member groups
- Utilize Community Health team
- Data and Analytics
  - Metopio
  - Power Bi
  - Centene SDoH Dashboard
  - Centene SDoH Community Dashboard
  - Centene Health Equity Dashboard
  - NEST Score
  - Health Risk Assessment (HRA)
  - Health Risk Survey (HRS)
  - Findhelp.org needs by area and category

meridian

Thank you!

ANY QUESTIONS?

HFS
Illinois Department of
Healthcare and Family Services

Molina Healthcare of Illinois

Health Equity & Quality Subcommittee

November 17, 2022

MOLINA HEALTHCARE

Analysis Completed and Gaps in Care: Race and Geography

Analysis Description

Steps of analysis completed

Which zip codes have 10+ members who received a Mobile Crisis Response?

- *Are there more Mobile Crisis Responses in DIA or Non-DIA zip codes?*
- *What is the overall geographic and ethnic break down of these areas*?
- *Is there a notable disparity in the admission rates across zip code and ethnicity within those zip codes?*

Observations

- In zip codes with 10+ MCR, there were more cases that occurred in non-DIA zip codes than in disproportionately impacted areas.
- Non-DIA zip codes the population of cases is predominately White (40.69%) and Unknown (49.66%) Members, with only 6.90% Black, and the remaining Asian and Other.
- Ethnic makeup of DIA zip codes are a little more proportionate with 36.88% Black, 35.46% Unknown, and 27.66% White
- *Black Members residing in DIA zip codes have an admission rate of 65.38% vs only 3.45% in non-DIA, Unknown 23.08% but admitted 27.59% of the time if they are in a non-DIA, and White members in DIA zips have 11.54% admission rate compared to the 68.97% admission rate of their counterparts in non-DIA zip codes.*

Geography		Overall Rate (10+ cases)			Cases				Admissions		
Zip Code	DIA	Total Cases	Total Admissions	Percent of Admissions	Black	Asian	Unknown	White	Black	Unknown	White
61821	N	29	3	10.34%	7	0	17	5	0	0	3
61701	Y	29	5	17.24%	8	0	11	10	2	1	2
61832	Y	24	0	0.00%	9	0	5	10	0	0	0
60639	Y	17	0	0.00%	3	0	7	7	0	0	0
61761	N	15	4	26.67%	1	1	7	6	1	1	2
61802	Y	14	4	28.57%	7	0	6	1	0	4	0
61554	N	14	2	14.29%	1	0	6	7	0	1	1
62040	N	13	1	7.69%	1	0	6	6	0	1	0
62966	Y	13	12	92.31%	12	0	0	1	12	0	0
61866	Y	12	0	0.00%	3	0	7	2	0	0	0
61704	N	12	1	8.33%	0	0	4	8	0	0	1
61604	Y	12	3	25.00%	4	0	2	6	2	0	1
61755	N	11	9	81.82%	0	0	2	9	0	0	9
61520	N	11	4	36.36%	0	0	7	4	0	1	3
60634	N	10	2	20.00%	0	0	6	4	0	2	0
61107	N	10	0	0.00%	0	0	4	5	0	0	0
62002	Y	10	1	10.00%	5	0	4	1	1	0	0
62052	N	10	2	20.00%	0	0	6	3	0	2	0
61104	Y	10	1	10.00%	1	0	8	1	0	1	0
61614	N	10	1	10.00%	0	0	7	2	0	0	1

Analysis Completed and Gaps in Care: Geography and Ethnicity

Analysis Description

Steps of analysis completed

What is the ethnic breakdown of members who have received Mobile Crisis Responses in zip codes with 10+ cases?

- *What percent of each zip code does each race make?*
- *Are there any results that are surprising?*
  - There are 6 non-DIA areas that have no Black members seen through a Mobile Crisis Response
  - In areas with 10+ cases, there was only 1 Asian member.

