L.A. Care HEALTH PLAN
For All of L.A.

ECAC
Meeting Presentations

June 14, 2023

ELEVATING HEALTHCARE IN LOS ANGELES COUNTY SINCE 1997

Housing & Homelessness Incentive Program (HHIP): ECAC Update

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ELEVATING HEALTHCARE IN LOS ANGELES COUNTY
SINCE 1997

Karl Calhoun, Director, Community Health
June 14, 2023

HHIP Background & Overview

The **Housing and Homelessness Incentive Program (HHIP)** is a voluntary Medi-Cal Managed Care Plan (MCP) Incentive Program. There are two goals:

1. Help MCPs develop the capacity and partnerships to connect members to needed housing services, and

2. Reduce and prevent homelessness.

To earn funds, MCPs must meet 16 different program metrics. This requires collaboration with local partners.

For more information: https://www.dhcs.ca.gov/services/Pages/Housing-and-Homelessness-Incentive-Program.aspx

HHIP Background and Updates

Goals: Ensure managed care plans (MCPs) have the necessary capacity and partnerships to connect their members to needed housing services; Reduce and prevent homelessness.

Total Funding Available: $1.288 Billion statewide; L.A. Care: up to **$290** million

Local Homelessness Plan (LHP): Submitted & received 100%

Investment Plan: Submitted & received 100%

MP1 Report: Submitted & received $91.4M (90%) in May 2023

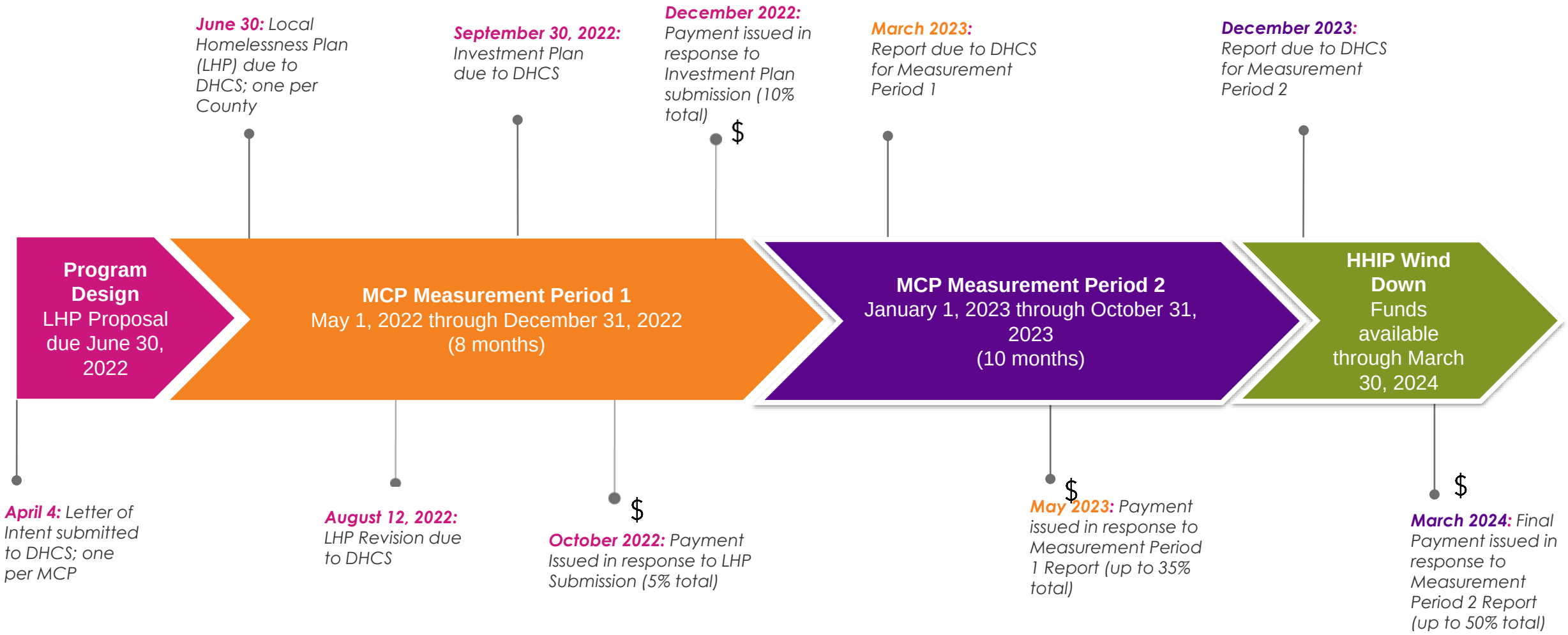
MP2 Report / S2 Submission: Due 12/29/2023; can earn up to $145M in March 2024 but expect more like $100M

