L.A. Care HEALTH PLAN®

For All of L.A.

Provider Equity Award

Program Description
For all Lines of Business

(Medi-Cal, Cal MediConnect, L.A. Care Covered, PASC)

Measurement Year 2020
Report Year 2021

LA3491 09/21

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Contact Us

EquityAward@lacare.org: Provider Equity Award questions

Introduction: L.A. Care Provider Equity Award

The Provider Equity Award measures and rewards provider performance on health equity efforts, which includes reducing health disparities and addressing the social determinants of health. Health equity is the fair opportunity for everyone to attain their full health potential and that no one should be disadvantaged from achieving this potential **(Center for Disease Control and Prevention).** Providers have long recognized and worked to address member health disparities and the social barriers that impede equitable access to health and health care. The goal of this award is to highlight providers' efforts and focus on improving health equity for members.

The purpose of this document is to provide a description of the Provider Equity Award including its goals and criteria. This document also includes information on the data sources, time periods, measures, and methodology for each domain outlined below.

Eligibility for Provider Equity Award

This is the inaugural year for the Provider Equity Award. All clinics, Independent Physician Associations (IPAs) and solo and small group providers may participate among any lines of business. Award includes recognition at the annual L.A. Care provider recognition ceremony, publication in provider newsletters and other ways to publicly recognize awardee.

How to Participate

Participation in the award is not mandatory. The Provider Equity Award this year will be based on self-nominations from the health care entity. No payments are included for this inaugural year.

Submission

Details on submissions for demonstrated efforts to address disparities and social determinants of health are below. Write-ups and evidence will be emailed to L.A. Care for consideration of the Provider Equity Award. Health care entity/provider must provide evidence for disparities reduction and social determinants of health measures, the full Equity domain, to be eligible for the Provider Equity Award. **All materials are due to L.A. Care on October 15, 2021.**

Measure Selection

Measures are selected for their clinical relevance, opportunity for improvement, and relevance to and broad impact on L.A. Care's patient population (the award includes measures targeting chronic diseases and birthing individuals). Additionally, these HEDIS measures were selected based on wide disparities exhibited in these measures. Food security is the focus for the social determinants of health domain due to its evidence-based impact on health outcomes and it being an L.A. Care priority.

Methodology

The grading rubric for each domain will be used to enumerate the health care entity/provider's points based on submitted evidence. This score will be used to grade and rank the health care entities/providers. An L.A. Care committee will review and discuss final scores to select the final awardee.

Domain: Equity | Sub-Category: Disparities Reduction

Data Source	Document(s) submitted by Provider Clinics/Practitioner/IPA confirming disparities reduction program.
Year Start	2021. Inaugural Year. Participation not required.
Groups	• Clinics • Practitioners • Independent Physician Associations
Data Source Description	Provide program description that demonstrates the health care entity/provider does the following: 1. Identifies and prioritizes opportunities to reduce health care disparities among their patient population. 2. Implements at least one intervention to address a disparity. 3. Evaluates the effectiveness of an intervention to reduce a disparity. 4. Intervention improves outcomes for prioritized disparity.
Source Year	Measurement Year 2021, Report Year 2022
Included Measures	Program description of intervention describing disparity reduction on one of the following HEDIS measures. a. Comprehensive Diabetes Control (<8%) (CDC) b. Controlling High Blood Pressure (CBP) c. Prenatal & Postpartum Care: Timeliness of Prenatal Care (PPC) d. Prenatal & Postpartum Care: Postpartum Care (PPC)
Methodology	Clinics/Practitioner/IPA will email L.A. Care at **EquityAward@lacare.org** with program description as noted in the Data Source Description. Subject of email will be "L.A. Care Provider Equity Award – Clinics/Practitioner/IPA name - Disparities Reduction."
Weight of Measure Tool	50%
Grading Rubric/Criteria	Based on the documentation, the organization: 1. Identifies and prioritizes opportunities to reduce health care disparities. 2. Implements at least one intervention to address a disparity. 3. Evaluates the effectiveness of an intervention to reduce a disparity. 4. Intervention improves outcomes for prioritized disparity.

