



SACRAMENTO COUNTY HEALTH AUTHORITY COMMISSION

General Meeting

August 13, 2024

Agenda Item #1: **Welcome/Opening Remarks** **& Updates**

Agenda Item #2: Agenda Review

1. Welcome/Opening Remarks and Updates
2. Agenda Review
3. SCHA Commission Vice-Chair Election
4. Appointment of Ad-Hoc Subcommittee for Strategic Implementation Plan #5
5. MCPs Present on Bold Goals
 - Discussion
6. SCHA Consultant NORC's Scope of Work Contract
7. Public Comment
8. Closing Comments & Adjournment

Agenda Item #3:

SCHA Commission Vice-Chair Election

Agenda Item #4:
Appointment of Ad-Hoc Subcommittee for
Strategic Implementation Plan #5

Agenda Item #5:
Managed Care Plan Presentation on
DHCS Bold Goals 1-3

CA State Vision

**BOLD GOALS:
50x2025**

STATE LEVEL

- Close racial/ethnic disparities in well-child visits and immunizations by 50%
- Close maternity care disparity for Black and Native American persons by 50%
- Improve maternal and adolescent depression screening by 50%
- Improve follow up for mental health and substance use disorder by 50%
- Ensure all health plans exceed the 50th percentile for all children's preventive care measures

Source: https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM_Infographic.pdf



CalAIM is a long-term commitment to transform and strengthen Medi-Cal, making the program more equitable, coordinated, and person-centered to help people maximize their health and life trajectory.

CalAIM Goals



Implement a whole-person care approach and address social drivers of health.

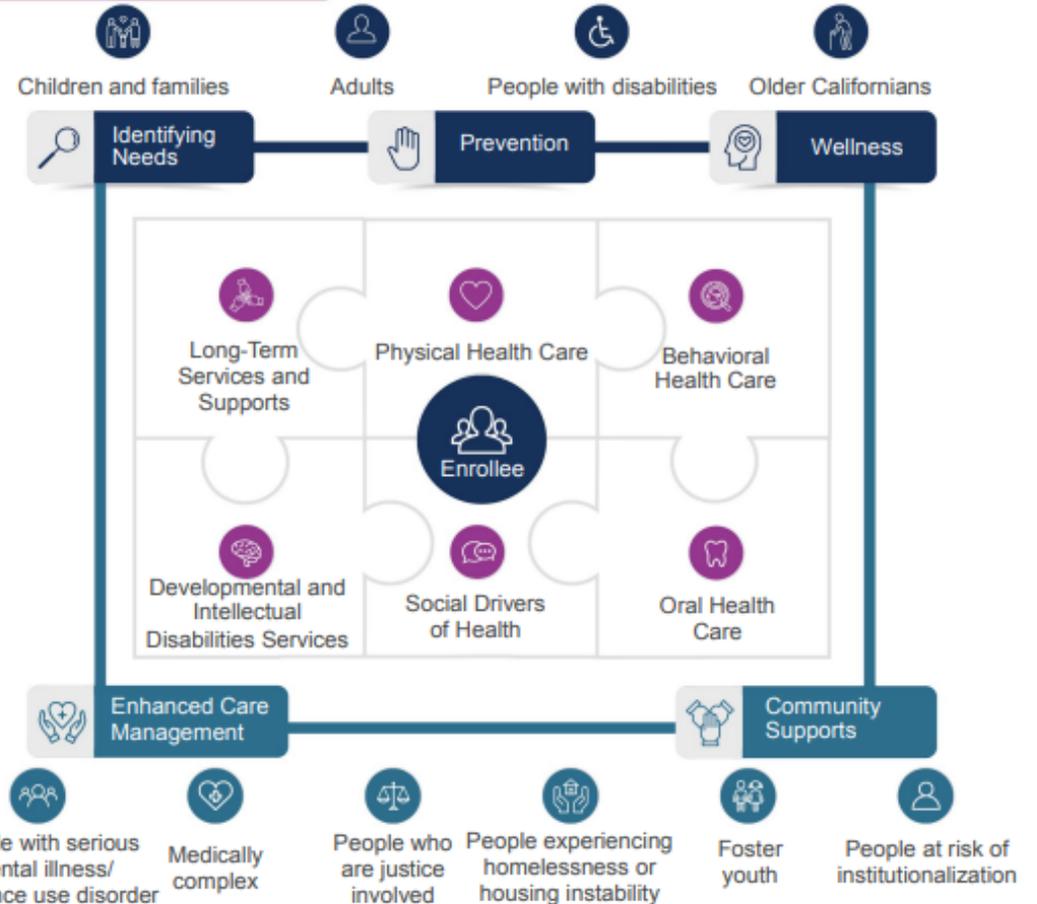


Improve quality outcomes, reduce health disparities, and drive delivery system transformation.



Create a consistent, efficient, and seamless Medi-Cal system.

Population Health Management



Community & Statewide Planning

- Goals ensure a comprehensive quality approach across multiple populations
- Achieved through partnerships with stakeholders across the state
- Goals and measures apply to Medi-Cal Managed Care Plans, Behavioral Health Plans, Dental Plans, etc.
- Goals are tied into multiple initiatives and reporting mechanisms