HHIP Investment Priorities and Progress

Infrastructure: HIE, Data Exchange, Workforce	Street Medicine	Programs to Get & Keep People Housed	Unit Acquisition Strategy	Activities of Daily Living (ADL) Expansion Strategy
• **Investment to LAHSA** for data sharing and HMIS integration. • **Investment to Long Beach CoC** for data sharing and HMIS integration • **Investment to DMH** for data sharing • NEW: Medi-Cal application and renewal assistance for people experiencing homelessness	• **Investments to Street Medicine Providers** for Street Medicine Capacity Building • **Investment to CCALAC** for Technical Assistance, Training, and Capacity Building	• **Investment to Glendale CoC** for PSH through their Shelter Plus Care Program • **Investment to CEO Homeless Initiative** (see Unit Acquisition and ADL Expansion categories) • **Capacity building support for Enhanced Care Management and Community Supports**	• **Investment to CEO Homeless Initiative** to make it possible to lease entire buildings by covering non-rent costs, paired w/tenant-based vouchers. Partner with COCs and County to increase utilization of tenant-based vouchers. Funds will cover long term costs of "slots" in order to unlock funding for third-party leasing	• **Investment to CEO Homeless Initiative in partnership with DHS Housing for Health** to fund field-based team to assess individual ADL needs for PEH, provide caregiving in interim housing for PEH w/ADL needs, and provide enhanced services funding to get members placed in Adult Residential Facilities (ARFs) and/or Residential Care Facilities for the Elderly (RCFEs)

Sources:	Stakeholder meetings with counties, COCs, Enhanced Care Management and Community Supports providers, CBOs, Clinics, MCP Collaborations, Lived Experience Advisory Board Feedback

HHIP Timeline



HHIP L.A. Care Main Points of Contact

L.A. Care Health Plan
Karl Calhoun, Director Housing Initiatives, kcalhoun@lacare.org Alison Klurfeld, Consultant, alison@klurfeldconsulting.com

Thank you

Diabetes Awareness & Intervention Updates

Alison Patsy, MHA
Quality Improvement Project Manager II

June 13th, 2023– ECAC

Objectives

- Discuss L.A. Care's Diabetes Intervention objectives and barriers.
- Update the committee on Diabetes Interventions.
- Ask the committees advice for other ways to encourage and empower members to manage their diabetes.

Self-Management of Disease[1]

- Empowering diabetes patients to take control of their health outcome:
  - Understanding diabetes and diabetes treatment through health education.
  - Healthy eating, being physically active
  - Taking medication
  - Checking blood sugar (self-monitoring)
  - Regular visits to the doctor for diabetic screenings
  - Participate in Diabetes Self-Management Education and support programs

[1] https://www.cdc.gov/learnmorefeelbetter/programs/diabetes.htm

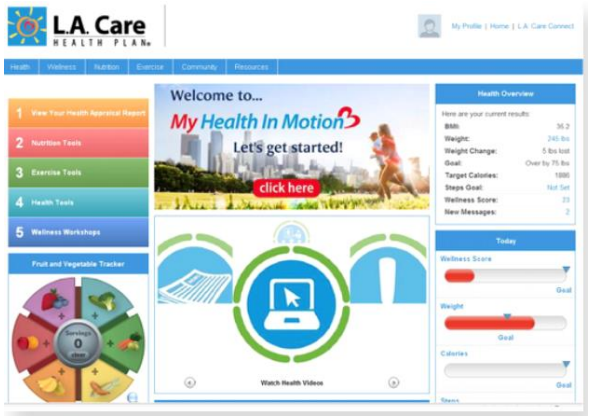
Barriers to Managing Diabetes

- Lack of provider-patient engagement
- Medication adherence
- Lifestyle changes
- Negative emotions about diabetes
- Lack of social support