100%	80%	50%	20%	0%
The organization meets 3+ factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factors	The organization meets no factors

Domain: Equity | Sub-Category: Social Determinants of Health

Data Source	• Document(s) submitted by Provider Clinics/Practitioner/IPA confirming food security screening. • L.A. Care data sources – z-codes.
Year Start	2021. Inaugural Year. Participation not required.
Groups	• Clinics • Practitioners • Independent Physician Associations
Data Source Description	1. Provide write-up and evidence that demonstrates the health care entity/provider does the following: a. Screens members/patients on food security (i.e. evidence may include submission of PRAPARE, Hunger Vital Signs, or other screening tools that assess patient's food security). b. Offers member/patient resources for indicated food security need. c. Utilizes data from food security screener question. d. Improves outcomes for member/patient population when food security issues addressed. 2. L.A. Care will validate if health care entity/provider uses food security z-code: a. Z59.4 - Use of Lack of adequate food and safe drinking water.
Source Year	Measurement Year 2021, Report Year 2022
Included Measures	Food Security
Methodology	Clinics/Practitioner/IPA will email L.A. Care at **EquityAward@lacare.org** with write-up and evidence of food security screening as noted in the Data Source Description. Subject of email will be "L.A. Care Provider Equity Award – Clinics/Practitioner/IPA name - SDOH"
Weight of Measure Tool	50%
Grading Rubric/Criteria	Based on the documentation, the organization: 1. Screens members/patients on food security. 2. Offers member/patient resources for indicated food security need. 3. Utilizes data from food security screener question. 4. Improves outcomes for member/patient population when food security issues addressed. 5. Utilizes and submits z-codes to L.A. Care.

100%	80%	50%	20%	0%
The organization meets 5+ factors	The organization meets 4 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets no factors

Examples of Equity Award Submissions | Disparities Reduction Example

Background

Community pharmacists are one of the most accessible health care providers in patients' neighborhoods, especially in underserved areas. Along with the Los Angeles County Dept. of Public Health and Inland Empire Health Plan (IEHP), L.A. Care Health Plan has partnered with the University of Southern California's (USC) California Right Meds Collaborative (CRMC) to expand access to healthcare for our most vulnerable high-risk patient populations. Our goal is to develop a network of highly trained and experienced CRMC community pharmacies to manage chronic diseases and ease the burden on our strained primary care system. This program provides our members more opportunities to speak with a provider, vital especially during COVID-19 when access to care has become increasingly more difficult. The longitudinal chronic disease state management offered by CRMC is essential to decrease members' risk of COVID-19.

Rationale for the Community Pharmacy Value-Based Program – California Right Med Collaborative (CRMC)

As of 2015, more than 30 million Americans (9.4% of the U.S. population) had diabetes and a quarter of these cases (7.2 million) were undiagnosed[1]. Black/African American and Hispanic/Latino populations are disproportionately impacted by diabetes diagnoses. The non-Hispanic Black population is twice as likely to be diagnosed than non-Hispanic White population, and comprise 12.7% of the 1.5 million Americans diagnosed every year with diabetes[2]. According to Centers for Disease Control and Prevention (CDC), Hispanic/Latino Americans are 1.7 times more likely to have diagnosed diabetes for adults aged 18 years and older than their non-Hispanic White counterparts[3]. Black/African American and Hispanic/Latino populations are also more likely to suffer complications from diabetes, such as end-stage renal disease and lower extremity amputations[4,5]. Los Angeles (L.A.) County data matches national trends. Of L.A. County residents, 9.8% were diagnosed with diabetes, with Black/African American (13.7%) and Hispanic/Latino (10.7%) populations showing high diabetes prevalence[6]. L.A. Care historical data has shown that L.A. Care's Regional Consumer Advisory Committee (RCAC) 1 (Antelope Valley) and RCAC 6 (Compton, Inglewood, Watts, Gardena, and Hawthorne) have the highest rates of uncontrolled diabetes. As a result, L.A. Care Pharmacy Department decided to partner with USC School of Pharmacy to implement our community pharmacy program to address health disparities and to reduce the uncontrolled diabetes population. The community pharmacy program started in January 2020 and is currently ongoing. The main focus is on the Medi-Cal, and Cal MediConnect (CMC) memberships.

Enrollment Criteria

- Member A1c ≥ 9% within 30 days OR
- Member A1c ≥ 11% within 90 days

1 Centers for Disease Control. National Diabetes Statistics Report, 2020: Estimates of diabetes and its burden in the United States. (2020). https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf
2 Centers for Disease Control. National Diabetes Statistics Report, 2020: Estimates of diabetes and its burden in the United States. (2020). https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf
3 Center for Disease Control. Diabetes and Hispanic Americans. (2021) https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=63
4 American Diabetes Association. Treatment and Care for African Americans. (2014). https://care.diabetesjournals.org/content/37/10/2864
5 Spanakis, E.K. & Golden, H.G. (2013). Race/Ethnic Difference in Diabetes and Diabetic Complications. Current Diabetes Report. DOI: 10.1007/s11892-013-0421-9
6 County of Los Angeles Public Health. 2015 L.A. County Health Survey. (2015). http://publichealth.lacounty.gov/ha/LACHSDataTopics2015.htm