			Cases							
Zip Code	DIA	Total Cases	Black	Percent of Total	Asian	Percent of Total	Unknown	Percent of Total	White	Percent of Total
61821	N	29	7	24.14%	0	0.00%	17	58.62%	5	17.24%
61701	Y	29	8	27.59%	0	0.00%	11	37.93%	10	34.48%
61832	Y	24	9	37.50%	0	0.00%	5	20.83%	10	41.67%
60639	Y	17	3	17.65%	0	0.00%	7	41.18%	7	41.18%
61761	N	15	1	6.67%	1	6.67%	7	46.67%	6	40.00%
61802	Y	14	7	50.00%	0	0.00%	6	42.86%	1	7.14%
61554	N	14	1	7.14%	0	0.00%	6	42.86%	7	50.00%
62040	N	13	1	7.69%	0	0.00%	6	46.15%	6	46.15%
62966	Y	13	12	92.31%	0	0.00%	0	0.00%	1	7.69%
61866	Y	12	3	25.00%	0	0.00%	7	58.33%	2	16.67%
61704	N	12	0	0.00%	0	0.00%	4	33.33%	8	66.67%
61604	Y	12	4	33.33%	0	0.00%	2	16.67%	6	50.00%
61755	N	11	0	0.00%	0	0.00%	2	18.18%	9	81.82%
61520	N	11	0	0.00%	0	0.00%	7	63.64%	4	36.36%
60634	N	10	0	0.00%	0	0.00%	6	60.00%	4	40.00%
61107	N	10	0	0.00%	0	0.00%	4	40.00%	5	50.00%
62002	Y	10	5	50.00%	0	0.00%	4	40.00%	1	10.00%
62052	N	10	0	0.00%	0	0.00%	6	60.00%	3	30.00%
61104	Y	10	1	10.00%	0	0.00%	8	80.00%	1	10.00%
61614	N	10	0	0.00%	0	0.00%	7	70.00%	2	20.00%

Analysis Completed and Gaps in Care: Race/Ethnicity

Analysis Description

Steps of analysis completed

Were do members live who have the most Mobile Crisis Responses?

- *What is the geographic and ethnic break down of these areas*?
- *What is the trend of admissions by geography and race/ethnicity?*

			Admissions					
Zip Code	**DIA**	**Total Cases**	**Black**	**% of Ethnicity**	**Unknown**	**% of Ethnicity**	**White**	**% of Ethnicity**
61821	N	29	0	0.00%	0	0.00%	3	60.00%
61701	Y	29	2	25.00%	1	9.09%	2	20.00%
61832	Y	24	0	0.00%	0	0.00%	0	0.00%
60639	Y	17	0	0.00%	0	0.00%	0	0.00%
61761	N	15	1	100.00%	1	14.29%	2	33.33%
61802	Y	14	0	0.00%	4	66.67%	0	0.00%
61554	N	14	0	0.00%	1	16.67%	1	14.29%
62040	N	13	0	0.00%	1	16.67%	0	0.00%
62966	Y	13	12	100.00%	0	0.00%	0	0.00%
61866	Y	12	0	0.00%	0	0.00%	0	0.00%
61704	N	12	0	0.00%	0	0.00%	1	12.50%
61604	Y	12	2	50.00%	0	0.00%	1	16.67%
61755	N	11	0	0.00%	0	0.00%	9	100.00%
61520	N	11	0	0.00%	1	14.29%	3	75.00%
60634	N	10	0	0.00%	2	33.33%	0	0.00%
61107	N	10	0	0.00%	0	0.00%	0	0.00%
62002	Y	10	1	20.00%	0	0.00%	0	0.00%
62052	N	10	0	0.00%	2	33.33%	0	0.00%
61104	Y	10	0	0.00%	1	12.50%	0	0.00%
61614	N	10	0	0.00%	0	0.00%	1	50.00%
TOTAL		**286**	**18**	**32.73%**	**14**	**25.45%**	**23**	**41.82%**

Analysis Completed and Gaps in Care: Geography and Gender

Analysis Description

Steps of analysis completed

Which zip codes have the most total admissions?
Are they mostly in DIA areas?
Do females or males have more admissions in the top zip codes?
Does the gender breakout change when its DIA vs Non?

