

Medicaid Health Plans of America

2014-2015

Best Practices Compendium

An anthology of Medicaid managed care best practices





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Message from the CEO

Jeff M. Myers

Dear Reader:


All MHPA member companies run innovative programs which improve the health of Medicaid enrollees by ensuring high-quality care.

In this edition of the Best Practices Compendium, you will find a diverse array of case studies ranging from outreach strategies to reduce preventable hospital readmissions, to programs that coordinate care for members with serious illness, to a program working to bring farmers market produce to low-income communities.

Where possible, health plans measure quality improvements through standardized metrics, a hallmark of health plan transparency. These best practices demonstrate accountability of Medicaid health plans for high-quality care, along with innovations that bring plans closer to the communities they serve.

Thanks to all our plans who contributed to this publication. Your sharing of knowledge and lessons learned provides a valuable service to our industry. But more important, you've contributed to improving the health of our nations sickest and poorest citizens, which is really what it's all about.

Sincerely,



Jeff M. Myers
President and CEO
Medicaid Health Plans of America



Part I:

Introduction



MHPA and Medicaid Managed Care Making a Difference

Welcome to Medicaid Health Plans of America's 2014-2015 Best Practices Compendium.

Medicaid Health Plans of America (MHPA) is the leading national trade association solely focused on representing the universe of Medicaid health plans. This 2014-2015 Best Practices Compendium showcases many of the groundbreaking strategies adopted by Medicaid health plans, along with proven programs designed to improve quality. By building on best practices and constantly innovating, health plans are able to serve Medicaid beneficiaries more effectively while being responsible partners to state Medicaid agencies.

Readers will find a wide variety of programs submitted by MHPA member health plans. Health plan initiatives that range from community outreach, enhanced communication and technological strategies, wellness and preventive measures for seniors and the disabled, and innovative efforts which focus on improved health care for infants, children and expectant mothers.

The Medicaid program serves 66 million people, with over half of them enrolled in Medicaid health plans. Medicaid health plans partner with states to deliver benefits to members and ensure that Medicaid beneficiaries have accessible, efficient, high-quality care. A hallmark of the Medicaid program

is the diversity of beneficiaries. Medicaid provides insurance coverage to low-income people, people with disabilities, foster children, and the poor elderly. Many of these individuals have multiple chronic conditions or physical health challenges coupled with mental health disorders. Recognizing the diversity of beneficiaries, health plans develop targeted, relevant and culturally competent approaches to engage members.

Low-income populations served by Medicaid often need supportive services such as language interpretation, transportation, or links to social services in order to gain the full benefit of health care services. Medicaid health plans are unique in their capability to deliver programs and coordinate services for these challenging populations. Medicaid health plans design outreach and care management services that promote better health and health care coordination for individuals. As evidenced in this Compendium, Medicaid health plans also work with communities and community members to improve the health of the population overall.

Medicaid health plans offer higher value to states and Medicaid beneficiaries than fee-for-service or other Medicaid delivery approaches. In addition to employing advanced care management strategies to serve members, Medicaid managed health plans offer a higher level of accountability for quality and cost management. Medicaid health plans compete to participate in state Medicaid programs, and once selected, are accountable to states and beneficiaries for the cost and quality of care delivered to enrolled beneficiaries. In short, plans consistently meet quality benchmarks while being accountable for cost of care.



Medicaid Health Plans of America (MHPA) is the leading trade association solely focused on representing Medicaid health plans. MHPA is a nonprofit, tax-exempt organization that provides advocacy, research, analysis, and organized forums which support the development of policies that enhance the delivery of quality health care.

MHPA's 2014-2015 Best Practices Compendium is a compilation of the best practices put forward by the Medicaid health plan community. This booklet, published annually, should serve as a valuable reference tool. The compendium also features award-winning case studies, a listing of the current state Medicaid directors, and an MHPA member health plan/vendor resource directory.

Unlike fee-for-service providers, Medicaid health plans:

- Perform outreach to patients who may need care, rather than wait for patients to seek out services;
- Track cost, quality, and health care utilization of patients;
- Implement programs to improve quality and efficiency;
- Help doctors, hospitals, and other practitioners develop capacity and improve office practices to improve quality of care;
- Report publicly on cost, quality, and access using standard definitions;
- Survey members about their satisfaction;
- Are evaluated by independent accreditation and quality organizations to ensure integrity of programs and processes;
- Carry out fraud detection and prevention activities; and
- Are accountable to states and members for managing costs while at the same time improving and reporting on quality.

They also offer the person-centered care needed to meet the complex health and social needs of low-income patients. Some of these strategies include:

- Helping members to find primary care practitioners to care for acute and chronic health care needs;
- Coordinating access to specialists as required by state standards;
- Having care coordinators and case managers on staff to help people with serious mental or chronic illness or other complex health problems;
- Offering enhanced enrollee benefits such as peer support, community-based programs and diabetes education;
- Linking members with behavioral health and primary care practitioners; and
- Facilitating access to care by providing language interpretation services and transportation to visits, as well as monitoring wait time and satisfaction with access.

MHPA applauds health plans submitting programs to this year's Best Practices Compendium, and is pleased to highlight the work of our member organizations. We invite readers to contact us for more information on how Medicaid health plans improve quality and manage costs in the Medicaid program.

Part II:

Best Practices Case Studies

Categories

1. Care Coordination and Improving the Health Care System
2. Healthier Babies and Children
3. Health Plan Innovations to Improve Health Care Results
4. Helping People Help Themselves
5. Prevention and Wellness



Care Coordination and Improving the Health Care System

Medicaid health plans rely on high-quality physicians and hospitals to deliver services to Medicaid beneficiaries. Health plans provide care coordination and supportive services to maximize the value of the delivery system. This section illustrates health plan innovations in helping to create a more effective delivery system by engaging providers and building medical homes. It also illustrates health plan activities to reduce unnecessary costly emergency room use and inpatient care, two types of services that often can be prevented through better care coordination and outpatient care. The following 13 case studies are presented in alphabetical order by title.

UnitedHealthcare Community Long Term Care Plan of Arizona An Interdisciplinary Approach to Improving Care in the Elderly and Physically Disabled Population

Description:

Diabetes and flu are significant contributors to adverse outcomes in the elderly and physically disabled (EPD) Medicaid population. Taking a closer look, coordination of care plays a major role in successful health outcomes for people in the EPD population. At UnitedHealthcare Community Long Term Care Plan of Arizona, effectively coordinated care is being achieved for EPD members by assigning them to care managers and interdisciplinary teams.

Abstract:

Diabetes and flu are significant contributors to adverse outcomes in the elderly and physically disabled (EPD) Medicaid population. Taking a closer look, coordination of care plays a major role in successful health outcomes for people in the EPD population. At UnitedHealthcare Community Long Term Care Plan of Arizona, EPD members are assigned to care managers who assist with and coordinate their individual care needs. The care management process includes face-to-face visits at either 90- or 180-day intervals, depending upon the member's acuity. Through these visits, in conjunction with ongoing telephonic care, and coordination with an interdisciplinary team made up of physicians and other health care professionals, the care manager works to ensure that members' healthcare needs are successfully actualized.

While monitoring of member diabetes and flu services is critical to guide care manager actions, a large portion of members often hold primary insurance coverage from plans other than UnitedHealthcare. This produces monitoring challenges when providers do not bill the secondary insurance plan, and result in reporting that is largely unhelpful to care managers. In an effort to ensure members receive timely immunizations, screening and testing, UnitedHealthcare Community Plan developed an infrastructure and process in Arizona to track receipt of immunizations, as well as HbA1c, LDL-C, and eye exams/tests for diabetic members and members in need of annual flu immunizations. This information was used to guide care manager actions, and was also used to communicate accurate and timely information to both health plan members and their primary care physicians regarding appropriate services.

Key Objectives:

- Enhance the patient experience of care, including quality, access, and reliability
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.

Actions Taken:

- **Accuracy of Services Rendered:** Because of the frequent absence of evidence in the administrative data that key services were performed, care managers assigned to members were asked to communicate with members, or their caregivers, during face-to-face visits to determine if services were rendered. In turn, efforts to motivate member or caregiver action for services that were not rendered included verbal discussions and supplying them with simple one-page documents indicating how to schedule necessary services. When administrative claim data was not available, the care managers also worked to verify receipt of diabetic services and flu immunizations by obtaining member chart information and documenting receipt of these services (if not available via other means).
- **Using Innovative Technology:** Given the difficulty of tracking information from both administrative and chart data for the full population, an application was launched in late 2012 to store member information for key diabetic indicators and flu immunizations. Information from administrative data was updated monthly, and care managers were able to scan and store chart documentation daily.
- **Maintaining a Clear Focus:** Care managers and supervisors were able to review their assigned caseloads to identify the remaining gaps, and identify members requiring further effort. Senior managers were also able to identify underperforming areas and take timely action when required.
- **Leveraging Member Data:** In addition to care managers contacting physicians, letters listing member-by-member gaps in care were sent to physician offices with a request to complete the critical services or transmit chart evidence of critical services to the health plan.
- **Partnering to Close the Gaps:** A contracted vision provider was supplied with lists of members who did not show evidence of diabetic retinal eye exams or a negative result from the year prior. As such, the provider initiated targeted phone calls to members and directly scheduled visits for an eye exam when successful contact was made.

Outcomes:

One outcome of this initiative was improved data acquisition which supported accurate monitoring of member gaps in care, despite incomplete administrative claims information. Easy access to reporting allowed supervisors and managers to swiftly act upon systemic barriers. Most importantly, care managers were able to track, support and engage members, and their caregivers, to close the gaps in care and improve health outcomes.

