Quarter 1 2025 Santa Clara County Public Health/Anthem Quarterly MOU Meeting

Date & Time February 18, 2025
Frequency Quarterly
Location Virtual
Meeting Leader Kalil Macklin

Attendees

Organization	Name & Title	Attended
Santa Clara County Public Health Department	Grace Meregillano	☒
	Rami Keisari	☒
	Beverley Macklin-White	☒
	Vivian Wong	☒
	Emma Mendez	☒
	Heidi Owens	
	Arianne Mine	
	Tonya Robinson	
Anthem	Kalil Macklin	☒
	Liz Tullis	☒
		☐
		☐
		☐

Agenda

	Topics	Presenters
I.	**Welcome & Introductions**	All
II.	**Follow-up Items** 1) 2)	All
III.	**MOU Updates:** Hopeful to sign these MOUs by Q2 1) **LHD/WIC MOU** 2) **IHSS/CWDA MOU** 3) **First Five MOU** 4) **Child Welfare MOU** 5) **Regional Center MOU**	Anthem

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<table>
<tr><th>Topics</th><th>Presenters</th></tr>
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IV. County Program Updates

1) General Updates- No Updates
2) Immunization (IZ) - No Updates
3) Sexually Transmitted Disease (STI) - No Updates
4) Tuberculosis (TB) - No Updates
5) Maternal Child and Adolescent Health (MCAH) - No Updates
6) California Children Services (CCS)

- CCS Program Update: Emma and Heidi provide updates on communication improvements with health plans for patient transitions, particularly transitioning out of Medi-Cal or CCS.
- Starting July, CCS will share transition plans with Anthem for all transitioning patients.
- CCS currently has 980 active Anthem clients, among which 126 are receiving medical therapy. Of these, 76 have cerebral palsy and require more intensive care.
- Children with cerebral palsy may qualify for ECM services. Discussion needed on sharing information about which CCS kids are enrolled in ECM.
- CCS can provide Anthem a list of patients to help identify those already enrolled in ECM, fostering collaboration.
- Anthem identified an HIV-positive patient at Valley Medical Center who should be referred to CCS, highlighting a potential gap in patient referrals.

7) Childhood Lead Poisoning Prevention Branch (CLPPB) – Blood Level Screening
8) Women Infant and Children (WIC)

- WIC Participation Update: Slight decrease in family participation within the county, potentially due to various reasons.
- Vivian is closely observing whether current administration changes are affecting caseload and participation.
- No changes in federal funding; WIC continues to serve families as usual.
- MOU Finalization: Looking forward to finalizing the MOU to address any gaps for Anthem members.

9) CCHP- No Updates
10) NFP- No Updates
11) Black Maternal Health Outcomes - No Updates
12) Black Infant Health (BIH)

- BIH Activities for Black History Month:
- Busy schedule includes Black Family Day, Black Joy Parade, and a "Walk with Me" event emulating the Selma walk, focusing on Black maternal health history.
- BIH's efforts have been recognized in a state-published journal, confirming their status as an evidence-based program with notable outcomes for African ancestry women.
- BIH has fully implemented in-person group sessions, currently running prenatal and postpartum group series.

</td><td>Santa Clara County Team</td></tr>
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• Released in November 2024 in response to requests from the Board of Supervisors to demonstrate BIH and PEI program outcomes related to Black infant and maternal health. • Previously had statewide data; now includes local data for better insight. • Reduced Disparities: • 30% lower maternal hypertension rates in BIH participants (7.7%) versus non-participants (11.8%). • 27.1% enrollment rate among eligible Black birthing people in 2003, showing a steady increase. • 100% satisfaction with doula services. • 92% improved stress management reported in BIH. • 78% reported stronger cultural identity reinforcement. • Qualitative Success Drivers: • Crisis support, homeless assistance, and hospital navigation. • 42% reported better-informed medical decisions. • Community and Doula Support: • Lifelong community connections and the 360 Doula Support Program. • Lactation specialist access improved breastfeeding outcomes (88%). • Quantitative Data (2015-2023): • Hypertension: 34.7% decrease in maternal hypertension rates for participants. • Gestational diabetes: 13.8% detection in participants vs. 9.2% in non-participants, showing a 50% screening increase. • STI screenings: 89% in participants vs. 72% in non-participants. • Postpartum depression: 18% in participants vs. 27% in non-participants, a 33% decrease. • Doula Program Impact: • 92% positive birth experience ratings. • 85% reported faster postpartum recoveries. • Overall Impact: • Both BIH and PEI programs have shown significant impacts on Black infant and maternal health in the community. • Plans to publish program outcomes in collaboration with the science branch. • Seeking feedback and collaboration opportunities to raise awareness of the program. • Willing to present outcomes to partners and stakeholders. 13) SIDS- No Updates 14) Foster Care- No Updates 15) Home Visiting- No Updates	