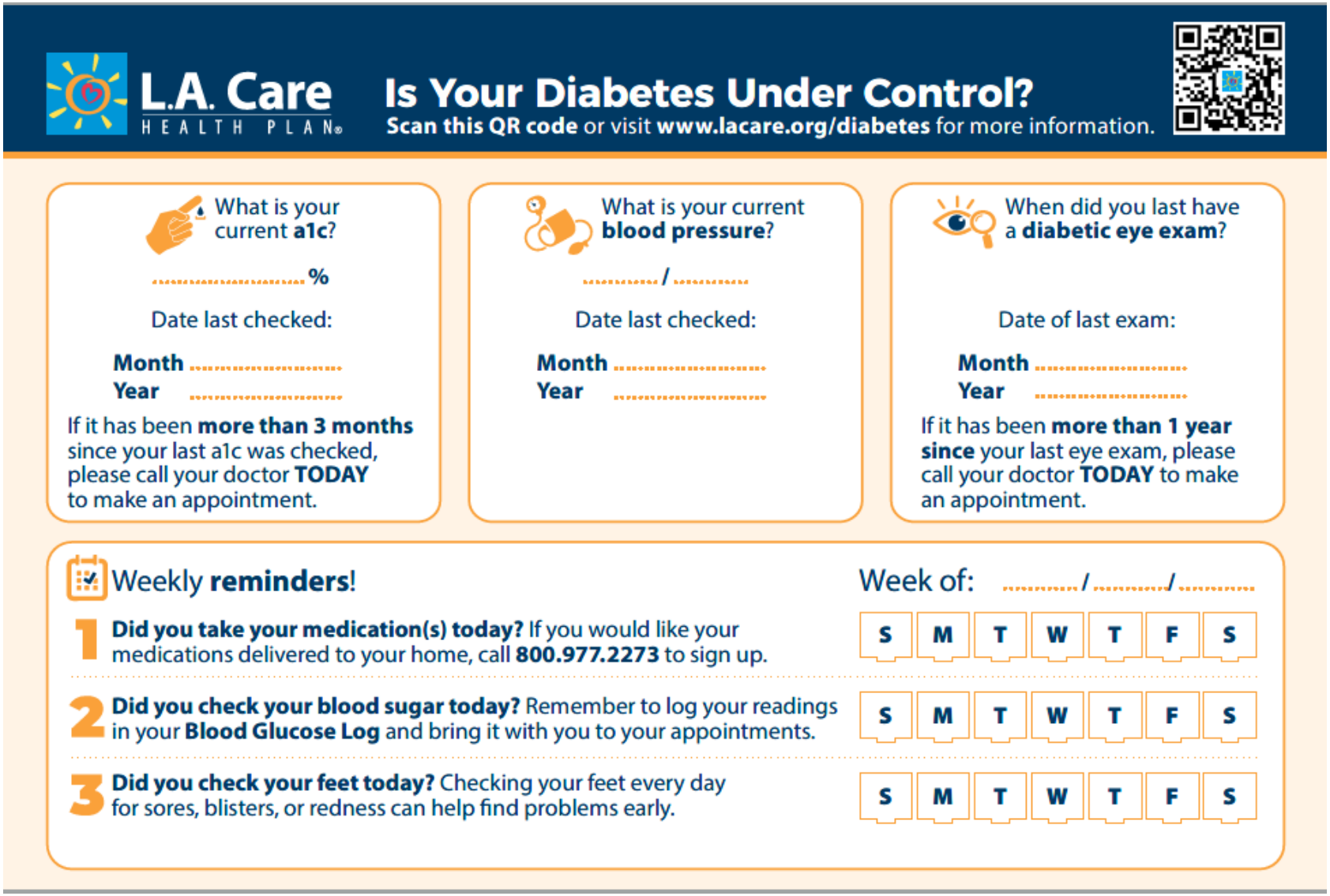
What has L.A. Care done?