Initiation of the program produced statistically significant improvements in recorded rates across all three targeted diabetes services, as measured by evidence of services in the full population of members meeting eligibility requirements applied for each contract year derived from NCQA HEDIS Comprehensive Diabetes Care measure criteria specified by 2012/2013 Technical Specifications. A statistically significant change was also observed in recorded rates for evidence of a flu vaccination for members continuously enrolled during a September to March flu season. Based on this program, the following year-over-year results were noted between 2012 and 2013: HbA1c testing rates increased 8%; LDL-C screening improved 11%; eye exams raised 18%; and flu shots increased by over 21%.

Location:

This program took place in Arizona.

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Meridian Health Plan

Care Coordination – It Takes a Team

Description:

Meridian Health Plan has an innovative approach to coordinate care for members living with chronic disease. The Meridian Care Coordination program integrates the medical and behavioral health needs of the member and addresses social determinants of health for members by improving access to care and linking members with community resources. The program provides patient-focused, individualized care coordination for members with active disease processes, those who require extensive utilization of resources and those at high risk for health complications. Meridian has seen a reduction in utilization of inpatient, emergency room and urgent care services for a cohort of members enrolled in the Medical Care Coordination program.



Abstract:

Chronic diseases (diabetes, cardiovascular disease, asthma, and hypertension) account for 70 percent of all deaths in the United States each year and are a leading cause of disability. About 25 million people, nearly one-in-10 Americans, suffer major limitations in daily living due to chronic disease. According studies through the Partnership for Solutions, the total direct health care costs for patients with chronic conditions is expected to increase from \$510 in 2000 to \$1.07 trillion in 2020. Patients with chronic and co-morbid conditions often seek care from multiple providers across multiple settings in a fragmented and poorly coordinated system.

Key Objectives:

The objectives of the program are to:

- Coordinate care for high-risk members living with chronic conditions
- Integrate medical and behavioral health needs
- Connect members with community resources to help address social determinates of health

The objectives of the program are to:

- Improve the health of the population
- Control or reduce the per capita cost of care or increase efficiency
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.

Actions Taken:

Key components of the program include:

- **Health Risk Assessment** completed for members within 90 days of enrollment to determine health, social, psychological and other needs and help establish care goals.
- **Predictive Modeling** to analyze member demographics, diagnosis, medical and pharmacy utilization data and stratify members into levels of care.
- **Care Coordinators (CC)** who are familiar with local community and healthcare resources for the members they serve. The Care Coordinator then works with the members to create a Care Plan where problem areas and health goals are identified.
- **Interdisciplinary Care Team** including the CC, nurse team leads, medical directors and behavioral health and pharmacy consultations. The Care Team help members by:
 - Working with members to create individualized care plans and periodically discussing or updating these plans
 - Identifying and removing barriers to accessing care
 - Linking members with community resources to facilitate referrals and respond to social service needs
 - Educating members on condition management, appropriate use of services and self-care techniques
 - Referring members to appropriate community resources to address medical, social and financial needs and following up to ensure fulfillment
 - Providing health education for patients and families
 - Working to decrease ER visits and acute patient stays
 - Promoting prevention of disease and wellness
- **Integrated Information** through Meridian's Managed Care System (MCS), including automated referrals and work-flow, color coded case prioritization, and automated notifications to CCs for inpatient and emergency room admissions.

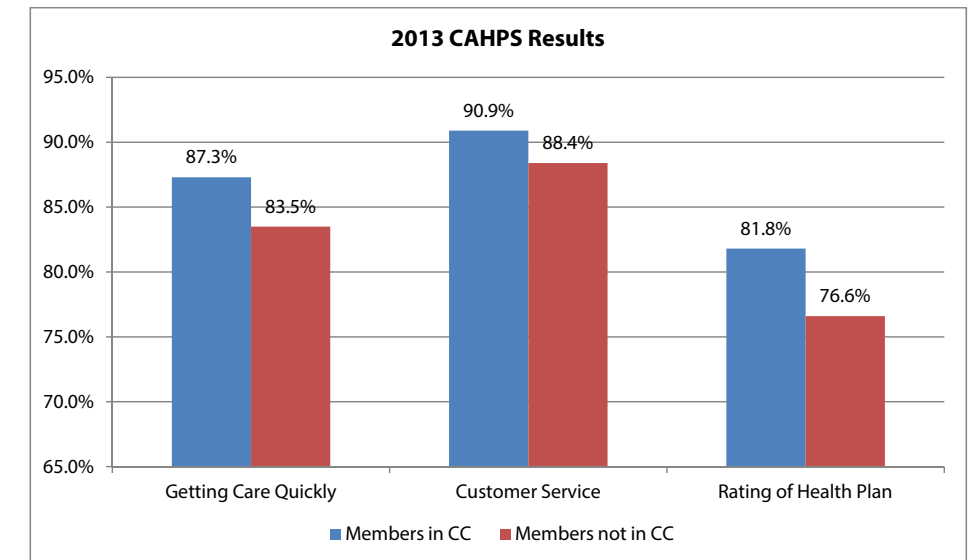
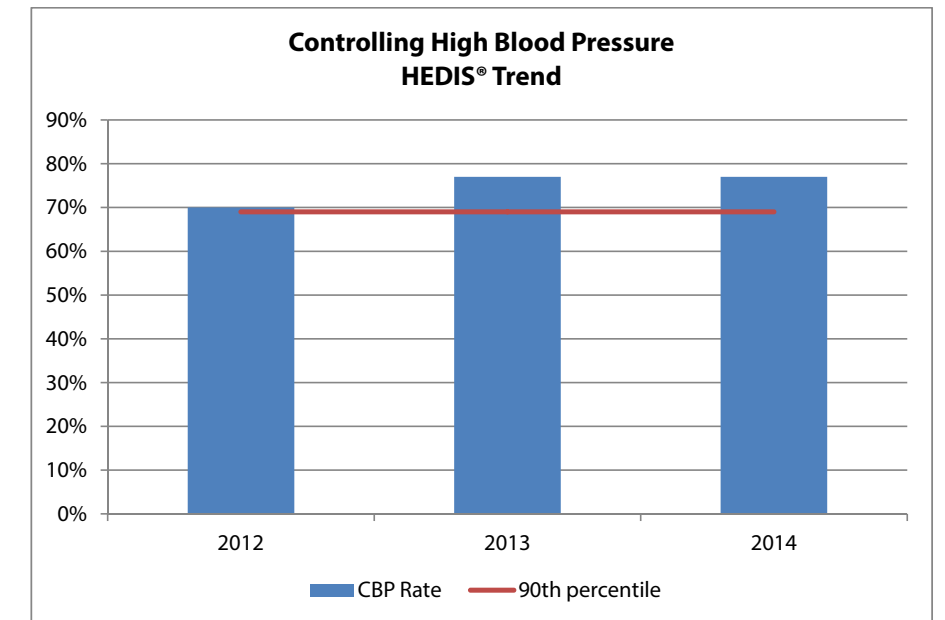
Outcomes:

Meridian has seen improvements in a number of outcome and service measures. Most notably are improvements in a number of chronic condition HEDIS® measures over the past three years. Meridian has seen improvements in its Controlling High Blood Pressure (CBP) measure, exceeding the 90th percentile when compared with Quality Compass national Medicaid benchmarks. Meridian also saw reductions in utilization data for a cohort of 4,209 Medical Care Coordination members:

- Inpatient Facility utilization declined by 26%
- Emergency Room utilization declined by 18%
- Urgent Care utilization declined by 22%

In addition to a reduction in utilization and improved quality scores, Meridian members who participate in the Care Coordination program are more satisfied with the Health Plan. Members in Care Coordination reported higher rates for the Getting Care Quickly, Customer Service, and Rating of Health Plan CAHPS questions.

Members who participate in the Meridian Care Coordination program appreciate having one point of contact at the Health Plan with whom they establish a relationship. The member can direct all questions to the Care Coordinator including questions about medications and community resources. The Care Coordinator can assist the member in appointment scheduling and post discharge follow up.



Location:

This program took place in Michigan, Illinois, and Iowa.



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WellPoint, Government Business Division

Case Management Stabilization

Description:

Case Management Stabilization is a health plan readmission management program that includes member identification strategy, nurse outreach protocols, and targeted interventions. After implementation the 30-day readmission rate decreased from 11% to 5%, with an estimated savings of \$1.2M for the study population (n=1,908).

Abstract:

Readmissions within a short period time (30 days) following a hospital stay adversely impacts on health care outcomes and costs. CMS has revised its Medicare hospital payment policies to promote effective discharge planning and effective admission management. According to the Healthcare Cost and Utilization Project (HCUP) Statistical Brief #89, Medicaid patients have a higher readmission rate than commercial health plan members (10.7% vs. 6.3%). And the Center for Health Care Strategies reports that non-dual Medicaid beneficiaries with disabilities have a 16% readmission rate. The Case Management Stabilization initiative addresses preventable readmissions to improve health care quality and to reduce hospital spend.

Key Objectives:

- Improve the health of the population
- Control or reduce the per capita cost of care or increase efficiency

Actions Taken:

The initiative had three key components: Member Identification, Nurse Outreach Protocols, and Targeted Interventions.

Member Identification – a readmission predictive model was built to provide an indicator of readmission within 30 days of discharge. The methodology included demographic, utilization, clinical and current admission data to predict admission risk. The Readmission Score (RAS) ranged from 0 to 100, where a score of 80 would represent an 80% likelihood of readmission within the next 30 days. The RAS appears on the health plan's Inpatient Daily Census and is recalculated daily using the most recent admission information.

Nurse Outreach Protocol – Nurse outreach to the member/caregiver would begin prior to or immediately after hospital discharge. The call protocol allowed for both outbound and inbound contacts. Members were engaged for 30 – 45 days post discharge.

