From Housing to Nutrition: We Use Data to Improve Whole-Person Care

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Why Whole-Person Care and Health Equity Matter

By Dr. Pooja Mittal

Each and every person has different roles and aspects of their life that matter to them.There's our personal life, work life, social life and more. For instance, I'm a mother of three, practicing family doctor and the Chief Health Equity Officer at Health Net.

Throughout my career, I've recognized the **importance of devoting attention and taking action to improve whole-person care.** When I interact with someone at my clinic, they may come in with the complaint of fatigue or stomach pain. In addition to evaluating these physical issues, I also prioritize talking with them about relationships, social needs, their job, stress and other factors that contribute to their overall health. Often, these social drivers are contributing in a significant way or even at the root of their physical ailments.

By addressing the whole person, we can better support people and improve their health outcomes All Californians deserve quality whole-person care, regardless of race, ethnicity, ability or any other factors.

Introduction

Better outcomes rely on better decisions based on better data. That ideal sequence doesn't happen in a vacuum. The challenge? To implement this approach across the health care ecosystem, including:

- Health plans
- Providers
- Community-based organizations (CBOs)
- Regulators

The question is, "How?" Resources and information seem like clear answers. But through a strategic approach we can get the best results through focused, steady goals. To effect change, we need to all agree on methods to reach our desired results. And, how to measure the progress.

For example, after childbirth, the care team (doctor, nurses and others) measures and tracks the vital signs of both parent and child to decide the care needed.

The same occurs when someone goes to the Emergency Room for a possible stroke.

Or, when a person who hasn't seen a doctor in years visits a health clinic.

In each instance, the amount of time for study and review differs case by case. Part of which includes data and facts that can affect care choices or health status.

Health Net knows that high quality of care must be equitable. That begins with innovative approaches and performance-based data to measure.

It's simple.

As data improves and needs are revealed, we need to assess which measures help and which don't. This includes:

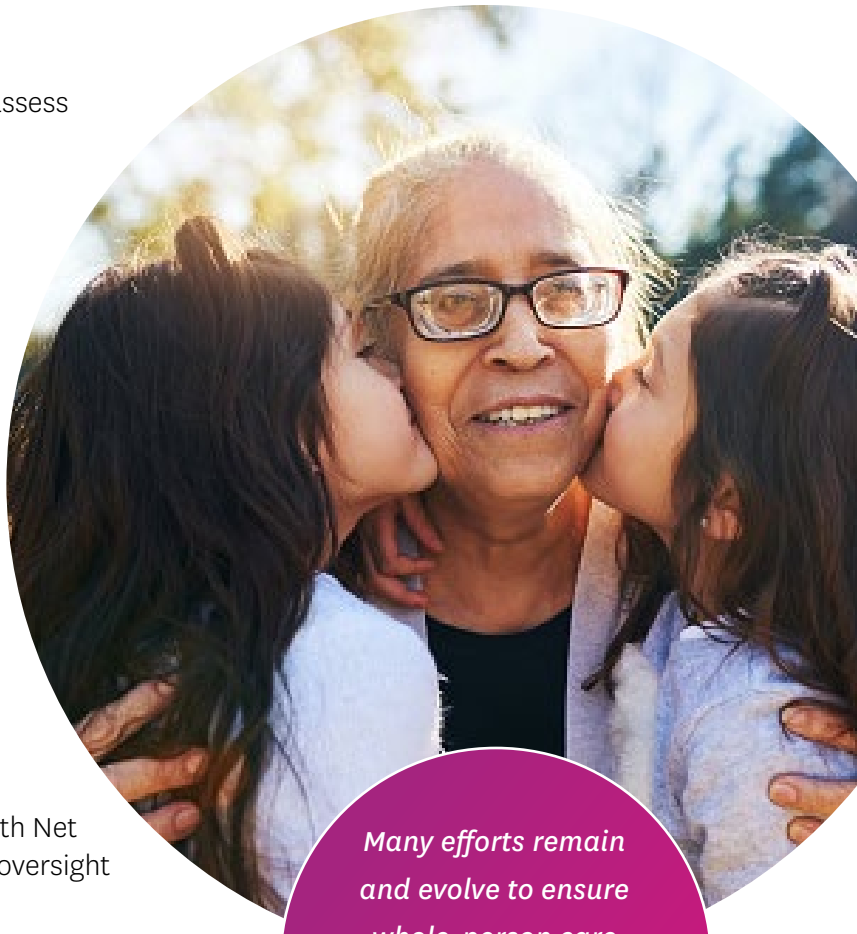
- Diabetes care
- Substance use
- Behavioral health
- Ways to reduce health disparities and more