Observations

- 18 zip codes have ≥7 total admissions
- 61% of the top zip codes are identified as DIA, and make up 62% of the total admits of these zip codes
- Females have an overall higher admission rate than males regardless of DIA or non

Zip Code	DIA	Female	Male	Total Admits
61832	Yes	14	12	**26**
61821	No	10	5	**15**
60634	No	11	1	**12**
61603	Yes	7	3	**10**
60609	Yes	6	3	**9**
62002	Yes	4	5	**9**
61820	Yes	7	2	**9**
61853	No	3	5	**8**
61520	No	4	4	**8**
61701	Yes	5	3	**8**
60623	Yes	3	5	**8**
62226	No	6	2	**8**
61401	Yes	5	3	**8**
61704	No	6	1	**7**
60651	Yes	4	3	**7**
61866	Yes	4	3	**7**
60639	Yes	4	3	**7**
61571	No	2	5	**7**
TOTAL		**105**	**68**	**173**

Analysis Completed and Gaps in Care: Geography and Race

Analysis Description

Steps of analysis completed

Which zip codes have 5+ BH In Patient Hospitalizations?

- *Do DIA areas have more admits than members residing in non-DIA?*
- *What is the racial/ethnic makeup of each zip code?*
- *How do these groups compare to the total admits for the zip code?*

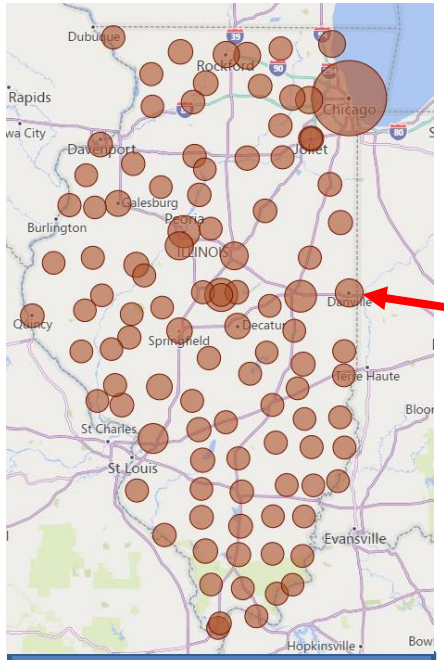
Observations

- 28 Zip Codes have 5+ BH In Patient admits; 15 are DIA (54%)
- There are no admits for Asian members residing in these zip codes
- White members have a larger percent of admits for non-DIA zip codes

Total In Patient Admissions (5+ Admits)										
Geography		Black		Asian		Unknown		White		Grand Total
Zip	DIA	Admits	% total	Admits	% total	Admits	% total	Admit	% total	
61832	Yes	5	31.25%			3	18.75%	8	50.00%	16
61821	No	3	25.00%			5	41.67%	4	33.33%	12
60651	Yes	3	30.00%			6	60.00%	1	10.00%	10
61701	Yes	2	22.22%			2	22.22%	5	55.56%	9
60201	No	0	0.00%			0	0.00%	8	100.00%	8
61520	No	0	0.00%			5	62.50%	3	37.50%	8
61802	Yes	2	28.57%			5	71.43%	0	0.00%	7
61611	No	1	14.29%			1	14.29%	5	71.43%	7
60634	No	0	0.00%			6	85.71%	1	14.29%	7
60617	Yes	0	0.00%			5	83.33%	1	16.67%	6
60609	Yes	0	0.00%			5	83.33%	1	16.67%	6
60623	Yes	1	16.67%			2	33.33%	3	50.00%	6
60160	Yes	1	16.67%			3	50.00%	2	33.33%	6
61401	Yes	0	0.00%			4	66.67%	2	33.33%	6
61704	No	0	0.00%			3	60.00%	2	40.00%	5
61853	No	0	0.00%			3	60.00%	2	40.00%	5
61764	No	1	20.00%			2	40.00%	2	40.00%	5
60639	Yes	0	0.00%			4	80.00%	1	20.00%	5
61883	No	0	0.00%			5	100.00%	0	0.00%	5
60641	Yes	0	0.00%			3	60.00%	2	40.00%	5
61761	No	2	40.00%			1	20.00%	2	40.00%	5
60643	Yes	1	20.00%			4	80.00%	0	0.00%	5
61820	Yes	0	0.00%			3	60.00%	2	40.00%	5
61008	No	0	0.00%			5	100.00%	0	0.00%	5
61866	Yes	0	0.00%			2	40.00%	3	60.00%	5
62052	No	0	0.00%			3	60.00%	2	40.00%	5
61604	Yes	1	20.00%			1	20.00%	3	60.00%	5
62223	No	5	100.00%			0	0.00%	0	0.00%	5