Ca IAIM

Ca IAIM IPP and
HHIP metrics

MCP Quality
Withhold

Office of Health
Care
Affordability

County Health
Assessments &
Health Improve-
ment Plans

DMHC Health
Equity Guidance

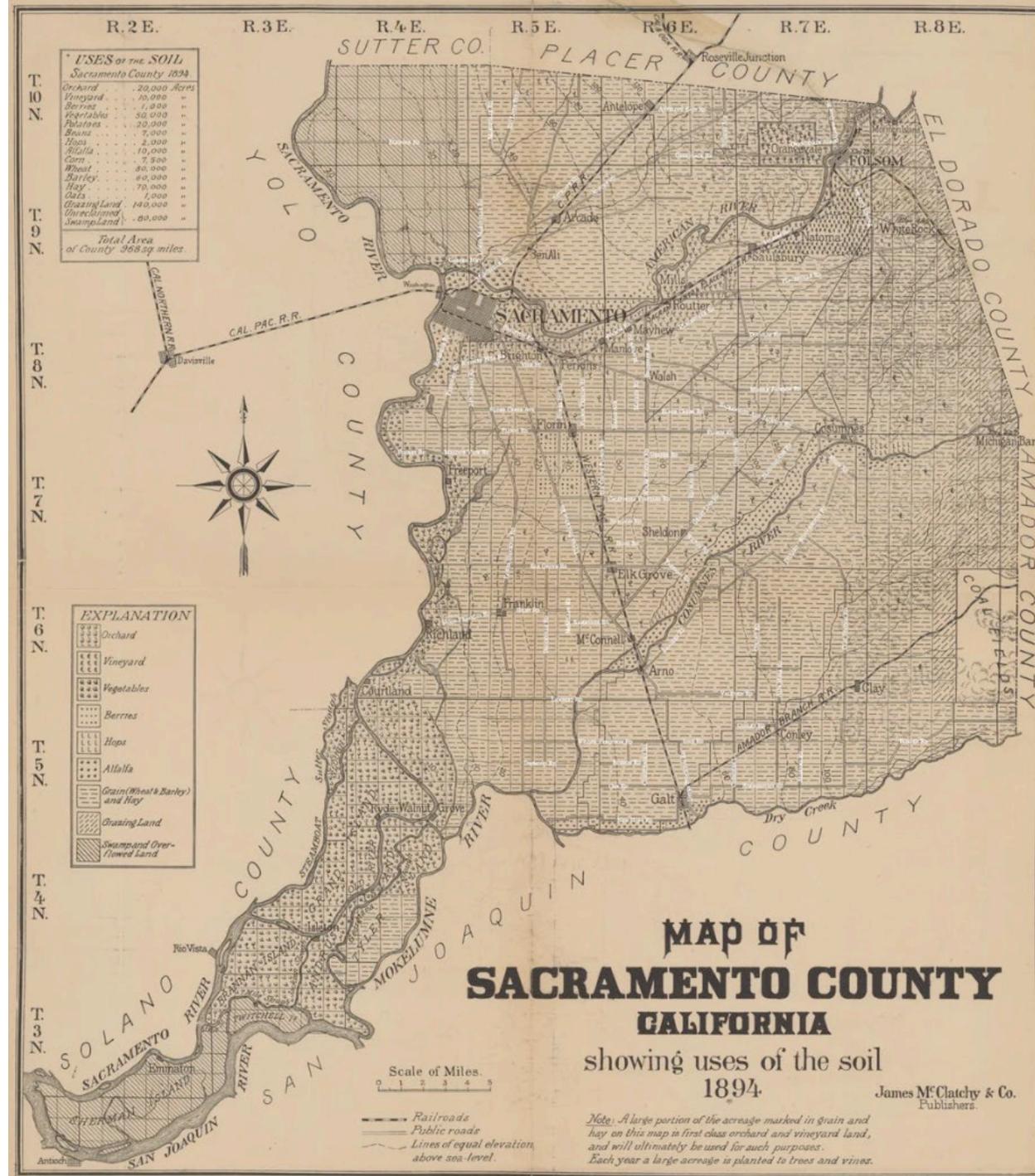
Community Collaboration to Achieve Goals - example

Sacramento County Community Health Improvement Plan SMART objective

By December 2025, leverage housing/homelessness community supports in Sacramento County to increase the number of individuals receiving housing services by 5% to attenuate barriers to care for:

- Adult members by increasing follow-up after mental health visits to the ER by 5%
- Pediatric members by increasing pediatric screening by 5%

MCPs are meeting with staff to support the SMART objective, broader CHA/CHIP efforts, and the completion of DHCS submissions



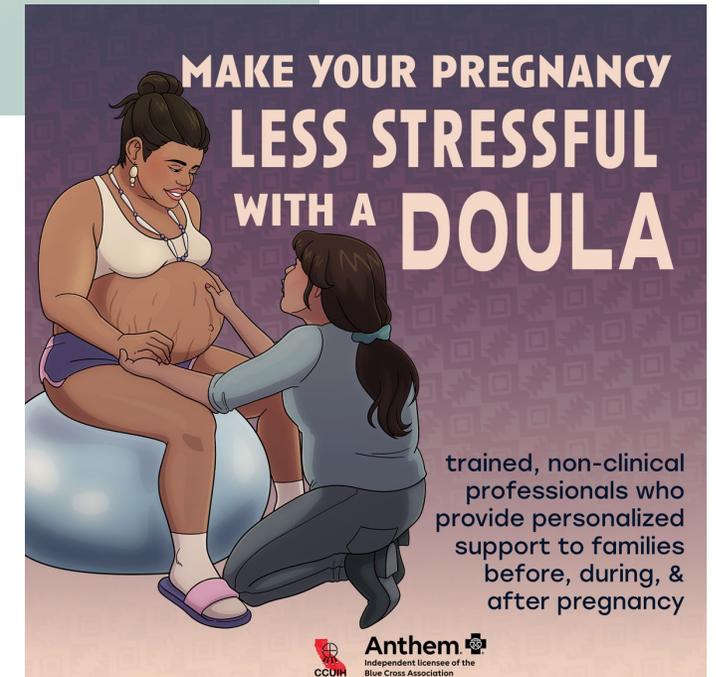
Anthem Managed Care Accountability Sets (MCAS) Data Summary

Measure	Measure Name	MY2023	MY2022	MY2021	MY2020
Childhood Immunization Status	Combination #10 (CIS-10)	23.11%	25.79%	32.6%	30.9%
Immunizations for Adolescents	Combo 2 Meningococcal Tdap/Td HPV (IMA-2)	34.81%	37.71%	37.23%	39.66%
Well-Child Visits in the First 30 Months of Life	Well-Child Visits in the First 15 Months (W30 6+)	44.76%	50.33%	35.5%	26.86%
Well-Child Visits in the First 30 Months of Life	Well-Child Visits for Age 15 Mos-30 Mos (W30 2+)	60.3%	62.79%	61.18%	66.03%
Child and Adolescent Well-Care Visits	Well visits for ages 3-21 (WCV)	43.9%	50.86%	49.17%	47.48%
Prenatal and Postpartum Care	Timeliness of Prenatal Care (PPC Pre)	85.07%	86.13%	89.05%	86.13%
Prenatal and Postpartum Care	Timeliness of Postpartum Care (PPC Post)	74.31%	78.83%	74.45%	77.62%

Note: Metrics for maternal and adolescent depression screening are dependent on LOINC/SNOMED codes, which are not billable and rarely used. This data has been omitted as it does not accurately reflect the work being done.