- L.A. Care does the following to encourage members to visit their doctor regularly and manage their diabetes:

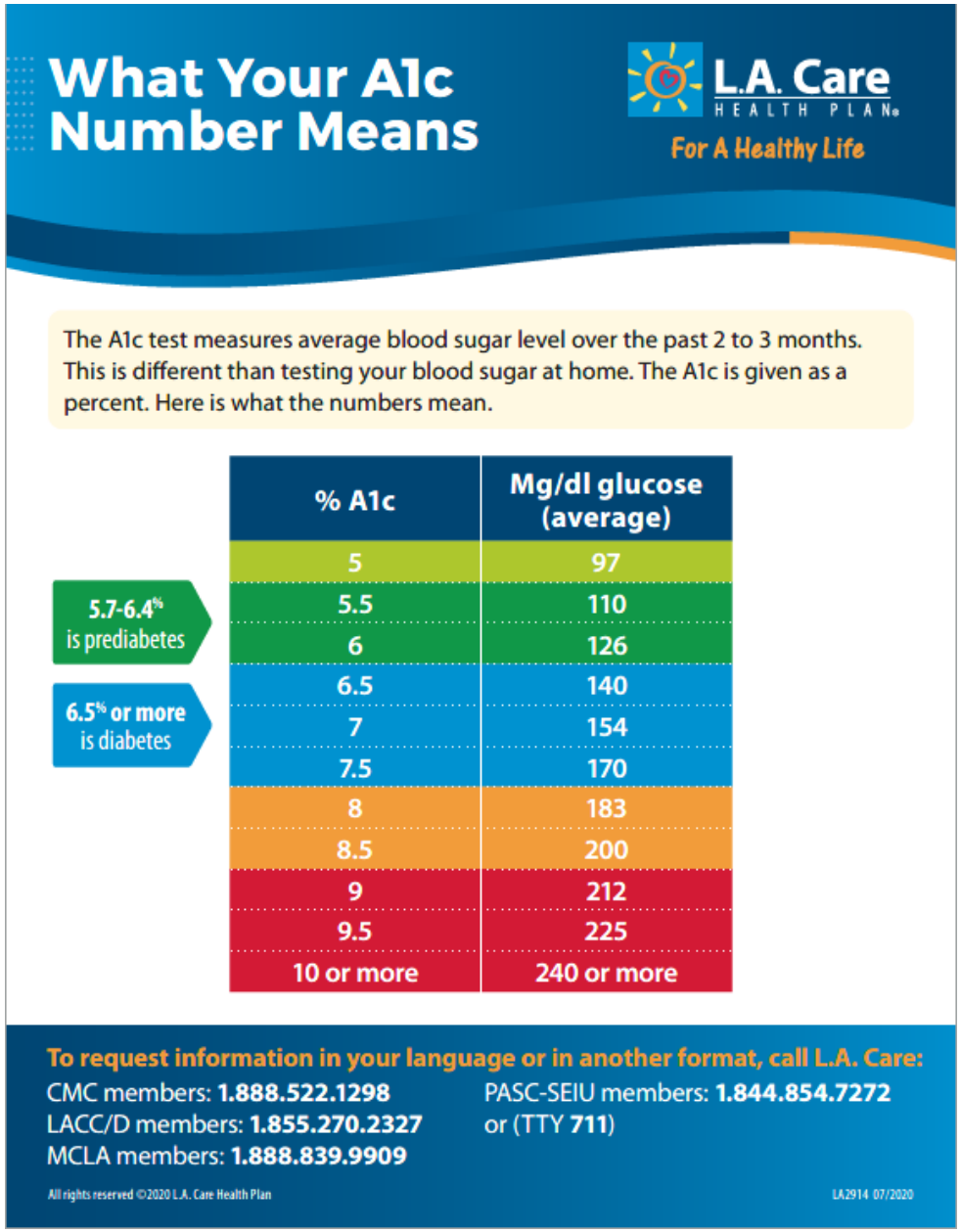
  - California Right Meds Collaborative (CRMC)
  - IVR Calls
  - Text-Message Campaigns
  - L.A. Cares About Diabetes® Program Member Letters
  - Diabetes Magnet Mailer



Example of Diabetes Magnet



Example of Health Education



What Your A1c Number Means

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The A1c test measures average blood sugar level over the past 2 to 3 months. This is different than testing your blood sugar at home. The A1c is given as a percent. Here is what the numbers mean.