Health Net increased our investments to get better patient encounter data[1] and to improve outcomes for all patients.[2] Our Encounter Data Improvement Program, a $50 million commitment, came through collaboration with the California Department of Managed Health Care. We also awarded funds to the Integrated Healthcare Association (IHA) to assess needs and pain points for:

- Dozens of frontline providers
- Provider organizations

The work, however, is far from finished. Through a Health Net grant, IHA will act as the Governance Entity to provide oversight in this field across California. That means IHA will:

- Oversee technical training and data regulation affairs
- Manage stakeholder communications
- Offer guidance on budget processes
- Direct business planning and funding efforts
- Provide data measurement and management impacts
- Act as liaison between regulators and industry partners
- Form workgroups and advisory boards



Many efforts remain and evolve to ensure whole-person care improves, not just for Health Net or Medi-Cal members.

[1]Providers collect encounter data during each patient visit or interaction. This creates a record of conditions and services, which is then goes to Managed Care Organizations (MCOs) for reimbursement.

[2]More information about these grants can be found in our "Innovating Within Medi-Cal" issue brief.

Data Can Improve Quality Outcomes for Health Net Members

KEY ELEMENTS

With a focus on many key health issues, we can address and reduce health Disparities. That includes those prioritized by the California Department of Health Care Services and National Committee for Quality Assurance (NCQA).[3]

The State of California has **Bold Goals for 2025,** which include:

- Reduce racial and ethnic disparities in well-child vaccinations by 50%.
- Reduce maternity care disparities for Blacks and Native Americans by 50%.
- Improve maternal and teen depression screening by 50%.
- Improve mental health and substance use disorder follow-up by 50%.
- Make sure all health plans exceed 50th percentile for all children's preventive care measures.

THE OUTCOMES

Health Net has received acclaim for our work on health equity. This includes awards from DHCS and NCQA. In 2023, we continue to champion that **every Californian deserves quality care at each stage of life.**

At the end of 2022, Health Net had nearly three million members – across all lines of business:

- About half (48%) self-identified as Hispanic/Latino, 12% Asian and 7 % Black
- Members spoke more than 150 languages
- Interpreters handled about 107,500 telephone calls
- Interpreters, including sign language services and video remote, conducted more than 8,000 in-person visits
- Members received materials in 77 translation and alternate formats[4]

Some of Health Net's key health equity metrics (measures required by NCQA for stratification by race/ethnicity for Health Equity Accreditation Plus) focus on:

1. Colorectal Cancer Screening (COL)
2. Controlling High Blood Pressure (CBP)
3. Hemoglobin A1c Control for Patients with Diabetes (HBD)
4. Prenatal and Postpartum Care (PPC)
5. Child and Adolescent Well Care Visits (WCV)

[3]https://www.ncqa.org/blog/stratified-measures-how-hedis-can-enhance-health-equity/

[4]Does not include pre-translated items sent to members in their preferred languages. Translation services are available for threshold languages, which vary by line of business and/or county).

Ensuring our members have knowledge of Health Net's various partnerships, programs and resources is essential to providing the highest level of quality care.

– Dr. Pooja Mittal

A prime example of our strategic and focused approach

Did you know that Black women are three to four times more likely to have a pregnancy or childbirth-related death than White women?