Member/Community Engagement Highlights

- Anthem partnership with SNAC and the California Consortium for Urban Indian Health to develop and disseminate health education materials on maternal health
- Anthem partnership with County Public Health to re-establish and co-lead the Sacramento Immunization Coalition
 - Includes WIC, First 5, clinics, MCPs and other community orgs.
 - Focused on advocacy, education, access, and closing gaps in disparities
- Sacramento Immunization Coalition partnership with Vaccinate Your Family
 - Offers free training on immunizations and understanding vaccine hesitancy
 - Recruiting CHW and Promotores orgs to participate



Key Challenges and Next Steps

Challenges	Next Steps
Data exchange	<ul style="list-style-type: none">• Re-evaluation of supplemental data feeds• Implementation of Data Exchange Framework• Expansion of internal ops/capabilities• Funding for County SHIE
Insufficient uptake of new benefits	<ul style="list-style-type: none">• On-going network expansion/funding• Increasing provider and community outreach
SDOH gaps – I.e. transportation, employment, childcare, food insecurity	<ul style="list-style-type: none">• Continue utilizing new benefits, community partnerships, etc. to close gaps for members
Multiple collaboratives/county/community activities with competing and overlapping priorities	<ul style="list-style-type: none">• Encourage broader alignment around bold goals and CHIP/CHA activities





Health Net Managed Care Accountability Sets (MCAS) Data Summary – August 13 Presentation to Sacramento County Health Authority Commission

Cathi Misquitta, Pharm.D., MBA, BCPS, BCGP, CPHQ, FCSHP, Vice President, Quality Management



Health Net MCAS Data Summary

MEASURE	SUBMEASNAME	MY2023	MY2022	MY2021	MY2020
Childhood Immunization Status	Combination #10	29.20%	28.47%	30.90%	34.31%
Immunizations for Adolescents	Combo 2 Meningococcal Tdap/Td HPV	41.12%	45.01%	40.39%	41.85%
Prenatal and Postpartum Care	Postpartum Care	72.52%	75.39%	74.09%	73.97%
Prenatal and Postpartum Care	Timeliness of Prenatal Care	84.66%	85.98%	83.84%	86.37%
Well-Child Visits in the First 30 Months of Life	Well-Child Visits for Age 15 Months-30 Months	64.65%	62.85%	62.86%	71.19%
Well-Child Visits in the First 30 Months of Life	Well-Child Visits in the First 15 Months	58.14%	48.39%	47.40%	41.92%
Child and Adolescent Well-Care Visits	Total	50.77%	54.51%	49.88%	49.70%

Note: The depression screening and follow-up metrics are dependent on LOINC/SNOMED codes, which are not billable and rarely used. We are educating physicians and other health care providers on how these should be captured to optimize reporting.



Race by Rate and Ethnicity for Select MCAS Measures

Race	Immunizations for Adolescents	Postpartum Care	Timeliness of Prenatal Care	Well-Child Visits First 15 months	Well-Child Visits 15-30 months	Child and Adolescent Well-Care Visits
AI/AN	46.43%	76.19%	57.14%	37.50%	73.08%	53.37%
Asian	52.82%	73.05%	83.38%	65.64%	72.64%	56.08%
Black	29.39%	56.31%	75.23%	40.24%	50.35%	44.45%
Latino	52.67%	74.18%	85.21%	63.25%	73.35%	57.63%
Pacific Islander	35.29%	50.00%	50.00%	0.00%	63.64%	44.64%
Not Latino	36.31%	65.66%	73.99%	55.98%	59.94%	47.23%
Other	51.50%	78.57%	80.95%	65.42%	75.19%	62.97%
Unknown Ethnicity	20.85%	73.78%	76.22%	53.97%	60.57%	47.39%
Unknown Race	41.11%	72.03%	81.78%	62.65%	62.16%	48.99%
White	29.95%	66.50%	70.72%	58.82%	62.48%	44.49%

- Green highlights better performance
- Orange highlights lower performance

Programs to Improve Quality of Care and Close Care Gaps

	CIS 10	IMA - 2	W30 6+	W30 2+	WCV	PPC PRE	PPC PST	PDS-E Screen	PDS-E FU	PND-E Screen	PND-E FU
Member Level Activity											
Pop Health outreach to inpatient MCAL members after delivery to schedule a postpartum and first infant well care visit.			X								
W30-6+ Clinical Performance Improvement Programs (PIPs), DHCS Quality management improvement programs	X		X	X							
Multi-gap call outreach/ Family Unit HEDIS Outreach	X	X	X	X	X						
Quarterly automated call messaging - CIS, W15, W30	X		X	X							
First year of life - case management program	X		X	X							
Update Infant Well Care Affinity Group Newborn Checklist			X	X							
Member Live Outreach Campaigns (telephonic, in-home, event-based) to improve well visits (all ages)	X	X	X	X	X	X	X				
Monthly automated calls for WCV on birthday month					X						
Member newsletter article on the importance of WCV and immunizations	X	X	X	X	X						
Immunization reconciliation project (also hospital calls for Hep B verification)	X										
First birthday interactive voice response call	X										
Start Smart for Baby - case management program	X		X			X	X				
Postpartum outreach from pop health team to members while still in hospital	X		X				X				
Provider Level Activity											
Institute for Healthcare Improvement (IHI) Child Health Equity Collaborative Sprints			X	X	X						
Provider Engagement and CPM Training on Pediatric MCAS measures for MY 2024			X	X							
Provider Action Plan Review by QI team		X	X	X	X						
Provider communications and workflows to improve access and awareness to Dyadic Care Services			X	X							
Provider Tips Sheets			X	X	X						
Training for provider facing team		X	X	X	X	X	X				
Provider incentives	X	X	X	X	X	X	X				
Provider care gap notifications	X	X	X	X	X	X	X	X	X	X	X
OB and provider group training						X	X				
Implicit bias training						X	X				
Provider training on doula services						X	X	X	X	X	X
Community Level Activity											
CalAIM-- Enhanced Care Management (ECM) for Children and Youth and Birth Equity for up to age 1; Community Health Worker; Doula Services for up to age 1	X	X	X	X	X	X		X	X	X	X
Dyadic Care	X	X	X	X	X	X		X	X	X	X
Collaborated with First 5 Sacramento, Sierra Health Foundation, the Greater Sacramento Urban League, Sacramento City Unified School District, County Supervisors, City Councilmembers and other organizations on childhood and adolescent immunizations.	X	X									
Doula services			X			X	X	X	X	X	X
Collaborating with a few groups to expand our maternal health work, including the Black Child Legacy Campaign, which is made up of several community-based organizations that serve the African American population			X	X		X	X	X	X	X	X
Collaborating with Mahmee to reduce maternal care inequities across the state.						X	X	X	X	X	X