% A1c	Mg/dl glucose (average)
5	97
5.5	110
6	126
6.5	140
7	154
7.5	170
8	183
8.5	200
9	212
9.5	225
10 or more	240 or more

5.7-6.4% is prediabetes

6.5% or more is diabetes

To request information in your language or in another format, call L.A. Care:

CMC members: **1.888.522.1298**
LACC/D members: **1.855.270.2327**
MCLA members: **1.888.839.9909**
PASC-SEIU members: **1.844.854.7272** or (TTY **711**)

LA2914 07/2020

Example of Text-Message Campaign

"<<First Name>>, You can control your diabetes! See your doctor at least twice a year. Your doctor will review your care plan and check your blood sugar and blood pressure. Schedule an appointment at {PcP Phone} especially if you are a new member."

"<<First Name>>, We understand it's hard to eat healthy. Here are some tips:

- Text A for tips to cut down on portion size
- Text B for tips for foods that don't raise blood sugar quickly

At your next diabetes screening, ask your doctor for healthy eating tips. Call your doctor at {PcP Phone} today.

"<<First Name>>, did you know that diabetes can affect your kidneys over the years? Here are some signs of unhealthy kidneys:

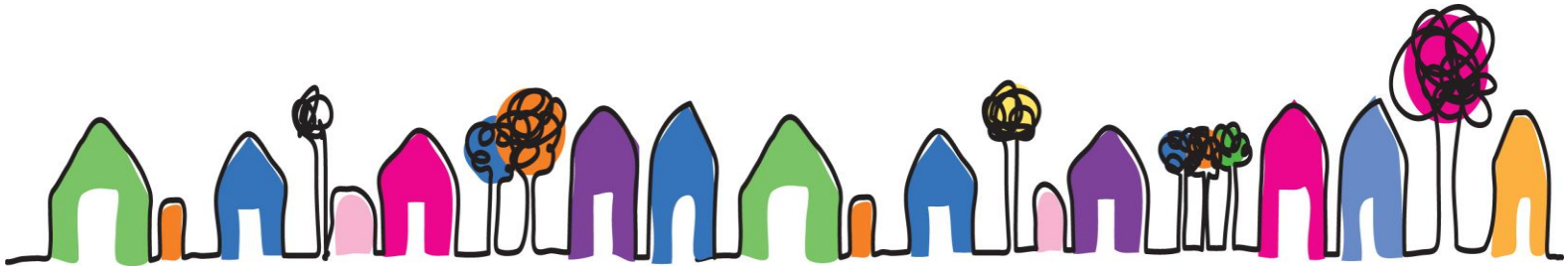
1. Swelling in your legs
2. Headaches
3. Feeling Tired

"Taking care of your feet when you have diabetes is important. Have you had your diabetes foot exam Mbr First Name? Numbness, tingling and weakness in feed can be symptoms of diabetic neuropathy. With checkups at leas twice a year, you can live a long, healthy life!

What else can L.A. Care do to help members manage their diabetes?

Awareness is Power!

Thank you for your help in our efforts to build healthy communities!



L.A. Care's Health Equity: Path, Philosophy and Plan

Executive Community Advisory Committee

L.A. Care HEALTH PLAN

For All of L.A.