Studies show Black mothers have more poor health outcomes.
Many levels of racism exist in our society's systems and cultural values.

The Institute for Medicaid Innovation recently recognized our partnership with the California Coalition for Black Birth Justice. **We support UCSF Preterm Birth Initiative and Cherished Futures for Black Moms & Babies, through a $150,000 grant.** The grant helps create a roadmap and strategy to improve Black maternal health outcomes statewide.

Maternal health efforts also include implementation of programs and initiatives to reduce infant mortality and close the care gap.

The Community Doula Project helped pregnant women with support during and after childbirth. The results showed why doula care matters within our state. The project focused on the high rates of cesarean sections (c-sections) for our African-American members in Los Angeles. The rate of c-sections for African-American mothers went down from 70% to 10% in less than six months. And, we are happy to have been part of the process to launch the new doula benefit!

Information Sharing Enhances Collaboration and Care

KEY ELEMENTS

Teamwork, both internal and external, drives our work toward better whole-person care.

PROCESS

Health Net uses Population Health Management data to decide where and how Californians in certain parts of the state can use our mobile/RV services most. We've used data to help at-risk members affected by severe weather events. We've also used data to warn residents in prior to threats, such as snowmelt and flooding. This included support such as:

- **Emergency contact information**
- **24/7 Nurse Advice Line**
- **Transportation services**
- **Phone outreach to impacted members**
- **Support with medications**

In addition, both Centene[5] and Health Net, use a platform (Epic Payer) that allows for data exchanges with hospitals and provider offices. The transfer of patient medical records quickly and securely is critical, especially in an emergency.

We also funded the expanded use of Cozeva. Cozeva is a population health platform that shares information with providers regardless of the health plan for the member. This helps providers know which vaccinations children need, which resources help pregnant women and which health conditions patients have.

[5]Centene Corporation is a diversified, multi-national health care enterprise that provides a portfolio of services to government-sponsored health care programs, focusing on under-insured and uninsured individuals. Centene acquired Health Net in 2017, but the latter continues to function as a health plan at the state-level.

Our Quality Improvement and Health Equity teams also find diverse needs and align ways to reduce care gaps.

Our Health Equity team leads projects to reduce disparities. Some of their partners have included:

Gospel Center Rescue Mission to create a 20-bed Homeless Women Recuperative Care Center

Neighborhood Initiatives Project to help the Black population in Los Angeles County with childhood vaccinations and well-child visits for the first 30 months of life

Los Angeles PPC Project to improve prenatal and postpartum care for Black women

The Source LGBT+ Center to provide indoor and courtyard places for 3,000 people each year to gather for events, learn about resources or find a safe space

Vouchers for Veggies to help more than 330 Central Valley families. In three communities (Yuba/Sutter, Stockton and Modesto), those families get access to fresh fruits and vegetables

Health Equity Accreditation Plus (via NCQA) requires a yearly disparity review for each line of business.

For any NCQA rules that involve quality metrics, our Quality Improvement team takes the lead. Plus, our Health Equity team provides support to ensure any changes or updates have the correct cultural and linguistic elements.[6]

Our Health Equity Team acts as consultants to internal departments on any issues related to:

- Race and Ethnicity
- Spoken and Written Language
- Sexual Orientation and Gender Identity (SOGI)

[6]Health Net uses segmented data by race/ethnicity and public use microdata areas (PUMA). Disparities identification comes via the lowest-performing population for each measure. The determination then occurs for which PUMA has the lowest compliance rates for the lower-performing population.

Innovation Occurs Through Action

KEY ELEMENTS

Funding and investments need to combine with partnerships and targeted campaigns for real change.

PROCESS

We meet people's needs where they are and when they're at their greatest through:

- Assessments
- Resources
- Policy changes
- Personalized outreach
- Tools, support and more

We can't do it alone and instead rely on our statewide, regional and local partners for help. From community-based organizations (CBOs) and foundations to policymakers and government agencies – they all lend insights and help make progress towards equal health care access for all.