Commitment to Addressing Health Equity

Health Net has pioneered an innovative and multipronged approach to advance health equity:

- Led by a dedicated health equity team that ensures the diverse cultures and languages of members and providers are understood and addressed.
- Based on meaningful engagement with members, providers and community organizations.
- Scaled our equity model as a national best practice by Centene.
- Health Net was invited by NCQA to participate in development of health equity standards. One of only nine plans nationally to receive an invitation.

Our dedication to advance health equity has earned accolades from:



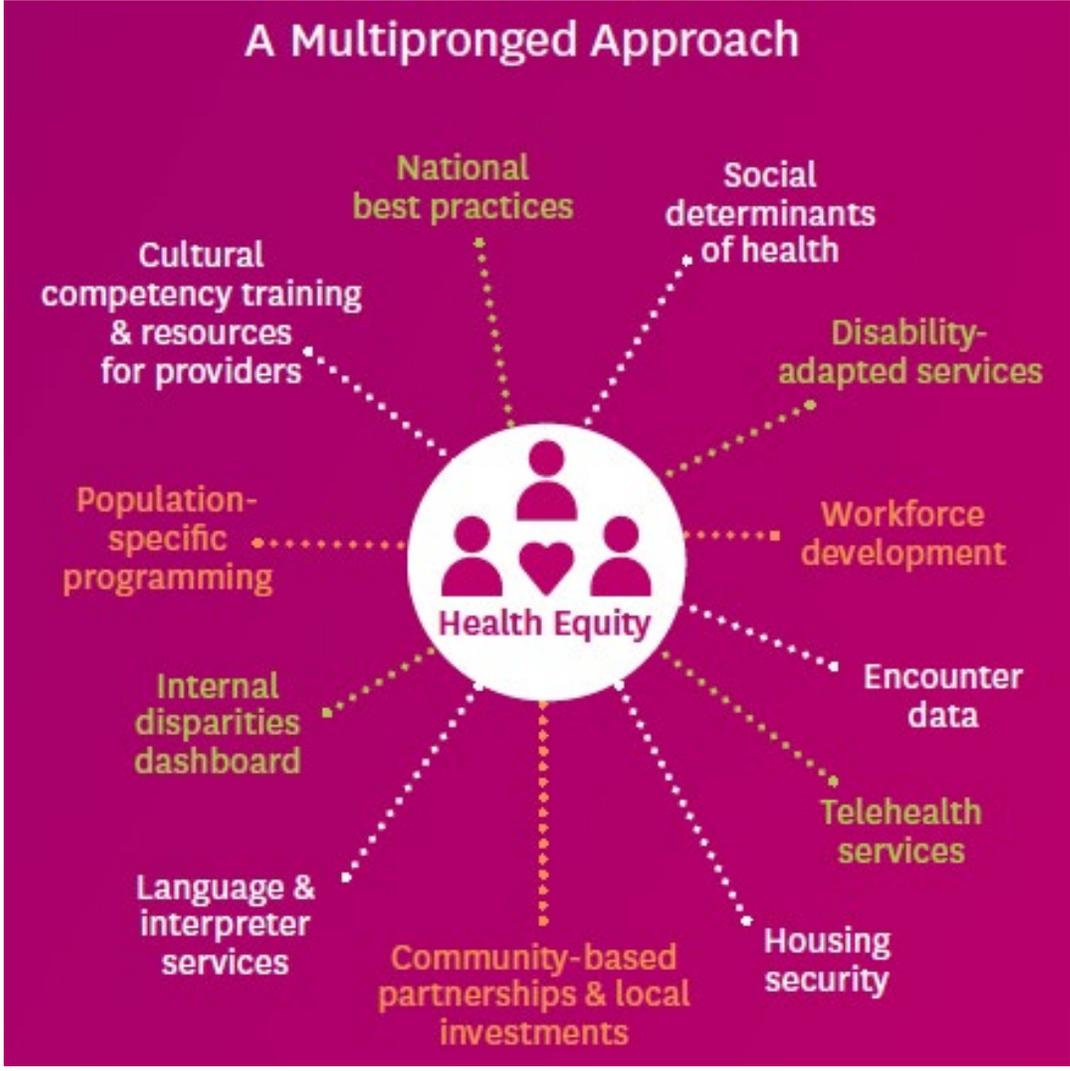
National Committee for Quality Assurance (NCQA) Multicultural Health Care Distinction