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16) Adolescent Sexual Health Advocates (ASHA) - No Updates	
V. Health Plan Updates 1) **Anthem** a. **Membership – 90,753** b. **Utilization Report** Q1 2025 Anthem Blue Cross _ Santa Clara PH MOU _Reports_2.18.2025.pdf i. **Transportation Benefits (NMT and NEMT)** Non-emergency medical transportation — provider certification statements - Provider News (anthem.com) ii. **LiveHealth Online** Live Health Online can be used by everyone. Encourage our members to use this platform. Urgent Care - See a Doctor 24/7 - LiveHealth Online	Anthem

	SSCASA (Santa C)
Jan 2024	44
Feb	20
Mar	36
Apr	22
May	39
Jun	41
Jul	33
Aug	36
Sep	26
Oct	43
Nov	24

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Dec	29

i. Cal-AIM Programs: ECM, CS and CHW

Anthem is continuing to implement CalAIM in Santa Clara County with regular meetings occurring with key organizations.

1. CalAIM Overview
1. Community Health Workers (ca.gov)
2. ECM Overview
3. CS Overview

Community Health Worker:

California Advancing and Innovating Medi-Cal (CalAIM) | Anthem Blue Cross

Community Supports:

California Advancing and Innovating Medi-Cal (CalAIM) | Anthem Blue Cross

Enhanced Care Management:

When providers are fully contracted they are posted on our website under “Find Care.” Find Care & Estimate Costs for Doctors Near You | Anthem.com Type ECM Field-Based in the search bar. That is the most real time update as required by DHCS.

California Advancing and Innovating Medi-Cal (CalAIM) | Anthem Blue Cross

Care Management | California Medicaid Anthem

ECM Referral Form Updates:

- ECM referral forms (for both adults and children & youth) will be revised and become available in Jan 2025 to include standardized referral language as set by the DHCS. You may continue using the current ECM referral forms until Jan 2025.

ii. ECM and CS Enrollment Data (Utilization Report)

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VI. Care Coordination

1) Updates between County and MCPs
2) Care Coordination Needs: Recognizing the necessity for better coordination to ensure eligible patients are enrolled in CCS services and don't fall through the cracks.

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<tr><td>VII. Referrals
1) Close Loop Referrals</td><td>All</td></tr>
<tr><td>VIII. Strategies to Avoid Duplication of Services</td><td>All</td></tr>
<tr><td>IX. Dispute Resolutions</td><td>All</td></tr>
<tr><td>X. Collaboration
A. CHA/CHIP PHM/PNA: Community Health Assessment/ Community Health Improvement Plan Population Health Management/Population Needs Assessment :
Conducting regular meetings to discuss our Goals, Deliverables, Time Frames, Measurables, Budget, Funding Proposals, etc.

GOAL 1: Lead: By the end of 2025, all health plans will achieve DHCS's Bold Goal of exceeding the 50th percentile for children's preventative care measures in partnership with Santa Clara County Public Health Department (SCC PHD) by supporting the Childhood Lead Poisoning Prevention Program (CLPPP), through the expansion of the number of lead awareness and outreach events by xx%, through the contribution of resources, data sharing, and by assisting with the planning of targeted provider education campaigns and follow up services.

GOAL 2: Oral Health: By the end of 2025, all health plans will achieve DHCS's Bold Goal of exceeding the 50th percentile for children's preventive care measures, in Partnership with the County of Santa Clara Public Health Department (SCC PHD) to move forward the Oral Health Strategic Plan, through training, data sharing, promotion and outreach, and referrals to improve the oral-systemic health among members ages 1-20.

Latino Heath Assessment:
• Housing and Neighborhood Conditions
• Access to Care
• Acute and Chronic Conditions
• Maternal and Child Health

We are currently collaborating on the 2024 Annual DHCS Strategy Deliverable Template for the CHA/CHIP.