Health Net will invest up to $34 million to help unhoused people in the Los Angeles area. Our partnership with L.A. Care Health Plan and the Los Angeles County Homeless Initiative brings the total to $114 million. The funding will secure leases on as many as 1,900 housing units. It will also pay for:

- Vacancy coverage
- Damage repair
- Trash services
- Greenspace
- Maintenance and/or pest control

Funding will also help pinpoint the needs of unhoused people and define who needs help with Activities of Daily Living (ADL) to move into stable housing. This is vital due to the number of seniors and people with disabilities who deserve a place to call home.

Expanded Access and Enhance Techquity (Digital Health Equity) Helps All Californians

KEY FINDINGS

Virtual services help to bridge the divide and reach people who may otherwise fall through the cracks.

PROCESS

We leverage data gathered with our partners to ensure greater access in community health clinics, schools and neighborhoods to help all Californians. This includes efforts with:

- Local providers
- Project Angel Food
- Hazel Health
- Kinsa
- Sacramento Native American Health Clinic and more

Project Angel Food – a Community Supports meal provider to Medi-Cal members

Health Net partners with Project Angel Food, one of our Community Supports meal providers, through CalAIM. Project Angel Food prepares and delivers over one million medically-tailored no-cost meals each year.

Clients get a custom menu and nutrition plan with their care manager and a registered dietitian. The Project Angel Food kitchen makes 13 versions of each menu.

Insight from Project Angel Food helps to:

- Educate Medi-Cal members
- Refer Medi-Cal members to services
- Improve review of member eligibility and referrals
- Enhance teamwork to align policies and practices that benefit members

Hazel Health – school-based telehealth company

Health Net has partnered with the Los Angeles County Office of Education, L.A. Care Health Plan and the L.A. County Department of Mental Health to bring no-cost mental telehealth services to Los Angeles school children in grades K-12. The services come via Hazel Health.

Health Net and L.A. Care Health Plan will **give up to $24 million over two years** to cover the cost of the program. **Hazel Health expects to provide Mental Health support for more than 1.3 million L.A. County students.**

The partnership comes at a critical time. Research shows 1 in 14 California children has an emotional disturbance that limits how they function in family, school or community activities.[7]

Kinsa Health – an early warning system to detect and respond to contagious illness

In December 2022, Health Net started to work with Kinsa. Kinsa helps support members with information about flu and COVID-19 and protection from sickness. User engagement grew and beat industry standards. That includes more email opens and higher click rates.

More than 80 percent of users[8] took preventative actions when they got health alerts. Others took more than one action, such as:

- Wear a mask again or more often (54%)
- Avoid large public events (51%)
- Wash hands more often (39%) or
- Get a COVID or flu shot (30%)

Sacramento Native American Health Clinic (SNAHC) – a non-profit 501(c)(3) Federally Qualified Health Center in midtown Sacramento

SNAHC works with Kinsa to plan for how illness might impact their need to remain flexible with their appointment schedules. Clinic physicians had done the vast majority of COVID testing and triage. **A forecast via Kinsa on caseloads lets SNAHC know how many in-person visits may occur.** It also enables limits on other types of visits to allow for more same-day access for those who are ill. Insights also inform general capacity to process respiratory health visits, including testing capacity.

[7]Source: 2022 California Health Care Almanac

[8]Survey conducted of pilot members.

Conclusion

Whole-person care and health equity continue to influence how we work to help all Californians. We will keep up efforts to improve data collection to gauge success, share information for better collaboration, innovate through action and expand access for techquity.

We know that empowerment in communities includes solutions for social drivers of health and focus on patients, their families and providers. This will help us reach people in the ways they want us to reach them.

Change fatigue exists. But, as we look at ongoing work and what's left to do, it's important to celebrate progress and successes with our partners.

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