Targeted Interventions – once engaged with a member, the nurse's interventions were based on the Coleman Care Transitions model: Medication Reconciliation, Red Flag Recognition, Follow-up Care, and Patient Centric Medical Record. The nurse would work with the member/caregiver to obtain the hospital discharge medication list to review against the medications in the member's possession. The goal of the reconciliation is to resolve any discrepancies with review with the outpatient provider. Our Red Flag Diagnoses were congestive heart failure, Angina, COPD, and Diabetes. A problem list including the admission diagnosis and comorbidities was created to identify the diagnosis and root cause of the admission. The nurse ensured that the member had follow-up appointments and contacted the treating physicians/ancillary providers to facilitate timely resolution of questions/issues. The nurse created a Care Plan shared with the member and treating physician which included the problem list, medication list, any red flags noted, and the discussion notes with the member/caregiver/other providers.

Outcomes:

The study population was 75% non-dual, 13% had both a behavioral health and physical health diagnoses, with the three top diagnoses being cardiovascular (27%), renal (17%), and behavioral health (11%). The RAS ranged from 3 to 100, with 75% at 20 or less. Members were managed on average 28 days. Evaluation showed that after implementation of the Stabilization initiative, the readmission rate for any condition decreased from 18.6% to 16%. The greatest improvement was seen in the readmission rate for like conditions which showed a decrease from 11% to 5%. The difference in the expected vs. actual readmissions translates to a savings of \$1.2M for the study population.

Location:

This program took place in the following Amerigroup markets: Florida, Maryland, Louisiana, New York, Tennessee, and Texas.

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Cigna-HealthSpring®

Cigna-HealthSpring Behavioral Health Intensive Outpatient Program

Description:

Serving the "sickest of the sick," including members with schizophrenia, bipolar disorder, substance use disorder, and personality disorder, the Cigna-HealthSpring Behavioral Health Intensive Outpatient Program is best described by its motto, "Do whatever it takes to allow the member to live as independently as possible in the community." The program is an intensive delivery of services in the home, under bridges, in shelters, or wherever the member is located. Services are provided by Cigna-HealthSpring contracted vendors, specifically using registered nurses with a behavioral health background. The nurse may visit as often as needed for as long as is needed. With close health plan physician oversight and coordination with the treating community physician the nurses ensure that services are delivered timely and with consistency. The nurses administer medication, perform mental status assessments, address and resolve social, housing, and financial issues. The nurses will even follow the member through the judicial system when needed. The program has resulted in remarkable outcomes including reduction of inpatient admissions as high as 90%, reduction of Medical Loss Ratios, and garnering numerous letters from members, family, and caregivers attesting to the life changing outcomes that are allowing families to come together for the first time in years.

Abstract:

Data analysis revealed that members with primary behavioral health and substance use disorders resulted in higher cost services, and unusual use patterns. Apart from transplants and a few extraordinary drug costs, 21 of the top 25 most expensive members were noted to have primary behavioral health and substance use diagnoses. As we investigated further, we found that these diagnoses were the primary cost and utilization drivers for our most expensive top five percent of members.

Additional review of the members with behavioral health and substance abuse diagnoses uncovered patterns of repeated Emergency Room (ER) use and hospital readmission rates that far exceeded all other member risk groups. Hospital admissions for some of these members occurred twice a month. The Health Plan discussed our concerns with the Texas Medicaid Health and Human Services Commission staff regarding super-utilizers and confirmed that these members had been tracked for years by the State, noting the same ER and hospital admission patterns.

Key Objectives:

- Enhance the patient experience of care, including quality, access, and reliability
- Control or reduce the per capita cost of care or increase efficiency
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.

Actions Taken:

The Cigna-HealthSpring Behavioral Health Intensive Outpatient Program (BH IOP) key initiatives are:

- Redefine the home health model of care by changing the focus from a service specific, time specific, frequency specific model to a member-centric, outcome driven model based on strong therapeutic relationships and trust.
- Removal of authorization limits with the close consultation and guidance of the plan Medical Director.
- Empowering the nurse to, "Do whatever it takes to keep the member living as independently as possible in the community." Vendor agency nurses with a behavioral health background are empowered to spend as much time as necessary and to visit the member as frequently as needed to comprehensively address all of the member's needs.
- Remove boundaries between areas of member need. Member needs may extend across physical health, behavioral health, and socioeconomic domains. The nurse may administer oral or injectable medication, take the member to appointments, monitor the member's involvement with the court system, provide feedback to the treating physician, and work to establish trust and cooperation among caregivers and family members. With support from health plan staff, the nurses are equipped with the resources necessary to find appropriate housing, arrange durable medical equipment, schedule appointments, and arrange for other services to stabilize the member's medical, behavioral and social conditions.



- Go wherever the member can be found. Unlike many programs, the BH IOP does not wait for a member outreach. Once identified, the nurses actively seek out members whether at home, in shelters, or in jail. Oftentimes, the nurses locate members who are reluctant to engage in their own care.
- Never give up. Nurses in the BH IOP are persistent advocates for the members in their care. Members often have little insight of their disease conditions/symptoms, which makes it difficult to engage them in their care, and may result in repeated relapse. Given the unique patient needs, the BH IOP nurses utilize every opportunity to gain the member's confidence and trust. The nurses work to reinforce the member's self-worth through the highs and lows of the treatment process.
- Real-time treatment intervention. By establishing a strong rapport with the member, the nurse is able to communicate a deeper insight into the member's needs with treating physicians. The close relationship allows the nurse to recognize subtle changes in the member's behavior, interactions with others, and to alert a provider before the member's symptoms and actions disrupt the member's life. The nurse is also positioned to immediately implement any medication adjustment or treatment orders, and to observe any resulting behavioral changes.

Outcomes:

The BH IOP has resulted in dramatic improvements in rates of ER use, inpatient admissions, decreased interaction with law enforcement and the court system, revitalization of member/family and caregiver relationships and appropriate use of resources. Some examples include:

- A male member with schizophrenia who lived under a bridge was reunited with his family, became medication compliant, and had a reduction in his medical loss ratio from 513% to 289%.
- A female with schizophrenia was previously alienated from her family. Her psychosis had invaded her ability to maintain a healthy relationship with her children. With assistance from the program, she was court committed to a psychiatric facility. That court commitment was then modified to the outpatient setting. With mandated compliance by the court, monitored by the nurses of the program, the member's psychosis was controlled. The member's family saw such improvement that she was allowed to attend her oldest son's graduation from a military boot camp, and her youngest son's graduation from high school.
- A male member with methamphetamine addiction and a cardiac ejection fraction of 20% was relocated from a crack house to an assisted living facility. The change in living conditions improved his medication compliance and sobriety. His medical loss ratio was reduced from 462% to 300%.
- A homeless female member with chronic psychosis was taken off the streets and reunited with her family. Her primary psychosis was controlled, and the severe side effects she suffered from the medications was minimized. Her medical loss ratio was reduced from 513% to 250%.
- A female with histrionic personality traits had twice a month psychiatric hospitalizations for years. After enrollment in the program, her admittance rate declined to two times in the last year.

Location:

The Cigna-HealthSpring Behavioral Health Intensive Outpatient Program is operational in the Texas Medicaid Hidalgo Service Delivery Area consisting of 10 counties in southwest Texas; and in the Texas Medicaid Tarrant Service Delivery Area consisting of six counties in the Fort Worth area.

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AmeriHealth Caritas Family of Companies

Community Care Management Team (CCMT) Hubs Reduce Inpatient Admissions, Number of Inpatient Days and 30-Day Readmissions in Superutilizers

Description:

AmeriHealth Caritas' Community Care Management Team (CCMT) approach was developed to support and engage high-need, high-cost members whose health care needs extend beyond the reach of physician practices and telephonic care management programs (so-called "superutilizers"). The CCMT provides intensive, face-to-face care coordination and timely, personalized interventions to 118 superutilizers in Pennsylvania (PA) and South Carolina (SC) as of early July 2014. Although results are preliminary, substantial, double-digit percent reductions have been observed in inpatient admissions, the number of inpatient days, and 30-day readmissions.

Abstract:

Superutilizers overuse emergency departments and hospital inpatient services, placing a huge burden on the health care system regarding both resources and cost. These members are generally high utilizers of health care services, have multiple/complex chronic conditions, are prescribed large numbers of medications, and have unmet social needs that impact their health outcomes. Moreover, providers do not have the capacity or staff to engage with these members and provide population-based care outside of the office environment. Our CCMT approach was developed as an industry-leading model to implement a community-based, high-touch individualized care management program that will lead to greater quality outcomes, reduced medical costs and more effective utilization of care for superutilizers. The expectation was that this high-touch support will lead to fewer emergency room visits and inpatient admissions of superutilizers at substantial cost savings and improved quality of life.

Key Objectives:

- Improve the health of the population
- Enhance the patient experience of care, including quality, access, and reliability
- Control or reduce the per capita cost of care or increase efficiency

Actions Taken:

The CCMT consists of professional care managers (nurses and social workers) and community care connectors (community health workers) under medical direction who engage superutilizers in their community through frequent, high-touch, in-person interaction, and provide follow-up to address physical, behavioral and socio-environmental needs. The team also functions as a convener of services for members, working with independent practitioners in the community and other stakeholders, as necessary, to ensure that hard-to-reach members with chronic disease(s) or at high risk of hospitalization are adequately supported and engaged.

The multi-phase approach includes: (1) identifying high-risk members with the highest utilization patterns through data mining or referral; (2) finding and engaging the members in the community where they live; (3) assessing and addressing immediate medical, behavioral and social need(s); (4) establishing a connection to the medical and behavioral health neighborhood and social services; (5) monitoring and supporting execution of a common plan of care by addressing barriers and closing care gaps; and (6) promoting independence in self-management where appropriate.