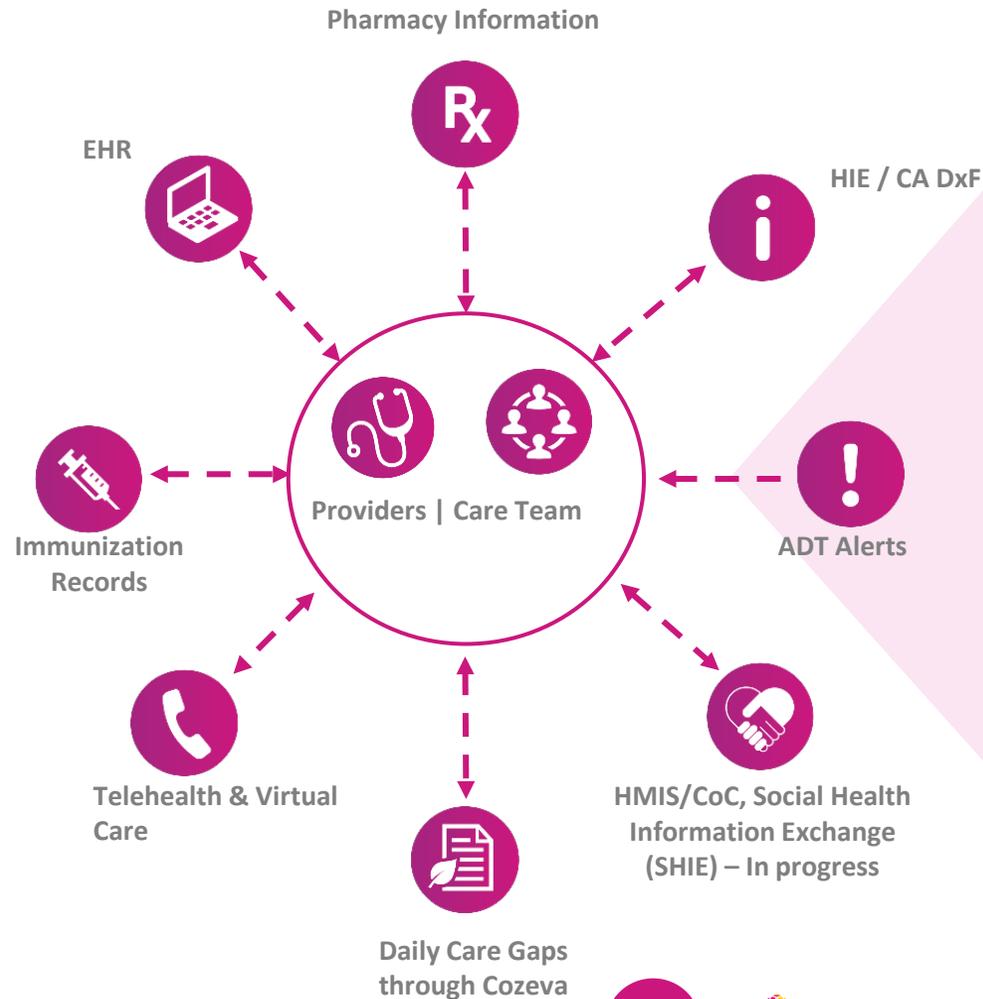
Department of Health Care Services



National Business Group on Health



Data Infrastructure and Sharing: Holistic Member Information



Functions enabled by the Health Net team focus on data sharing, HIE/EDT/EMR/housing alerts data from HMIS/CoCs connectivity and data from counties (as part of BHQIP), Cozeva and encounter analytics/engagement supported further by Centene’s national expertise and resources:

Providers, Specialists, & IPA:

- Data: ADT, RX, Care Gaps, HMIS/CoC etc.
- Channel: Cozeva, EMRs, Portal, SFTP
- Action: Engage Members, Coordinate Care, Close Care Gaps, Review Care Plan, Improve Quality

Internal Care Management:

- Data: HIE, EHR, Telehealth
- Channel: TruCare Cloud, Internal ADT reports
- Action: Inform care management outreach and pop health programming

Telehealth

- Data: HIE, EHR, Telehealth,
- Channel: SFTP & Secure Provider Portal
- Action: Improve access, coordinate with PCP, address health needs and improve quality

CBOs

- Data: SHIE (in progress), HMIS/CoC
- Channel: SFTP & Secure Web Portal
- Action: Address social needs in the context of full health



Data Infrastructure and Sharing: Invested in Bi-Directional Data Exchange

We leverage bi-directional data sharing internally as well as externally to exchange claims and encounter data, authorization and pharmacy data with our partners including IPAs to support the care management process.

We access Provider EMRs to acquire recent member medical information to inform our CM engagement activities and update our records.

We maintain, share and receive Care Plans for our members to ensure a collaborative care model.

We assess SDoH needs of Members, assist with closed loop referrals and coordinate with Providers / CBOs, through partners like FindHelp and through the SHIE efforts going forward.



Encounters

HIE

EMR

ADT

Care Plan

Care Gaps

SDoH



We connect with HIEs to ensure we collect relevant member health information; we store this in our EDW and present this back to Providers via our Portal/SFTP. We are currently connected to 5 HIEs in CA.



We receive over 150,000 notification messages statewide / day that are available and provided to our providers to ensure we engage with members during a time when they need care most.



We calculate care gaps daily and provide this information to PCPs to ensure they address and close needs. They can access this information via Cozeva.



Delegation: Relationship with and Oversight of IPAs



Making space for providers to lead and putting our members first, Health Net does not delegate Member Services, Quality, Grievances, or Appeals. This gives us direct line of sight to access and quality of care concerns.

We have delegated agreements with **River City Medical Group, Hill Physicians Group, and UC Davis Medical Center**. These physician organizations offer value to FQHCs and other provider groups through access to EMRs, ownership opportunities, clinical training, and support meeting quality targets linked to financial incentives. Enabling physician organizations with focused support creates space for community based accountable care. We maintain our **relationship with and oversight of IPAs** through:

Pre-Delegation and Continuous Monitoring for Capacity	Monitoring the Member Experience	Practice Performance Support	Delegation Oversight
<ul style="list-style-type: none"> • Pre-delegation assessment of financial solvency, clinical processes, and operational capabilities • Annual Medi-Cal network filing for Timely Access and Network Certification • Real Time Monitoring of PCP Panel Adequacy 	<ul style="list-style-type: none"> • Grievance and Appeal trends at the IPA and subdelegate levels • Real-time and direct resolution for individual member needs • Appointment scheduling support and monitoring • Regular member Net Promoter Score and Satisfaction surveys 	<ul style="list-style-type: none"> • Quarterly Joint Operating Committees chaired by Health Net’s Sacramento Regional Medical Directors • Collaborative problem solving to create capacity, such as during the Public Health Emergency • Quality, encounter and other incentives at IPA and PCP level 	<ul style="list-style-type: none"> • Annual delegation audit • Monthly monitoring of key delegated functions metrics (e.g., authorization turnaround times and denial rates) • Monthly monitoring of encounter data submission • Engagement through Corrective Action Plans