We completed the LHJ/MCP Worksheet.
CHIP Priorities: 1: Behavioral Health
2: Access to Care
3: Economic Opportunity
Funding Proposal:
Total membership in Santa Clara is 417,837 members.
SCFHP has 67% of membership with 280,606 members.
Anthem has 22% of the membership with 92,487 members.
Kaiser has 11% of the membership with 44,744 members</td><td>All</td></tr>
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<tr><td>The financial support from Anthem will be $15,400 based on the membership breakdown and our commitment based upon that membership breakdown. Let me know if you have any questions.

B. DEI: Participating in a workgroup that consists of Santa Francisco Health Plan, Santa Clara Family Health Plan, Kaiser, and Anthem to discuss how we will collaborate to fulfill the DEI APL requirements below.

<u>Sharing and Exchange of Educational Resources</u>
MCPs located in the same county must coordinate DEI trainings that are reflective and encompassing of the criteria outlined in this APL so that if an MCP, Subcontractor, Downstream Subcontractor, or Network Provider completes the training for one MCP within the same county, then they will have met the obligation to complete the training for all other MCPs within the same county and can provide an attestation of training completion. All MCP HEOs within a similar geographical region or county must collaborate on DEI training criteria to ensure alignment and accurate training records.

PDF
APL23-025 diersity equity inclusion.pdf</td><td></td></tr>
<tr><td>XI. Member Engagement
Benefits, Programs, and Services:
<u>Medi-Cal Plan Benefits and Programs | California Medicaid Anthem</u>

Healthy Rewards Program:

Through our Healthy Rewards Program, members can earn $10 to $80 for getting certain health services. At the same time, you increase your practice's quality scores by providing members with the vaccinations, screening visits, and medications they need. When an Anthem member meets the eligibility criteria for the activities listed below and completes the service, they will earn the corresponding reward amount after the service is confirmed by the Claims department. The reward dollars are loaded into the member's Healthy Rewards account and can be redeemed for a variety of retail gift cards. Please ensure you file your claims timely so the members can receive their awards.</td><td>All</td></tr>
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12292504 1057170CAMSPABC Healthy Rewards BR MKT 02 24.pdf 12292504 1057170CAMENABC Healthy Rewards BR MKT 02 24.pdf CA_CAID_PU_HealthyRewardsProgram.pdf Provider Flier only. **<u>Anthem Resources for Maternal Mental Health</u>** **Member Brochures on New Baby, New Life:** English ca_caid_pregnancyandbeyond_eng.pdf Spanish: ca_caid_pregnancyandbeyond_spa.pdf **Info found under "Get Help" Health and Wellness- "Pregnancy and Women's Health" section:** https://mss.anthem.com/california-medicaid/get-help/health-wellness/pregnancy-womens-health.htm **Healthy Rewards Program includes New Baby New Life Incentives:** Medi-Cal Plan Benefits and Programs | California Medicaid Anthem Medi-Cal Plan Benefits and Programs | California Medicaid Anthem. Our OB CM's always educate our members on Post Partum depression and resources. **Live Health Online Maternal Menal Health Service:** ca_caid_pregnancyandbeyond_eng.pdf (anthem.com) www.bemomaware.com https://www.postpartum.net CA_CAID_PostpartumMoodDisorderFlier.pdf (anthem.com)	
XII. **Action Items** 1. Diversity, Equity, Inclusion Training: Coordinate with Dr. Keisari to discuss and plan the training. (Complete) 2. MOU Execution: Contact Heidi, Vivian, and Dr. Keisari to progress on executing various MOUs, including those related to WIC, LHD, and CCS. (Complete) 3. CCS Transition Meeting: Schedule a follow-up meeting regarding CCS transitions and member identification within the system. Invite Heidi, Dr Keisari, Eric, Debra, and Chantal	All

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4. ECM Referrals: (Complete) - Follow up with Heidi on referring 76 members to ECM services. - Explore more efficient referral methods to handle these cases. - Can we send you a list of our CP clients for referral into ECM and community supports, or is a more formal referral process required? Specifically, do we need to fill out forms and submit them through a portal, or is there a more efficient method for handling these referrals? I'll reach out to Alana and Eric to confirm if there's a quicker way for our county partners to inform us about ECM referrals. 5. Opportunity for Tonya to present for 5-10 minutes to the Community Advisory Committee. (Complete)	
XIII. Open Forum Discussion	All
XIV. Next Meeting: May 20, 2025 @ 11:00 am	All