Outcomes:

AmeriHealth Caritas has developed community hubs in the cities of Chester and Philadelphia, PA; Charleston, SC; and Baton Rouge, LA (not reported here). The Chester and Philadelphia hubs were activated in September 2013 and April 2014, respectively, with robust member growth since their initiation (Figure 1). In total, the PA-based hubs are engaging 86 active members (as of early July 2014) and are on track to reach their target membership goal. The Charleston hub was activated on November 2013 with almost linear member growth since its initiation (Figure 1), and is currently engaging 35 active members (as of early July 2014).

Preliminary results indicate that both PA- and SC-based hubs have made considerable progress in achieving their 2014 inpatient utilization targets. Double-digit percent reductions have been observed in inpatient admissions per member per year; in the number of inpatient days; and in 30-day readmissions. The example of a single member — one of our earliest participants — illustrates the success of this approach. Mr. S is a 46 year-old male living in a residential boarding home with type I diabetes, coronary artery disease and a cognitive disability. His medication and glucose monitoring are managed by the boarding home staff. Keystone First Case

Management was unable to engage him telephonically. When the CCMT first engaged this member, he had not seen his provider for a year, and had 32 admissions in 18 months for diabetes with ketoacidosis. In the month following CCMT engagement, he had one 11-day hospital admission and for the next two years following engagement, he had only one additional five-day hospital admissions (Table 1). The 2011 pre-engagement claim cost for Mr. S alone was over \$180,000, and was reduced by 96 percent after one-year post-engagement (August 2012–2013).

Figure 1: Actively engaged members in Community Care Management

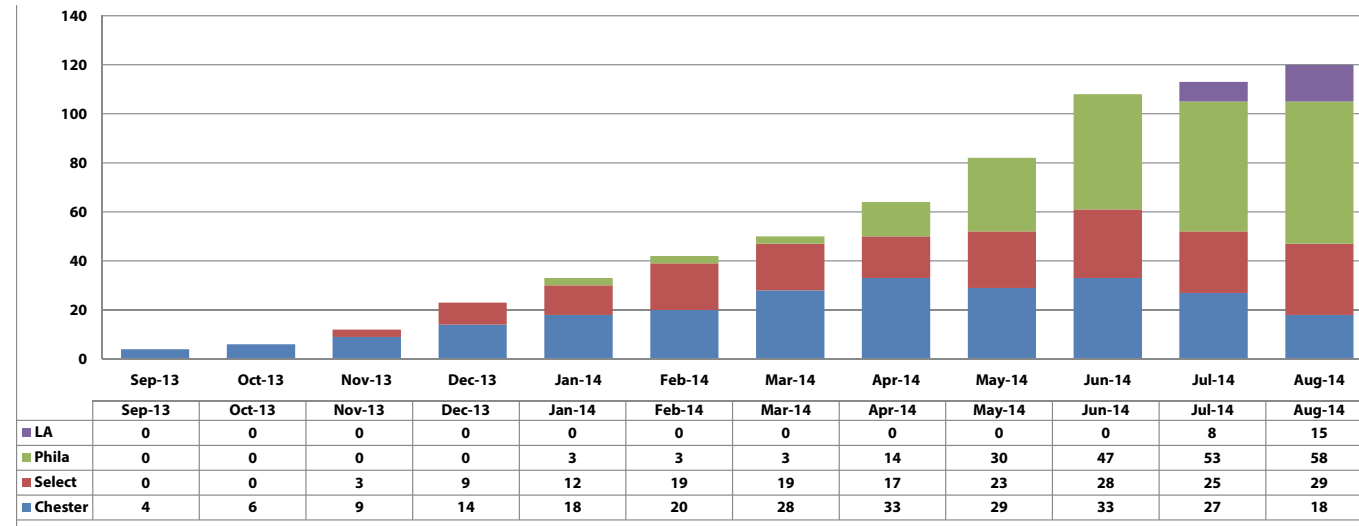


Table 1: Hospital Utilization of a Sample Patient from Philadelphia

	PRE-ENGAGEMENT	POST-ENGAGEMENT	
Mr. S	Baseline 1 – 6/2011	1st Month into engagement* 7/2012	2 Years post-engagement* 7/2012–2014
Admissions (ICU)-coded Ketoacidosis	32	1	1
Inpatient days (% total days)	167/548 (30%)	11 (35%)	5 (1%)
Days out of hospital (% total days)	377/548 (70%)	20 (65%)	725 (99%)
#30 Day Readmit	28	1	0
Different Hospitals	4	1	1

* CCMT services are being provided by CCS Inc.

Location:

This program took place in Chester and Philadelphia, Pennsylvania, and Charleston, South Carolina.

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Arbor Health Plan

Developing Patient-Centered Medical Home (PCMH) Expertise in a Health Plan Network: 2014 Update

Description:

Arbor Health Plan continues to develop and implement a practice-transformation program to assist primary care practices in meeting the requirements of a patient-centered medical home (PCMH). The program provides a step-by-step guide and monthly meetings with Arbor Quality staff to assist practices to meet Nebraska PMCH requirements and position itself for National Committee for Quality Assurance (NCQA)-certification. Arbor Health Plan has engaged 11 practice sites; all 11 practices have applied for NCQA PCMH certification and five practices have met the state's Tier I and Tier II PCMH requirements within two years of implementation.

Abstract:

The PCMH is a transformative model for the delivery of comprehensive primary care whose key principles have been defined as:

- Access to a personal physician who leads the care team within a medical practice
- A whole-person orientation to providing patient care
- Integrated and coordinated care
- Focus on quality and safety (2007 Joint Principles for the Patient Centered Medical Home)

Using the PCMH model, practices seek to improve the delivery of care by ensuring it meets the individual patient's needs first and foremost. No PCMH-certified practices existed in Arbor's service area prior to the initiation of Arbor Health Plan's PCMH program.

Key Objectives:

- Enhance the patient experience of care, including quality, access, and reliability
- Control or reduce the per capita cost of care or increase efficiency
- Improve delivery of benefits



Staff at Children and Adolescent Clinic in Hastings receives PCMH award.

Actions Taken:

Arbor Health Plan created a comprehensive workbook and master audit tool to educate and guide the participating practices, outlining the steps and processes the practices needed to complete in order to fulfill the PCMH requirements. A Six Sigma approach was used to identify core practice-transformation processes and areas of focus. The process was divided into phases, with each section building on the work of the prior phase. The practices performed a self-analysis regarding the extent of their progress against the standards of full PCMH implementation, thereby identifying areas that required additional attention and resources. Arbor Quality staff met monthly to coach participating practices in meeting PCMH criteria, assisting with policy workflow development, sharing resources, and providing recommendations.

Outcomes:

Eleven practice sites were engaged to participate in the PCMH program, all of whom applied for NCQA certification as a PCMH (Table 1) by May 2014. One site (Community Action Partnership of Nebraska) is expected to achieve final NCQA certification shortly. Additionally, five practices met Nebraska Tier I and Tier II requirements by May 2014, one year in advance of the state's contract requirements. Award ceremonies were held during the third and fourth weeks of June (Table 1).

Table 1: PMCH Site Practice Transformation Program: Status Update

PCMH Site	Location	Start Date	NE DHHS Tier I/II Status?	NCQA Certification Status	Met Contract Requirements
Pawnee Hospital and Rural Health Clinic	Pawnee, NE	Dec 2012	Yes	Applied	Yes
Falls City Hospital and Family Medicine Clinic	Falls City, NE	Dec 2012	Yes	Applied	Yes
Children and Adolescent Clinic	Hastings, NE	May 2013	Yes	Applied	Yes
Prairie Pediatrics	Sioux City, IA				
1. Pierce Street Clinic		Sept 2013	Yes	Applied	Yes
2. Morningside/Glenn Ave. Clinic		Sept 2013	Yes	Applied	Yes
Mary Lanning Clinics	Hastings, NE				
1. Blue Hill Clinic		Oct 2013	N/A	Applied	Additional Site
2. Edgar Medical Clinic		Oct 2013	N/A	Applied	Additional Site
3. Hastings Family Care		Oct 2013	N/A	Applied	Additional Site
4. Community Health Center		Oct 2013	N/A	Applied	Additional Site
Community Action Partnership of NE	Gering, NE	May 2014	N/A	Final NCQA Certification Pending	Additional Site
Thayer County Health Services	Hebron, NE	May 2014	N/A	Applied	Additional Site

Arbor Health Plan's efforts in assisting practices attain PCMH certification have earned praise from Senator Mike Gloor, Chairman of the State Legislature's Health and Human Services Committee.

Location:

This program took place in Pawnee City, Falls City, Hastings, Gering, and Hebron, Nebraska; and Sioux City, Iowa.

Contact:

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Meridian Health Plan

Driving Quality through Provider Engagement

Description:

Meridian Health Plan takes a proactive role in empowering its provider network with the tools to deliver the highest quality of care. We do this by visiting their offices in person each month. Educating providers is key to impacting patient outcomes. Meridian's Provider Network Development Representatives (PNDR) live in the communities they serve. Every month a representative visits each primary care office in the network. That was over 43,000 visits in 2013. At these monthly visits, providers are given actionable reports, evidence based guideline information, and assistance in accessing resources and tools through the Meridian provider portal 24 hours a day, 7 days a week. These in person visits allow providers to give feedback, ask questions, and work in partnership with the plan to hit quality and access measures. This best practice has proven beneficial to our organization, and contributes to our overall success.