PPG Performance: Enhanced Performance Management & Governance

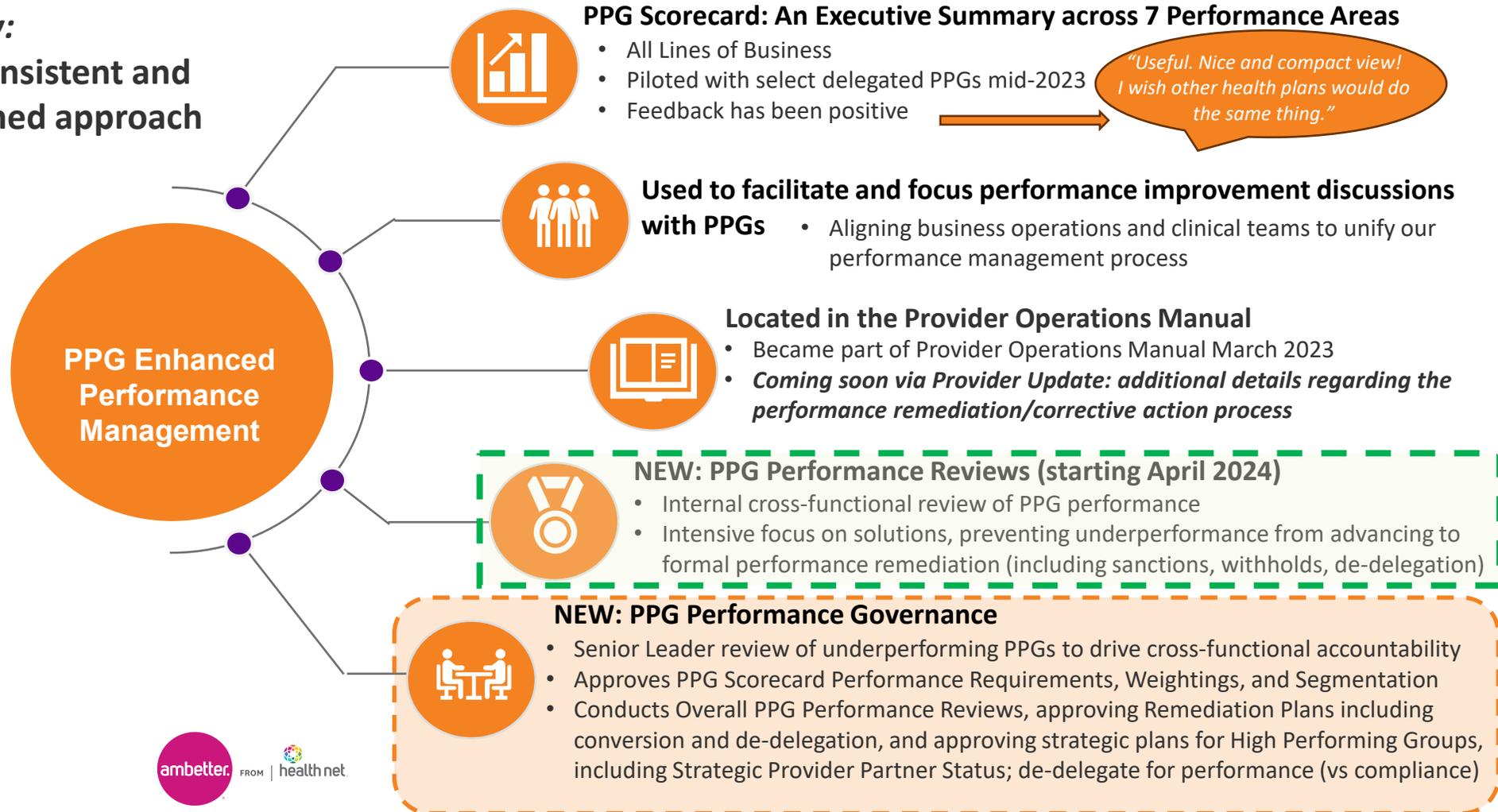
As part of Health Net's commitment to the State to elevate our performance partnerships with delegated PPGs, we have begun to assess and manage performance holistically through a new aligned approach.

Before:

- Performance data from different Health Net departments was available, but not consolidated



Now:
A consistent and aligned approach



Key Challenges and Next Steps

Challenges	Next Steps
Members lack of awareness and knowledge of required infant well care visits, importance of immunizations, due to limited member resources.	Through QR codes, providers can now access resources to promote health education pediatric well-visit benefits and immunizations
Data exchange	Working with 10 high volume pediatric providers in Sacramento County to reconcile well-child visit data.
Provider access and conversion of sick-visits to well-visits	Providing practice tips through provider facing teams
Insufficient uptake of doula benefit	Implemented a virtual doula and pregnancy support program Member notification letters describing benefit Improved call center talking points to assist members



Working Hand in Hand with Local Partners in Sacramento County

Health Net is committed to reinvesting in the communities we serve.



Local Investments Include

Homelessness & Behavioral Health

- \$508,000 grant to **Community HealthWorks** to support 20 Homeless Engagement Workers to support City/County engagement teams
- \$100,000 **Trauma Informed Training Program** Grant to the County
- \$90,000 to UC Davis to support **Sacramento Street Medicine**

Health Equity

- Ongoing engagement with **First 5** to drive black maternal and birth health outcomes
- Dedicated Wellness Room at **La Familia's Maple Neighborhood Clinic**
- \$100,000 to Elica Health Centers for their resource center expansion

Workforce Development

- The Black Child Legacy Campaign's Cultural Brokers Program**
- The Community Health Worker Pathway Program** developed in collaboration with Greater Sacramento Urban League, the Los Rios Colleges Foundation, Sacramento City College, and others
- A \$150,000 grant to WellSpace Health to increase their capacity for internal growth by creating a **training program for medical assistants**

COVID-19 Emergency Response

- Donate4Sacramento** (\$150,000)
- A \$15,000 financial contribution to the **Sacramento Food Bank and Family Services**
- A total of **17,000 cloth face coverings** provided to **CBO and provider partners in the Sacramento Region**



Kaiser Permanente Managed Care Accountability Sets Summary

Presentation to the Sacramento County Health Authority Commission
August 13, 2024

Claire Horton, MD, MPH, VP, Associate Chief Medical Officer, National Medicaid
Banafsheh Siadat, ScD, Executive Director, Medicaid Operations & Care Delivery