June 14, 2023

Alexander (Alex) Li, MD

ELEVATING HEALTHCARE IN LOS ANGELES COUNTY SINCE 1997

Path to Health Equity at L.A. Care

- Part of L.A. Care's DNA (Mission)
  - Explicitly calling out and addressing "Health Equity and Disparities"
    - Statement of Principles on Social Justice and Systemic Racism (2020)
      - Established an Equity Steering Committee and three sub-committees: Members/Consumer Health Equity Council, Providers, L.A. Care Team (Staff)
  - Inaugural Chief Health Equity Officer (CHEO) -James Kyle, MD (2021-22)
    - Health Equity Department

- New Chief Health Equity Officer (Alex Li, MD) began in March 2023
  - Develop a Health Equity and Disparities Mitigation plan
  - Build upon the existing work
  - Lead where there are gaps
  - Measure impact
  - Ensure compliance*

L.A. Care | Health Equity

Path and Observations

- Many people have their own definitions of “health equity” or specific disparities that they focus or work on.
  - Target rich environment
  - Changes and impact will take time
    - Many disparities initiatives are not connected or coordinated.
      - Work needs to be synergistic and coordinated and not territorial; Can’t do it alone!
  - Many L.A. Care Departments work on health equity:
    - E.g. Community Resource Centers, Community Health, Community Benefits, Health Education, Quality Improvement etc.
- “Health Equity” requirements are written into L.A. Care’s DHCS and Covered California contracts and for our future NCQA accreditation.
- CHEO for the health plans are not all physicians or have worked at a health plan.
  - Best to be familiar with the health plan resources and align with the mission

Philosophy

- **The Who? (Priority Populations and Initiatives)**
  - L.A. Care and/or community members
  - Mom and young kids
    - Birthing individuals/moms, infants and young children (TANF ~1.2M)
      - Preventive measures and services (e.g. perinatal services, vaccines)
    - Black women and infants (FY 21-22 ~1,500 births)
  - Homeless/unhoused individuals (~50K)
  - School-aged children and teens (650K)
  - Other key anchor areas and social drivers of poor health
    - E.g. Gun violence prevention, “Food as Medicine,” closing technical/digital divide
  - Optimize health plan and community resources for our members and the community