Intervention

- Enrollment in this program begins with L.A. Care, the primary care physician, or a clinic/FQHC referring high-risk members.
  - With the help from the Quality Performance Management (QPM) department and various Health Informatio Exchanges (HIE), L.A. Care pharmacy team identifies members who have uncontrolled A1c > 9% or A1c >11%.
- L.A. Care pharmacy technicians/clerks will outreach to the eligible members with a focus on the Black/African American, Latino, or Hispanic population residing in RCAC 1 and RCAC 6.
- If member is interested, we will refer the member to one of our partnered community pharmacists who will schedule the initial appointment and follow-up appointments.
- Pharmacist will conduct in-person or telehealth appointments to include:
  - Comprehensive medication review
  - Plan to overcome barriers to disease control (i.e. lifestyle changes, medication adherence, disease state education)
  - Recommended medication changes sent to provider
- Member will be considered at goal if A1c ≤ 8% or at least a 2% reduction with A1c < 9% (seen ≥ 6 months, and ≥ 5 visits) AND blood pressure < 140/90 mmHg AND on a statin therapy, if clinically appropriate. Member will then be discharged from the program.

Interim Results

To date, there are eight pharmacies participating in this program that have assisted 176 members including 164 Medi-Cal members and 12 Cal MediConnect (CMC) members (Table 1). Overall, there has been an average A1c reduction by 1.4%. By line of business, Medi-Cal members have a 1.6% A1c reduction, whereas CMC members saw a slight increase. However, due to the small CMC population (n=12) a large increase (+2.3%) by one member contributed to this result. Additionally, 67% of members in this intervention have a blood pressure <140/90 mmHG with 68% for Medi-Cal members and 60% for CMC members. At this time, there is a low enrollment of CMC members, but L.A. Care will continue to outreach to CMC members that fit the stated program criteria.

Table 1

Total # of Pharmacies	Total # of Members	Average A1c Baseline	Average A1c Reduction	% of members with BP < 140/90
		Total		
8	176	11.5%	-1.4%	67%
		Medi-Cal		
8	164	11.4%	-1.6%	68%
		CMC		
8	12	11.8%	+0.3%*	60%

*Small population pool. One member had an increase of 2.3% A1c and increased the overall average.

Examples of Equity Award Submission | Social Determinants of Health Example

Describe and attach food security assessment used.

The clinic utilizes the PRAPARE assessment. The assessment is attached. The assessment is provided to patients as they wait to be seen by the provider. The assessment is available in English and Spanish. Additionally, if the assessment needs to be translated an interpreter is called to go over the questions with the patient to ensure the assessment is performed for all required languages. The assessment is done before the provider examines the patient.

Describe and attach examples of resources provided to members/patients to address food security needs.

Patients are provided with CalFresh information. Clinic patient navigator assists patient with CalFresh sign-up. Referrals to L.A. Care's Saturday Food Pantry Event at the Inglewood Community Resource Center are also provided.

Show and/or attach examples of data aggregates used by the health care entity/provider.

	Patient Number
Total Number of Patients Screened	2,000
Total Number of Patients with Positive Food Security Screen	660
Total Number of Patients Provided with Resource to Address Positive Food Security Screen	500
Total Number of CalFresh Applications Submitted for Patients	75
Total Number of Successful CalFresh Applications Approved for Patients	60

Describe improved outcomes based on efforts, if available.

Our data shows that 95% (2000 patients) of all clinic patients are screened for food security needs. Of those screened, 33% have a positive screen. Seventy-six percent of patients with a positive screen were provided resources to meet this need. The clinic's patient navigators submitted 75 CalFresh applications for patients. To date, sixty have been approved from January to June 2021. The clinic will continue to build community-based partnerships focused on food security to refer patients to when there is a positive screen in order to increase the clinic's success rate. Additionally, the clinic will use and inform patients about L.A. Care's Community Link (**communitylink.lacare.org**), to identify additional food security resources.

(For additional information please refer to the American Academy of Family Physicians, Addressing Social Determinants of Health in Primary Care.[7])

7 American Academy of Family Physicians. Addressing Social Determinants of Health in Primary Care, Team-based approach for advancing health equity. Health in Primary Care, Team-based approach for advancing health equity.
https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/team-based-approach.pdf.