Abstract:

Meridian has a large provider network spread across both urban and rural communities in Michigan. The Plan has also expanded operations into Illinois and Iowa. In order to drive quality improvement and contain costs during a period of rapid health care reform, it is imperative that the network keeps abreast of new benefit plans and innovative approaches in health care delivery such as patient-centered medical homes, team-based care, and current clinical practice guidelines. To ensure providers are aware of and take advantage of new information and Plan tools available in print and electronic format through the provider portal, Meridian takes a hands-on approach to communicate with its provider network.

Key Objectives:

The program objectives are to:

- Educate providers on clinical practice guidelines and patient centered medical home models of care
- Provide actionable reports and information to help provider offices drive quality improvement
- Offer tools that leverage quality improvement activities across the entire network
- Reduce missed opportunities for needed services and patient education when members visit their provider by identifying member specific preventive and clinically needed services based on clinical guidelines
- Improve the likelihood that members act on reminder notices by printing them on behalf of providers (members are more likely to act on messages sent by their provider than the Plan)

In working to achieve these objectives, Meridian strives to achieve the following goals:

- Improve delivery of benefits
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.



Actions Taken:

Meridian Health Plan takes a proactive role in empowering its provider network with the tools to deliver the highest quality of care. Educating providers is key to impacting patient outcomes. Meridian employs PNDRs that live in the communities they serve. Monthly, PNDRs visit each primary care office in the network. That was over 43,000 visits in 2013. During the visit, every office is given a report card, by practitioner, outlining all patients due for services, which services, the due date, and outstanding incentive earnings. The report card displays all time-sensitive screenings, such as immunizations and well child visits, at the forefront of the report to draw attention to these important needed services. Meridian created a "hot list" for those services that are due in the next 60 days. This allows the practitioner to place special focus on these items.

PNDRs also deliver double-sided educational pieces to highlight evidence-based guidelines. One side outlines the importance of the service, who should get it, and why it is important, while the flip side provides information outlining how to bill, incentives tied to the service, and claims processing. During their monthly visits, PNDRs also provide information and support to help practices achieve recognition as a Patient Centered Medical Home (PCMH). In 2013, in Michigan a total of 319 PCPs were either nationally certified as a medical home, or had completed a self-assessment demonstrating compliance with PCMH principles.

Meridian has a provider portal available online to offices 24 hours a day, 7 days a week. Monthly visits allow PNDRs to train offices to utilize the portal to verify eligibility of our members, submit supplemental data, review claims of members, send postcard reminders at no cost to them, to remind their members of the outstanding services that are due. Meridian prints these postcards weekly right from our headquarters in Detroit, MI. These postcards provide the contact information of their PCP so they may schedule an appointment.

Outcomes:

By personally visiting PCPs monthly, Meridian is able to drive quality health care delivery by promoting evidence based guidelines, fostering patient centered medical home models, and providing actionable reports and tools to help providers outreach and engage with their patients. Positive outcomes from this activity are reflected in high performance in the following areas:

- Meridian was one of only two Medicaid plans in 2013 to meet all of the State of Michigan's performance monitoring measures — including high performance in clinical measures and low rates of member complaints.
- Meridian had the second highest point score in the State of Michigan's performance bonus measures, reflecting high performance across women's care, living with illness, pediatric care, access to care and member satisfaction performance measures.
- Meridian has gained enrollment market share reflecting both increases in member self-selection of the plan and increased auto-assignments due to quality performance.

This best practice has proved successful to our organization and our provider partners alike.

Location:

This program took place in Michigan, Illinois, and Iowa.

Contact:

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NurseWise

Emergency Department Cost Avoidance in Pediatric Medicaid Recipients

Description:

Centene and NurseWise initiated a comprehensive outreach program that focused on early identification of new enrollees in the targeted age group and health screening, education and information that promotes: PCP selection and visits, use of the nurse line to triage symptoms, and use of non-emergency care settings for non-emergent issues. Per an evaluation of our program results, this educational approach was found to be effective with parents and guardians of young children in avoiding inappropriate use of the Emergency Department (ED).

This study was based on analysis of the Emergency Department utilization of newly eligible health plan members who were continuously eligible for at least 180 days (26,689 total members). To measure the effects of the program on member education and behavior, claims data related to treatment patterns were analyzed against whether the members received an assessment.

The study revealed that individuals who underwent assessment had significantly lower number of admin claims per member ($p < 0.001$). Additionally, there is a significant reduction ($p < 0.001$) in the proportion of admin (non-urgent) ED claims out of total ED claims. These findings support that members who participated in the EDE assessment program are visiting the ED more for urgent treatment and less for non-urgent treatment than the non-assessed members. Year over year, the program continues to perform at best practice levels and to show strong results.

Abstract

Preventable Emergency Department visits are a significant cost driver for any managed Medicaid organization covering the TANF (Temporary Assistance to Needy Families) and CHIP (Children's Health Insurance Plan) populations. As a subsidiary company of a multi-enterprise Managed Health Care Organization, developing programs to educate our members about how to appropriately access medical services based on health care needs is a significant contribution to our mission to provide better health outcomes at lower cost.

We determined that the best use of our telephonic outreach expertise was to focus on pro-active education before members had the chance to use the ED. With the historical high volume utilization in the 1-5 year age group, and a close secondary volume for the 6-13 ages, we resolved to target those age groups.

Key Objectives:

- Enhance the patient experience of care, including quality, access, and reliability
- Control or reduce the per capita cost of care or increase efficiency
- Educate patients to make informed decisions regarding seeking care

Actions Taken:

Our Emergency Department Education program has four primary goals:

- Reduce health care utilization of emergency room
- Increase utilization of alternate resources: physician office visits, urgent care and nurse advice line
- Promote participant engagement with Primary Care Provider (PCP)
- Empower decision-making through provision of information and resources

Our identified outreach strategies with Medicaid member parents or guardians to meet our goals are as follows:

- Establish a relationship with a primary care physician
- Screen for health needs that may need follow up
- Provide access to case management/complex care when indicated
- Educate on recognizing emergent symptoms, and to seek professional advice when needed
- Inform of available resources for after-hours care, including PCP access, urgent care, and nurse advice line
- Educate about access to transportation benefits and problem-solving options

Outcomes:

	Non-Assessed	Assessed	% Improved	Significance
Ratio Total ED Visits to Member	0.35	0.22	37.2%	P<0.001
Ratio Admin. ED Visits to Member	0.31	0.18	42.2%	P<0.001

	Non-Assessed	Assessed	% Improved	Significance
Prevalence Admin. ED vs. Total ED	89%	82%	7.9%	P<0.001

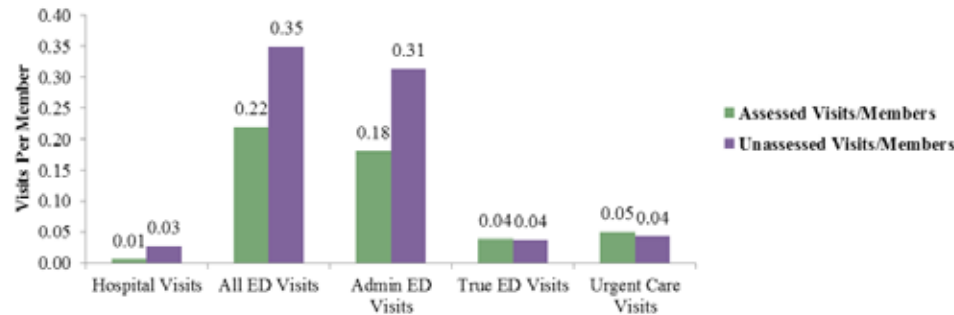
The greatest impact was noted for the children Ages 1-2.99.

	Non-Assessed	Assessed	% Improved
Age Category 1-2.99 yrs	0.31	0.24	24.4%

These measures indicate that members who participate in the ED Education program have a greater understanding of how to access alternative resources and are empowered to manage their care with their physicians. All results are statistically significant.

We also observed significantly fewer total ED visits (driven by the reduction in non-urgent visits) and hospital visits in the group that received the phone interview assessment, compared to the Non-Assessed group. The numbers of urgent ED visits and urgent care visits per member were similar between groups. These results indicate that members are not reducing non-urgent ED visits by increasing utilization of urgent care facilities or hospitals. We did see a difference in subsequent utilization of the nurse advice line between the assessed and non-assessed groups.

Health Plan Member Service Visits Within 180 Days of Enrollment



	Non-Assessed	Assessed	% Improved	Significance
Utilization of Nurse Advice Line	1.5%	3.1%	106.7%	P<0.001

Our Emergency Department Education program model supports members' decision-making by giving them the education, tools and resources to determine appropriate action when seeking health care services during and after physician office hours. It serves as a model for a national best practice implementation based on its positive promotion concept that addresses utilization behavior before the perceived need occurs. It interweaves education and screening and is oriented to encourage a trusting relationship between the member and their PCP.

Location:

This program took place in Georgia. NurseWise serves clients across the entire United States.

Contact:

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Home State Health/Centene® Corporation Emergency Department Super-User Outreach Program

Description:

Home State Health initiated a comprehensive outreach program in 2013 that focused on members who were frequent users of the emergency department. Using both claims and facility real time emergency department visit date, this program was designed to educate members on appropriate emergency department use, offer alternatives such as urgent care and nurse triage services, and to promote members' engagement with their primary care physician. Home State Health has seen a significant reduction in use of the emergency department (ED visits/1,000) from our baseline period (July-Dec 2012) through the first six months of 2014. In addition, nearly 60 percent of the members who receive outreach through this program refrain from additional emergency department visits during the subsequent 90-day period.