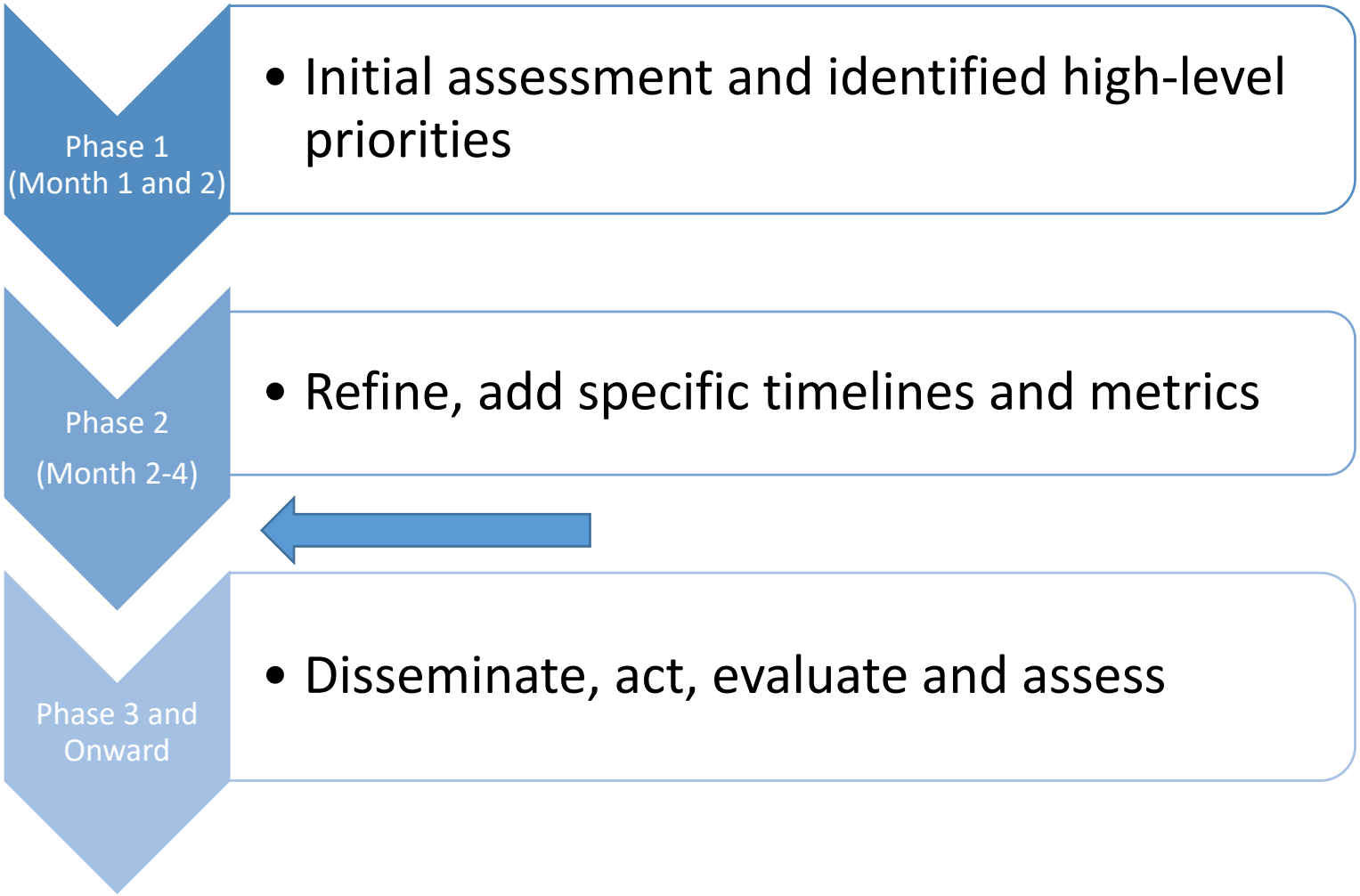
Philosophy

- **The What? (Focus Area)**
  - Use a public health and community foucs framework
  - Support and work with L.A. Care service areas and initiatives that impact health equity
  - Target and when possible work with programs that are sustainable

- **The How! (Getting things done)**
  - Leverage and partner with existing departments and community based organizations
  - Lead in areas where additional health equity work needs to be done or be a “Chief Health Equity Coordinator” when needed
    - Example: Black Infant and Women’s Health
  - Measure impact
  - Ensure Compliance