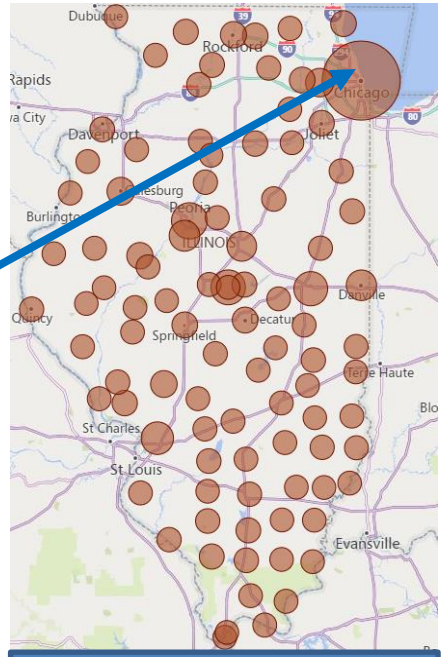
Targeted DIA Outreach: Gap Closure

Q4 Enhancements: Leverage compliance history data to identify members who are *always*, *sometimes*, and *never* compliant for specific services, as well as flag members living in DIA zip codes for whom there is no historical data in order to complete more targeted scheduling outreach to those who have historically *always* been compliant and those who have *never* been engaged/compliant.



Pap smear Heat Map

Q4 Targets			
	Sometimes	**Never**	**No Data**
Total Targets	14,519	22,641	19,160
DIA Targets	7,818	12,976	9,240
Top Zip DIA Zip Codes	**61832**; 61604; 61605; 61603; 61401	60628; **60619**; 60651; 60617; 60620	60629; 60085; **61832**; **60619**; 60639



Mammogram Heat Map

ANY QUESTIONS?

HFS
Illinois Department of
Healthcare and Family Services

VII. Public Comments

HFS
Illinois Department of
Healthcare and Family Services

Public Comments

Update:

A. None

VIII. Additional Business: Old & New

HFS
Illinois Department of
Healthcare and Family Services

A. Items For Future Discussion

B. HFS Announcements

B.1. Ethics Training For All Subcommittee Members

A. All appointees must complete the following trainings on OneNet:

1. Diversity, Equity, and Inclusion Training
2. HIPAA and Privacy Training
3. Security Awareness Training
4. Harassment and Discrimination Prevention Training
5. Ethics Training

You can access the trainings at the following link:
http://onenet.illinois.gov/mytraining

Please see attached memo for additional details. Please complete the trainings through OneNet no later than December 16, 2022.

B.2. New MAC and Subcommittee Membership Questionnaire

Medicaid Advisory Committee (MAC)

HFS > About Us > Boards and Commissions > Medicaid Advisory Committee (MAC)

The Medicaid Advisory Committee (MAC) advises the Department of Healthcare and Family Services with respect to policy and planning related to the health and medical services provided under the department's Medical Programs including Medical Assistance, All Kids and FamilyCare pursuant to federal Medicaid requirements established at 42 CFR 431.12.