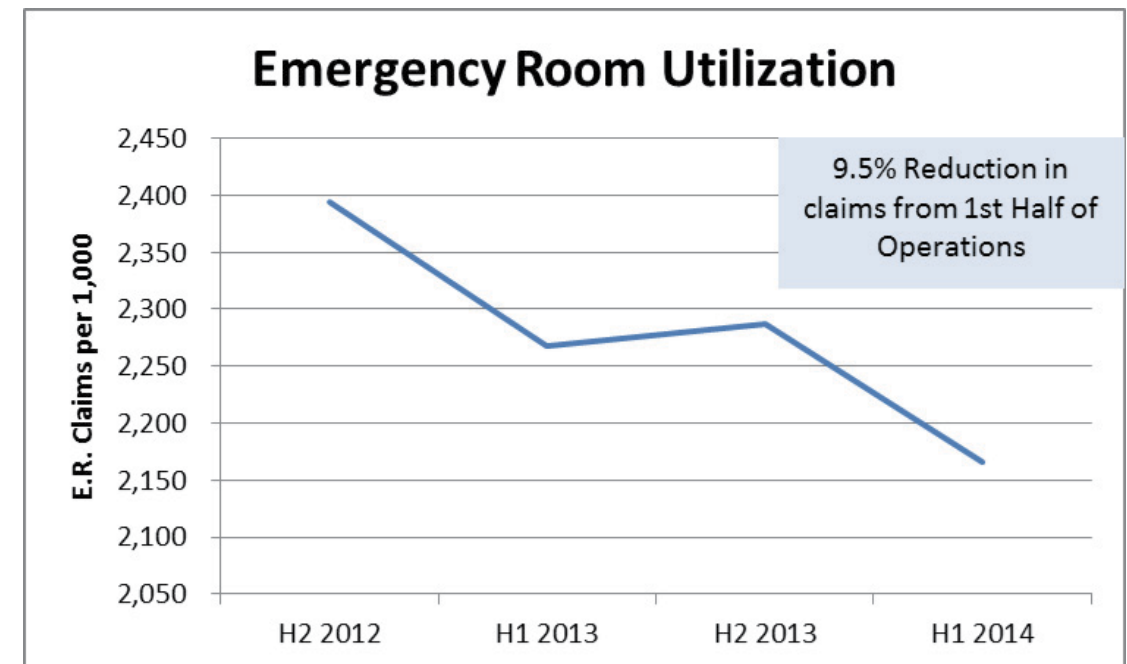
Abstract:

Preventable emergency department visits are a significant cost driver for any managed Medicaid organization covering the Temporary Assistance to Needy Families and Children's Health Insurance Plan populations. Developing programs to educate our members on how to appropriately access medical services based on healthcare needs is a significant contribution to our mission to provide better health outcomes at lower costs.

Since beginning operations in 2012, Home State Health has experienced a member emergency department utilization rate far greater than anticipated or experienced in other Centene managed Medicaid markets. Frequent emergency department use, especially for non-emergencies, can indicate a host of issues including lack of a primary care provider, lack of knowledge about urgent care centers or transportation benefits, and possibly mental health issues. Frequent emergency department use for true emergencies likely indicates a need for case management and assistance.

Key Objectives:

- Enhance the patient experience of care, including quality, access and reliability
- Control or reduce the per capita cost of care or increase efficiency
- Educate patients to make informed decisions when seeking care
- Promote engagement with primary care physicians



Actions Taken:

This program was designed to provide education and case management/care coordination to members who are found to be using the emergency department at a rate of three or more visits in the last 90 days. Case managers, program coordinators and Member Connection representatives called and met with members. We educated members about available benefits including transportation, nurse triage and urgent care availability, as well as appropriate use of the emergency department. We also coordinated and set up primary care physician appointments and provided associated transportation. We assessed the member's overall health to identify the need for case management or to refer the member to other services such as disease management or social services assistance. In 2014, we also offered in-home primary care physician visits to our emergency department super-users.

Outcomes:

Since beginning the emergency department outreach program, Home State Health has seen a statistically significant (p-value=0.034) 9.5% reduction in emergency department claims per 1,000 since our baseline period (July-Dec 2012). In addition, we see a corresponding cessation of subsequent emergency department visits by nearly 60% of members who receive outreach from this program.

In addition to a reduction in ER utilization, one of the key benefits of this outreach program was the assistance provided to members to establish a relationship with a primary care physician who will serve as their health home. This health home provides overall coordination of care which can prevent hospitalizations, treatment complications, adverse drug reactions, duplication of tests, and overall poor health outcomes.

Location:

This program took place in all 54 Medicaid managed care counties in Missouri.

Contact:

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Trusted Health Plan™

Health and Wellness Outreach Center Designed to Reduce LANE (Low Acuity Non-Emergent) Admissions to Emergency Rooms

Description:

Trusted Health Plan is a fully-licensed health maintenance organization in the District of Columbia. Trusted began providing comprehensive managed care services to Medicaid recipients in the District of Columbia on July 1, 2013.

Abstract:

One of the primary challenges articulated by the Director of the Department of Health Care Finance for the District of Columbia Managed Care Organizations was to reduce LANE (low acuity non emergent) emergency room visits. We decided to create a "health and wellness outreach center" in the heart of the Medicaid community — East of the River — with the overriding goal to provide a comprehensive approach to reducing LANE visits. The Center is located in an old community service office building well known to Medicaid recipients. We renovated the building to include a demonstration kitchen, multi-purpose exercise/conference room, children's library, "cyber café", and offices for case management, health education, diabetic education, quality, EPSDT, outreach and member services staff.

Key Objectives:

- Improve the health of the population
- Control or reduce the per capita cost of care or increase efficiency
- Enhance the patient experience of care, including quality, access, and reliability

Actions Taken:

The following actions were taken:

- Located Member Services staff in Center for members to resolve any problems, arrange transportation, identify and change PCP, provide replacement ID cards, and coordinate appointments.
- Located EPSDT staff on-site to explain importance of services, coordinate appointments, and assure that members are assigned to PCP.
- Located outreach team in Center. Outreach team calls every member that has gone to an ER and coordinates them with the on-site case manager, as appropriate. The members are invited to come to the Center and provided a full tour of facility and invited to upcoming events, as well as participation in exercise, cooking demonstrations and health education.
- Developed a case manager/outreach team to work directly with emergency room "abusers" — members who went to the emergency room more than 10 times in six months.

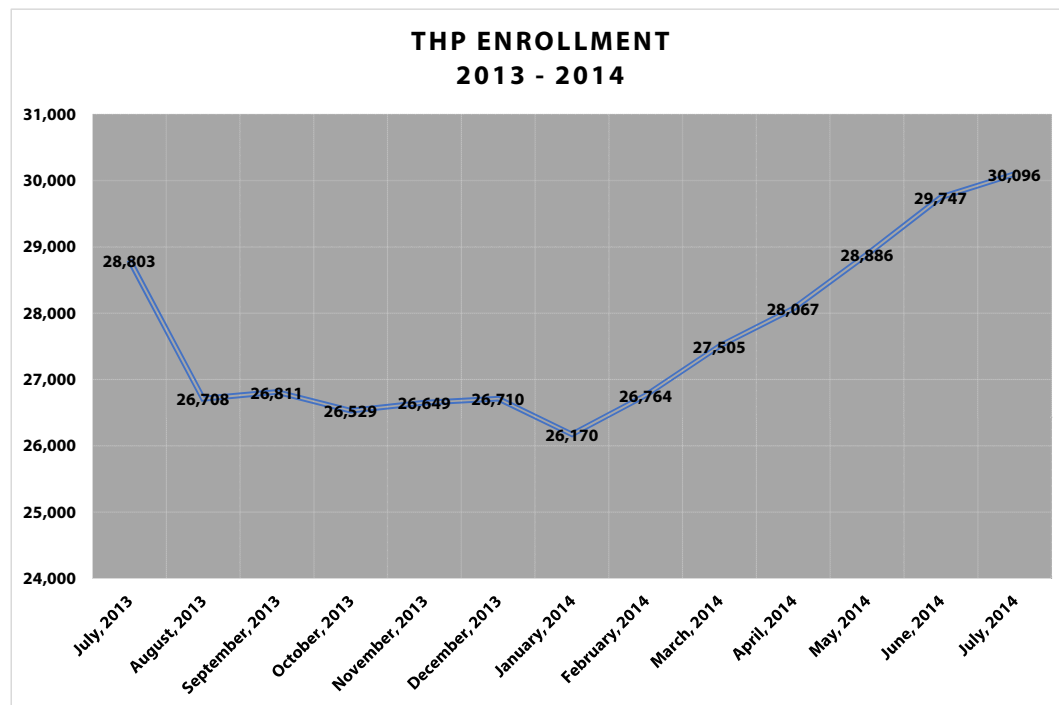
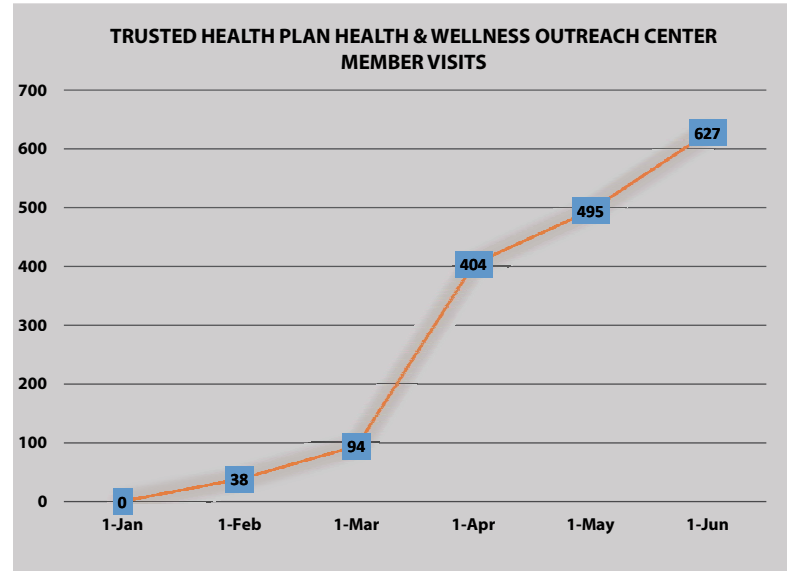


- Provided a full range of activities for members to participate in, including aerobic exercise, yoga classes, cooking demonstrations, weekly events for pregnant women "Healthy Beginnings" and monthly events for targeted populations.
- Located Diabetic Health Education Program in Center. Provides on-site screening, education, nutritional consultation, glucose monitoring and care coordination for diabetic members.
- Located our Quality Department in the Center to monitor outcomes and implement strategic programs to improve HEDIS measures.