Kaiser Permanente Managed Care Accountability Sets (MCAS) Data Summary

MEASURE	Sub Measure Name	MPL 2023	HPL 2023	MY2023	MY2022	MY2021	MY2020
Childhood Immunization Status	Combination #10	30.9%	53.44%	48.87%	49.45%	54.89%	54.98%
Immunizations for Adolescents	Combo 2 Meningococcal Tdap/Td HPV	34.31%	48.8%	65.63%	63.16%	61.43%	NR
Prenatal and Postpartum Care	Postpartum Care	78.1%	84.59%	81.32%	78.56%	77.77%	76.59%
Prenatal and Postpartum Care	Timeliness of Prenatal Care	84.23%	91.07%	90.92%	91.07%	64.01%	93.29%
Well-Child Visits in the First 30 Months of Life	Well-Child Visits for Age 15 Months-30 Months	66.76%	77.78%	76.43%	73.45%	54.35%	61.7%
Well-Child Visits in the First 30 Months of Life	Well-Child Visits in the First 15 Months	58.38%	68.09%	75.21%	75.73%	67.78%	68.17%
Child and Adolescent Well-Care Visits	Total	48.07%	61.15%	53.7%	48.03%	46.76%	33.82%

Color-Code Definition
Green: Met or exceeded HPL
Yellow: Between MPL and HPL
Red: Below MPL

Retroactively applied 2023 MPL and HPL to MY2020, MY2021 and MY2022 performance



Improvement Activities

Close racial/ethnic disparities in well-child visits and immunizations by 50%

- Childhood Immunization Status (CIS 10)
- Immunizations for Adolescents: Combination 2 (IMA-2)
- Well-Child Visits in the First 30 Months of Life (W30 6+)
- Well-Child Visits in the First 30 Months of Life (W30 2+)
- Child and Adolescent Well-Care Visits (WCV)

Close maternity care disparity for Black and Native American persons by 50%

- Prenatal and Postpartum Care (PPC PRE)
- Prenatal and Postpartum Care (PPC PST)

Improve maternal and adolescent depression screening by 50%

- Postpartum Depression Screening and Follow-Up (PDS-E SCREEN)
- Postpartum Depression Screening and Follow-Up (PDS-E FU)
- Prenatal Depression Screening and Follow-Up (PND-E SCREEN)
- Prenatal Depression Screening and Follow-Up (PND-E FU)

Abbreviations:

CBO: Community Based Organization

CS: Community Supports

DEI: Diversity, Equity and Inclusion

NLE: Network Lead Entity

ECM: Enhanced Care Management

QIHEC: Quality Improvement and Health Equity Committee

SBARIT: Screening, Brief Intervention, and Referral to Treatment

	CIS 10	IMA - 2	W30 6+	W30 2+	WCV	PPC PRE	PPC PST	PDS-E Screen	PDS-E FU	PND-E Screen	PND-E FU
Member Level Activity											
Information Added to After Visit Summaries to support Bold Goals (resources and next steps)	x	x	x	x	x	x	x	x	x	x	x
Expanded Education Materials Sent Via Secure Messages (KP.org)	x	x	x	x	x	x	x	x	x	x	x
Health Education Materials Updated for Literacy Level and Threshold Languages (My Doctor Online)	x	x	x	x	x	x	x	x	x	x	x
Visit Reminders enhanced (KP.org, text, and phone call for those not web enabled)			x	x	x						
Proactive outreach to members without a visit scheduled (16, 18 and 22 months of age)			x	x							
Scheduling ahead: 18 and 24 month visit at 1 yr visit				x							
Contracted with Black Infant Health to promote their program	x		x	x		x	x				
Standard SBIRT captured and in place for all pre and post natal depression screening								x	x	x	x
Increased utilization of Care Coordination to support members during pregnancy and postpartum						x	x	x	x	x	x
Provider/Admin/Quality Level Activity											
Provider Training on DHCS Age Guidelines for Medi-Cal Members (up to 21) for AFM Physicians					x						
Care Gap Alerts (updated for DHCS children's domain measures)	x	x	x	x	x	x	x	x	x	x	x
SmartSets (updated to include lab orders and immunizations in alignment with DHCS periodicity)	x	x	x	x	x	x	x	x	x	x	x
Diversity Equity and Inclusion Training (2025)	x	x	x	x	x	x	x	x	x	x	x
Race and Ethnicity Data Mapping Monthly for NCQA required MCAS measures (Quality)	x	x	x	x	x	x	x	x	x	x	x
Q&A for providers and staff on birthing challenges faced by Black birthing people						x	x	x	x	x	x
Community Level Activity											
QIHEC committee launched with stakeholders across the enterprise and community partners	x	x	x	x	x	x	x	x	x	x	
Contracted with NLE's to provide ECM and CS through subcontracted CBO's	x	x	x	x	x	x	x	x	x		
Grant Provided to Sac County WIC Program to fill Lactation Education Gaps						x	x				

Challenges, Opportunities, and Next Steps

Challenges	Identified Opportunities and Next Steps
Culturally and linguistically relevant health education materials for members to explain reasons for and benefits of service.	<ul style="list-style-type: none"> Utilizing translation services for new and existing member facing materials. Reviewing and updating existing materials for accessibilities for a variety of literacy levels. Cultural competency training for providers (2025).
Clinical Data Captures	<ul style="list-style-type: none"> Education to providers about essential documentation needed for accurate data collection. Optimization of visit templates and order sets to reduce clerical burden for providers. Incorporating outside data into our metrics
Recognizing Quality Opportunities	<ul style="list-style-type: none"> Converting sick-to well visits. Utilizing OBGYN and other non-pediatric visits for WCV 18-21 yrs.
Limited stratified data to support Bold Goals, HEQMS and NCQA race stratified measures	Building infrastructure to support QI efforts for Health Equity including: analyzing social vulnerability index for regionally based interventions and mapping race/ethnicity data monthly for MCAS required stratified measures.

Working Hand in Hand with Local Partners in Sacramento County

Kaiser Permanente is committed to improving the health of the communities we serve



Local Investments and Initiatives Include:

Mental Wellness & Homelessness

\$250,000 in grant funding and clinical mental health resources to five school districts serving more than 180,000 students and educators.