- Medicaid Advisory Committee Opportunities (pdf)

Medicaid Advisory Committee (MAC)

- MAC Home
- Overview
- Members
- Bylaws

Step 1

HFS
Illinois Department of Healthcare and Family Services

Medicaid Advisory Committee Opportunities

The **Medicaid Advisory Committee (MAC)** is seeking candidates interested in advising the Illinois Department of Healthcare & Family Services (HFS) on its Medical Assistance Program.

The MAC was created to advise HFS about health and medical care services under the Medical Assistance Program pursuant to the requirements of 42 CFR 431.12 with respect to policy and planning involved in the provision of medical assistance.

The MAC shall have the opportunity to advise on policy development and program administration, including furthering the participation of recipient members in the agency program pursuant to 42 CFR Section 431.12(e).

Vision Statement: The Medicaid Advisory Committee shall ensure that populations covered under HFS' Medical Assistance Programs have timely access to high quality medical care delivered in a cost-efficient manner that meets customer needs regardless of sex, race/ethnicity, primary language, geography, age, disability or other socioeconomic factors.

Please see descriptions of subcommittees under the MAC:

Community Integration Subcommittee: Established to advise the Medicaid Advisory Committee on short- and long-term recommendations to increase the number of seniors and persons with all types of disabilities receiving services in community settings. The subcommittee, comprised of a diverse group of stakeholders including Medicaid customer and will identify systemic barriers to achieving greater community integration and will review, discuss, and develop recommendations on strategies to ensure that long-term services and supports in the community are accessible and equitable. These strategies will be informed by established evidence-based practices, federal funding opportunities, programmatic requirements, and the practical realities of Illinois' medical programs. **(This subcommittee is no longer accepting application submissions.)**

Health Equity & Quality Subcommittee: Established to advise the Medicaid Advisory Committee concerning strategies to improve customer outcomes by ensuring that populations covered under HFS' 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.

Public Education Subcommittee: Established to advise the Medicaid Advisory Committee concerning materials and methods for informing individuals about health benefits available under the Department of Healthcare and Family Service's medical programs including, but not limited to, All Kids, FamilyCare, Aid to the Aged, Blind, or Disabled (AABD) medical.

N.B. Stakeholder Subcommittee: On January 16, 2018, United States District Judge Jorge L. Alonso approved the terms of the N.B. Consent Decree, which was agreed to by the state of Illinois and the Plaintiffs. The purpose of the Consent Decree is to design and implement a systemic approach through which all Medicaid-eligible children under the age of 21 in the State of Illinois, with reasonable promptness, will be provided the Medicaid-authorized, medically necessary intensive home and community-based services, including residential services, that are needed to correct or ameliorate their mental health or behavior disorders. The Stakeholder Subcommittee will be asked to provide feedback and input on specific aspects of the Implementation Plan, as requested by HFS.

To apply for consideration:

1. Interested parties must complete the required questionnaire HERE for consideration.
2. If you need further information, please contact Melishia.Bansa@Illinois.gov.

Step 2

Medicaid Advisory Committee (MAC) & Subcommittee Application

Request for Membership Application

* Required

Please provide your contact information.

1. Name (Last, First, Middle Initial) *

Enter your answer

2. Employer (If you are working in a paid position; list all if more than one.) *

Enter your answer

Step 3

B.3. Resources

A. To receive email notifications regarding public meeting notices, sign up for our MAC and Subcommittee Listserv:

1. Medicaid Advisory Committee (MAC) | HFS (illinois.gov)
2. MAC and Subcommittees E-mail Notification Request | HFS (illinois.gov)

B.3. Resources

B. The Illinois Department of Healthcare and Family Services (HFS) utilizes a range of social media accounts to better reach our customers and stakeholders. We encourage you to follow us on Facebook, Twitter, and LinkedIn for important news, announcements and alerts. And please spread the word to your own followers.

Together, let's keep those we serve well informed, educated and empowered!

ANY QUESTIONS?

HFS
Illinois Department of
Healthcare and Family Services

IX. Adjournment

THANK YOU

HFS
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