Outcomes:

We expect to reduce LANE admissions by over \$1.2 million during the next fiscal year. Participation at the Center has averaged over 500 visits per month, with approximately one-third members coming for health education activities (including cooking demonstrations), one-third for case management and the balance divided between member services, center events and utilization of Children's and Adult libraries.

We are tracking center utilization by activity. We are measuring outcomes based on increasing PCP visits, reducing LANE ER utilization, hospital readmissions, diabetic, hypertensive, and asthma-related HEDIS measures.



Location:

The Health and Wellness Center is located in Ward 7 in Washington, DC.

Contact:

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MDwise, Inc.

Integrated Healthcare in Indiana: Collaborating with Network Partners

Description:

MDwise has run successful integrated care programs in Indiana, with a statewide presence involving multiple community mental health centers and thousands of consumers. Many network providers provide integrated care that includes Community Mental Health Centers and Federally Qualified Health Centers. MDwise has capitalized on these relationships to increase the use of integrated models of service delivery and to improve health outcomes. MDwise members have noted satisfaction with the care they have received.

Abstract:

Increasing the use of integrated care in the MDwise network to reduce the cost of care in high cost members and improve HEDIS rates in well-care measures and LDL by using CMHC's and their relationships with MDwise members to increase compliance with needed services.

Key Objectives:

- Improve the health of the population
- Enhance the patient experience of care, including quality, access, and reliability
- Control or reduce the per capita cost of care or increase efficiency

Actions Taken:

MDwise is working with its network providers to integrate behavioral health and medical services and to improve the overall health of MDwise members, with a particular emphasis on members with serious mental illness. MDwise provides technical support and data to these sites to support their efforts to integrate care. The CMHC's working on the improvement of HEDIS measures meet regularly with MDwise. MDwise also provides administrative data on the results of these efforts.

Outcomes:

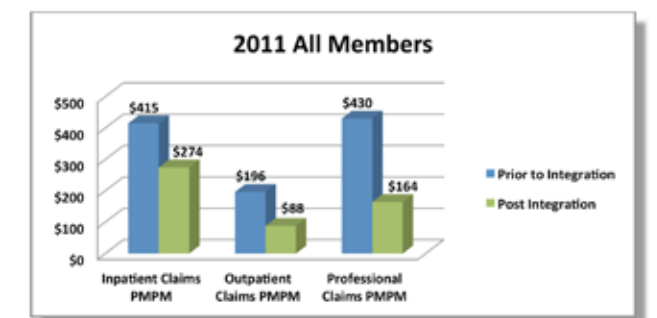
MDwise's Medical Economics team analyzed members who were enrolled in integrated care programs. Members were required to have at least one month of eligibility prior to and following enrollment in the program. Additional analyses were also completed for members with six months of eligibility in MDwise before and after enrollment. Additionally, we evaluated members who were high cost members who had total healthcare spending more than two standard deviations above the average enrollee. The data show positive outcomes for these programs over the last three years as described below. The trend is clear, integrated care results in cost savings for high cost members.

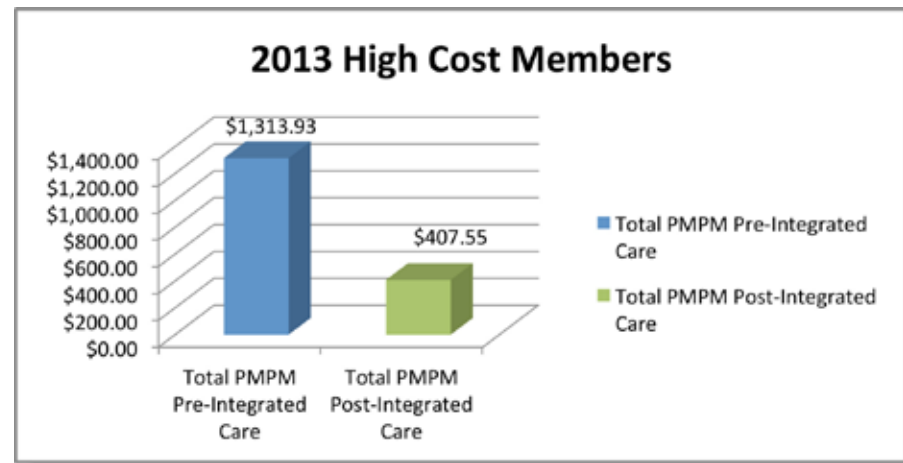
MidTown and North Shore Members with at least one month of eligibility prior to and after initial integration visit.

	Prior to Integration	Post Integration
Inpatient Claims PMPM	\$115	\$90
Outpatient Claims PMPM	\$62	\$58
Professional Claims PMPM	\$120	\$93

MidTown and North Shore Members with at 6+ months of eligibility prior to 9+ months after initial integration visit.

	Prior to Integration	Post Integration
Inpatient Claims PMPM	\$415	\$274
Outpatient Claims PMPM	\$196	\$88
Professional Claims PMPM	\$430	\$164





CMHC HEDIS Project

Working with six Community Mental Health Centers, we have focused on access to preventive medical care for our members. By using hot-spotting data analyses, we identified members who had been receiving behavioral health services, but had not received well-care visits. The partner CMHCs were given lists of MDwise members who received behavioral health services in their centers, but had not received care measured under HEDIS measures for childhood, adolescent, and adult preventive care and/or cholesterol screening (AWC, W34, LDL) each center designed outreach efforts to increase compliance with these measures. Additionally, provider incentives were set for reaching certain benchmarks for each measure. All six centers earned incentive monies for improving the receipt of preventive care for their work in 2013.

This project was one of several initiatives designed to improve HEDIS rates for these measures.

MEASURE	MDwise HEDIS 2013 REPORTED RATE	MDwise HEDIS 2014 REPORTED RATE
W34	69.34%	76.89%
AWC	50.85%	58.88%
LDL-C	66.24%	69.53%

For AWC, rates of member compliance ranged from 41.1%-60.7% across the 6 centers.

For W34, rates of member compliance ranged from 53.1%-83.3% across the 6 centers.

For LDL, member compliance rates ranged from 61.1%-80.4% across the 6 centers.

Location:

This program took place in Indiana.

Contact:

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WellPoint, Government Business Division

Rising Star

Description:

Members with three or more admissions over a six-month period for behavioral health disorders or lengthy behavioral health hospitalizations are offered the opportunity to be connected to a behavioral health home hospital/ hospital physician and home provider to encourage enhanced care quality from someone knowledgeable about the member's history with the ultimate goal of getting members involved in their health care decisions and direction. Providers are chosen for their willingness to work with members who may be difficult to engage and may have challenges adhering to treatment plans. Home hospitals/ providers are similarly chosen because of experience with such members and willingness to jointly create treatment plans with managed care case managers, member's home provider and the member and to hold the institution accountable for consistent enforcement of the treatment plan. No financial incentives are provided to the providers/hospitals but an agreement to release the provider/hospitals from traditional utilization management for members enrolled in the program. Each member is also assigned a field-based case manager that visits the member as needed in hospital or clinic and is able to work with the member and the members providers around care coordination.

Abstract:

Individuals with significant behavioral health challenges are frequently disadvantaged and underserved by the health care system. We have been working to identify a variety of protocols and programs to improve their care delivery and better meet their needs. More specifically we wanted to remedy the high utilization, lack of care coordination, and limited engagement by individuals with behavioral health needs.

Key Objectives:

- Improve the health of the population
- Enhance the patient experience of care, including quality, access, and reliability
- Control or reduce the per capita cost of care or increase efficiency

Actions Taken:

Each member that met the eligibility criteria worked with case manager to choose a willing home hospital and home physician. Members were provided support to obtain care from the home hospital and home physician. Home providers were exempted from some utilization management activities and provided supports to more fully engage members. Members were also assigned a WellPoint Case Manager who was able to engage the member in the field as needed.



Outcomes:

The program was initiated in the Houston Texas health plan and resulted in a dramatic reduction in hospital utilization, total medical and behavioral costs as demonstrated in the table and better stabilization of the member in the community. In Tennessee, the program resulted in a 48% reduction in Total Paid for Medical and Behavioral Costs, 47% reduction in admissions, 59% reduction in Length of Stay, and a 56% reduction in Readmissions of the Rising Star members. This also has resulted in a longer period of stabilization in the community and the program has “graduated” 18 members of the original 50 members in the program who have not been hospitalized for one year, a milestone not achieved by these members prior to their joining this program.