KP jointly funded a 75-bed, \$14M new medical respite center for discharged homeless patients. Additional **\$450,000 per year to seven agencies** to improve the capacity of the homeless response system across the County.

Health Equity & Access

\$200,000 to expand outreach, navigation, and enrollment support for Medi-Cal members including grants to **Community HealthWorks, La Familia Counseling Center, and Asian Resources Inc.,**

KP's new Community Health Care Program (CHCP) fills an eligibility gap for individuals who make too much for Medi-Cal. No premiums or co-pays on KP Platinum health plan.

Workforce Development

\$250,000 in grant funding to 10 agencies across Greater Sacramento that are increasing employment training and job opportunities for youth and adults who face barriers to employment. **\$50,000 in completion scholarships** for allied health students graduating from Los Rios Community Colleges certificate programs.

KP Launch offers young adults paid internship opportunities in Sacramento and Roseville hospitals, medical offices, and public affairs departments. The program goal is to build and sustain a diverse, culturally competent workforce for the future.

COVID 19 Emergency Response

KP Vaccine Equity Grants (\$985,000) regional grants to eight CBOs in Sacramento and Placer Counties administered over 31,000 vaccine doses. 60,000 individuals engaged through outreach efforts.

Grantees include **Health Education Council, La Familia, Sacramento ACT, Asian Resources Inc, Latino Leadership Council and more**



Molina's Presentation to Sacramento County Health Authority Commission (SCHA)

Bold Goals & Quality Performance Updates

August 13, 2024

MCAS Data Summary

MEASURE	SUB MEASURE NAME	MY2023	MY2022	MY2021
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Well-Child Visits in the First 30 Months of Life	Well-Child Visits for Age 15 Months-30 Months	18.86%	41.86%	34.20%
Well-Child Visits in the First 30 Months of Life	Well-Child Visits in the First 15 Months	58.09%	60.18%	63.16%
Child and Adolescent Well-Care Visits	Total	42.30%	49.10%	45.38%
Postpartum Depression Screening and Follow Up	Total	1.54%	-	-
Prenatal Depression Screening and Follow Up	Total	2.12%	-	-

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Quality Improvement Activities

	CIS 10	IMA - 2	W30 6+	W30 2+	WCV	PPC PRE	PPC PST	PDS-E Screen	PDS-E FU	PND-E Screen	PND-E FU
Member Level Activity											
Expand member incentive materials to be culturally appropriate for audience	x	x	x	x	x	x	x				
Multi-prong member engagement approach	x	x	x	x	x	x	x	x	x	x	x
ECM/CHW member HEDIS gap data sharing	x	x	x	x	x	x	x				
Provider Level Activity											
3 IPAs collaborating with Molina on SMART AIM/PDSA work	x	x	x	x	x	x	x				
8 FQHCs collaborating with Molina on SMART AIM/PDSA work	x	x	x	x	x	x	x				
Awarded IPP and HHIP Funding to ECM and CS providers to support capacity building, infrastructure, quality reporting	x	x	x	x	x	x	x	x	x	x	x
Community Level Activity											
Clinic days at Molina 1-stop centers					x						
Lunch and Learn session for key community partners through DHCS/CA Black Media to increase awareness of CalAIM services	x	x	x	x	x	x	x	x	x	x	x
Partnership with Continuum of Care (CoC) to receive HMIS data to better identify members who are homeless and improve unable to contact rates through additional data sources	x	x	x	x	x	x	x	x	x	x	x
Partnership with City/County on Homeless outreach pilot to impact members who are difficult to reach	x	x	x	x	x	x	x	x	x	x	x

Close racial/ethnic disparities in well-child visits and immunizations by 50%
Childhood Immunization Status (CIS 10)
Immunizations for Adolescents: Combination 2 (IMA-2)
Well-Child Visits in the First 30 Months of Life (W30 6+)
Well-Child Visits in the First 30 Months of Life (W30 2+)
Child and Adolescent Well-Care Visits (WCV)
Close maternity care disparity for Black and Native American persons by 50%
Prenatal and Postpartum Care (PPC PRE)
Prenatal and Postpartum Care (PPC PST)
Improve maternal and adolescent depression screening by 50%
Postpartum Depression Screening and Follow-Up (PDS-E SCREEN)
Postpartum Depression Screening and Follow-Up (PDS-E FU)
Prenatal Depression Screening and Follow-Up (PND-E SCREEN)
Prenatal Depression Screening and Follow-Up (PND-E FU)

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Key Challenges and Next Steps

Challenges	Next Steps
1. Members lack of awareness and knowledge of required infant well care visits, importance of immunizations, due to limited member resources.	Through QR codes, expanded member incentives, launch of Molina’s 1-stop help center
2. Data exchanges (no centralized HIE; multiple IPAs/FQHC systems)	Partner with vendor to receive ADT alerts; continue to partner with IPAs/FQHCs systems to ingest HEDIS supplemental data
3. System Migrations	Continuing to work with provider network to ensure data completeness
4. Insufficient uptake of doula benefit	Implemented a virtual doula and pregnancy support program Member notification letters describing benefit Improved call center talking points to assist members

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Community Partnerships in Sacramento County

Molina has reinvested over \$750k in Sacramento County CBOs, Providers, and County partners in IPP funds.

Through HHIP, Molina has invested over \$1.4M to address homelessness in Sacramento County through our partnerships with Sacramento Steps Forward, housing service providers, and street medicine providers.

Molina has participated in the All-In Sacramento process for planning the next steps in working to serve the unhoused population in Sacramento.

Molina has committed to train providers on Maternal Mental Health through Be Mom Aware, a project of the Sacramento Maternal Mental Health Collaborative.

Molina has also committed funding to develop the CHW workforce in Sacramento County, including infrastructure startup costs for providers and both direct and reimbursed training for CHWs.

Molina is using our Achieving Equity in Primary Care grant program to fund the changes necessary to increase preventive services in the PCP office. Funds are used for increasing in staffing, point of care services, etc. with a goal of creating a one-stop-shop for our Members.



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Agenda Item #6: SCHA Consultant NORC's Scope of Work Contract

Agenda Item #7: Public Comment

Agenda Item #8:

Closing Comments & Adjournment