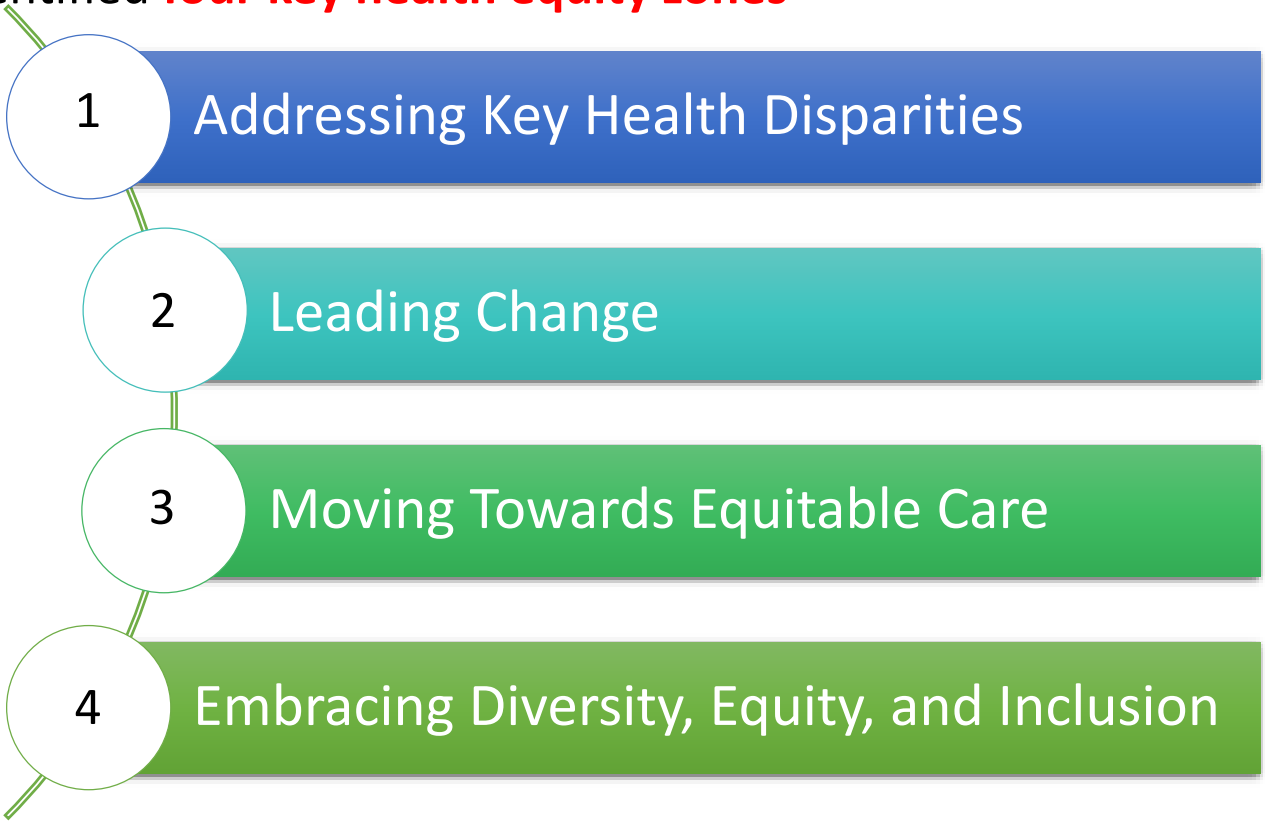
L.A. Care. Health Equity

Our Approach and Action Plan



Health Equity and Disparities Mitigation Plan and Health Equity Zones

- Informed by L.A. Care's history of work within and for the safety-net, member needs, our community partnerships, and internal assessment.
  - Identified **four key health equity zones**



L.A. Care. Health Equity

Address Health Disparities

Health Equity Zone 1: **Close racial and ethnic gaps in health outcomes among our member.**

- Implement interventions to **increase vaccination rates for children 2** and younger
- Implements initiatives to **address health for Black birthing individuals and infants**
- Strengthen **provider network for unhoused community**
- Expand physical and behavioral **wellness programs for school age youth**
- Address disparities for **Black, Latino/Hispanic, AIAN communities with chronic disease**

Lead Change

Health Equity Zone 2: **Provide leadership and be an active ally for key community partners to promote health equity and social justice.**

- **Create partnerships and shared agendas** with internal and external partners
- Promote **gun violence education and prevention**
- Explore and identify **additional areas for advocacy**
  - Community Health Investment Fund, Elevating the Safety Net
  - Medical Debt Relief
  - Community generated and drive improvements

L.A. Care. Health Equity

Move Towards Equitable Care

Health Equity Zone 3: **Ensure that our members have access to care and services that are free of bias and that our providers are supported in delivering equitable, culturally tailored care.**

- Improve **data collection and analysis**
  - **REaL and SOGI**
- Strengthen **SDOH data** collection
- Promote patient and **provider concordance**
- Promote health equity through **Provider Equity Award**
- Health Equity in **Appeals and Grievances and Utilization Management and other key health plan processes**

L.A. Care. Health Equity

Embrace Diversity, Equity, and Inclusion

Health Equity Zone 4: **Serve as a model in supporting an equitable and inclusive work environment, as reflected in our workforce and business practices.**

- **DEI training plan**
- **Compliance** for all regulatory, contractual, and accreditation **health equity requirements**
- Support **diverse employees** and allow equitable **opportunity to advance and thrive**
- Promote health equity through **Provider Equity Award**
- Provide employees with **training and tools** they need to provide **bias-free services and care**

Framing Questions and Areas for Guidance

- How can we do a better with engaging you and our members?
  - Frequency?
  - Regional Community Advisory Committee?

- What other health inequities and health disparities are you concerned about?

- What would you like to see to make the future conversations productive and where we can develop some regional action plan?