Table 1. Member Characteristics (Texas Only – initial pilot)

Outcome Mean (Min, Max) [25 th , 75 th percentile]	Baseline all Members (N=38)	Baseline Members Completed Program (N=18)	Post-Pre Program Difference (N=18)	p-value
Study Characteristics				
Length of Pre-program eligibility (months)	5.68 (1.5, 6.13) [5.97, 6.10]	5.36 (1.50, 6.10) [5.03, 6.10]	-	
Length of Active-Stage program eligibility (months)	10.53 (0, 27.52) [5.41, 14.70]	10.55 (1.67, 21.83) [6.50, 14.70]	-	
Length of Post-program eligibility (months)	1.01 (0, 6.00) [0, 0]	4.65 (0.93, 6.00) [3.07, 6.00]	-	
Study Outcomes				
Total Medical Episodes/month	5.23 (0.49, 46.8) [1.79, 5.28]	8.06 (0.99, 39.34) [2.30, 8.60]	6.34 95% CI: 1.81 – 10.88	0.009
Total Medical Cost/month	\$4,114 (\$36, \$14,733) [\$2,281, \$5,166]	\$4,306 (\$36, \$13,180) [\$2,396, \$4,970]	\$3,082 95% CI: 1,312 - \$4,852	0.002
All Inpatient Days/month	1.18 (0, 3.93) [0.66, 1.63]	1.23 (0, 3.93) [0.75, 1.33]	0.88 95% CI: 0.39 – 1.37	0.001
All Inpatient Cost/month	\$3,842 (\$0, \$13,556) [\$2,246, \$4,965]	\$3,874 (\$0, \$12,839) [\$2,314, \$4,498]	\$2,883 95% CI: \$1,298 - \$4,468	0.001
Total medical less BH Episodes/month	4.28 (0, 44.00) [0.98, 4.31]	7.12 (0.33, 35.74) [1.33, 8.20]	5.69 95% CI: 1.50 – 9.87	0.011
Total medical less BH Cost/month	\$616 (\$0, \$7,672) [\$36, \$606]	\$1,082 (\$36, \$7,672) [\$80, \$616]	\$703 95% CI: -\$342 – \$1,748	0.174
Mental Health/Substance Abuse Episodes/month	0.95 (0, 3.61) [0.50, 1.30]	0.94 (0, 3.61) [0.66, 0.99]	0.66 95% CI: 0.22 – 1.10	0.006
MH/SA Cost/month	\$3,498 (\$0, \$13,363) [\$2,201, \$4,235]	\$3,224 (\$0, \$7,584) [\$2,049, \$4,354]	\$2,379 95% CI: \$1,275 - \$3,482	<0.001
ER Visits/month	0.98 (0, 26.07) [0, 1.01]	2.22 (0, 26.07) [0.25, 1.65]	1.91 95% CI: -0.97 – 4.78	0.179
ER Cost/month	\$230 (\$0, \$3,346) [\$0, \$281]	\$390 (\$0, \$3,346) [\$38, \$409]	\$351.1 95% CI: -\$35 - \$737	0.072

Location:

This program took place in Texas (multiple counties) and Tennessee.

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UnitedHealthcare Community Plan of Arizona Tech and Touch Topples High-Risk Readmission

Description:

UnitedHealthcare Community Plan of Arizona is the largest Medicaid (AHCCCS) and Arizona Long Term Care Services (ALTCS) provider, with over 30 years of experience serving the needs of the Medicaid population. This health plan conducted a readmission reduction pilot in 2013 by the Telemedicine and Accountable Care teams, who creatively combined the use of electronic home monitoring, secured patient portal and care coordination follow-up to reduce readmissions among high-risk congestive heart patients from 20.6% to 8.3%. Pilot success in 2013 is setting the stage for horizontal and vertical expansion in 2014.

Abstract

Recent Medicare reimbursement changes place hospitals and health plans at financial risk for patients readmitted to the hospital with the same diagnosis within 30 days of discharge. Monitoring changes in weight and blood pressure, case managers were able to review findings with patients, coordinate follow-up care with primary care/specialty providers and keep members out of the hospital.

Key Objectives:

- Improve the health of the population
- Enhance the patient experience of care, including quality, access, and reliability
- Control or reduce the per capita cost of care or increase efficiency

Actions Taken:

UnitedHealthcare Community Plan of Arizona targets reductions in readmissions among congestive heart failure patients. Participants are provided with home monitoring equipment that collects, tracks and electronically reports vital sign information through cloud-based connectivity to a secure patient portal. A health care advisor monitors the portal, follows up with the patient and communicates alerts with PCP and specialty providers as needed. The program is expanding intervention methodology to include the use of telemedicine technology to provide post-discharge, follow-up visits between patient and PCP or specialty provider. Telemedicine will also be used to support medication reconciliation, patient assessment and provide an additional dimension to high-touch readmission reduction efforts.

Outcomes:

The proof of concept readmission reduction pilot tracked and monitored two or three patients every day for 30 days post-discharge. The pilot was conducted over a six-month period and included collaboration between UHCCP-AZ Yuma Regional Hospital and Preferred Home Care. Prior to the pilot, base line readmission rates for high-risk congestive heart failure patients were consistently running 20.6%. Monthly readmission rates during the pilot were reduced to 0% in some months and never exceeded 8.3% in any given month.

Location:

This program took place in Yuma, Arizona.

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Healthier Babies and Children

The Medicaid program is one of the largest sources of health insurance for children. According to the Centers for Medicare and Medicaid Services (CMS), Medicaid and the Children's Health Insurance Program (CHIP) provide health coverage to more than 43 million children. Health plans are accountable for ensuring that children receive necessary preventive services, including immunizations, well-child check ups, and dental care. Since Medicaid plans also provide services to pregnant women, they also have well established programs to improve prenatal care and care of newborns. The 12 programs described in this section illustrate health plan innovations and creative outreach strategies to improve the health of children and infants.

UnitedHealthcare Community Plan of Arizona Arizona Community Partners Oral Health Collaborative

Description:

The Arizona Community Partners Oral Health Collaborative is a partnership between philanthropic, business, non-profits, dental provider groups, and UnitedHealthcare Community Plan of Arizona (UHCCP-AZ). UHCCP-AZ, Arizona's largest Medicaid payer, has been providing care for the Medicaid and special needs populations for over 30 years. This collaborative seeks to expand oral health education to at-risk families through encounters at community centers, Head Starts, daycare, public health locations and school-based settings. Additionally, this collaborative combines forces to test real-life integration of oral health education initiatives by acting as outreach, health education and navigator to deliver on-site dental screenings to a growing Medicaid population. Target population is 120,000 UnitedHealthcare dentally-eligible members (aged 0 – 20), filtered by ZIP code and school/district settings.



Abstract:

Arizona state statistics shows 75% of third graders have had, or currently have, dental decay. Additionally, 50% of children aged 0–4 have never visited a dentist (Arizona Department of Health Services, 2009). Within the Child Health System Performance, Arizona ranks 49th for children's health, and 50th for children's oral health problems (Muggeridge, 2011). UnitedHealthcare currently serves approximately 200,000 dentally eligible children (aged 0–20) across 13 counties in Arizona. Internal data shows approximately 120,000 of these members have not had a dental exam in over 12 months.

Key Objectives:

- Improve the health of the population
- Enhance the patient experience of care, including quality, access, and reliability
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.

Actions Taken:

Recognizing the needs, UHCCP-AZ re-launched the UnitedHealthcare Dental Education Program. This program is a comprehensive presentation for students, school administrators, teachers and parents. The education program teaches adults to recognize oral health care needs, and the importance of promoting preventive dental habits in children. Furthermore, the UnitedHealthcare team decided to bring the clinical dental team to the schools during the education outreach to provide the students with a preventive service (prophylaxis, exam, fluoride varnish). A systematic approach was taken to identify the target districts, and schools within the district, which according to internal data showed the greatest disparities. UHC team dental department management evaluated the social landscape surrounding these districts, and outreached to community partners servicing the corresponding landscape. Additionally, strategic network recruitment was done to employ large dental in-network groups who have ties to the community, strong presence within the target districts/population, and the resources to complement the efforts. A collaborative meeting between UnitedHealthcare and community partners was set for a round-table discussion. Goals were to identify the target population by: phase, district, school, age range and encounter opportunity. Furthermore, all partners would volunteer their resources, strategies and networking opportunities for an all-over evaluation on how these resources could have the greatest impact when combined.

Target Population Data		Target ZIP Codes
Member Age Groups	Total Count per Age Group	Total Count of ZIP Codes
Age 0 – 10	78,028	304
Age 11 – 20	61,884	

ZIP Codes/Districts per Phase		
Estimated ZIP Codes per Phase	Estimated Districts per Phase	Estimated Member Count per Phase
3 – 4	12 – 20	10,000

Outcomes:

Community partners that agreed to participate in the collaborative are:

- **Esperança** – Global organization whose local projects include oral health education, screenings and community outreach to target low-income areas within Phoenix.
- **Golden Gate Community Center** – Community center within the Isaac School District in Phoenix. Serves over 7,000 adults, children, youth and seniors annually. Programs include Head Start for preschool children, referral case management for the community and adult education classes.
- **Discovery Triangle** – Organization that connects like-minded partners to encourage collaboration and creativity within the “discovery triangle” sector of Phoenix. Furthermore, manages a mobile unit that brings fresh fruits and vegetables to target low-income schools/neighborhoods.
- **Risas Dental Group** – Large clinical dental group that serves several counties within Arizona. Primary target population is Medicaid and uninsured individuals. Efforts include a weekly radio program that provides free dental education to a mass population within Phoenix. This group has a strong presence within the Hispanic population.
- **Murphy Children's Dental Clinic** – On-site, school-based, comprehensive dental home for the Murphy School District (Phoenix). This dental office is the only portable, self-contained, school-based comprehensive dental clinic in Arizona.
- **Arizona Tooth Doctor for Kids** – Dental group whose brick-and-mortar locations include offices in Phoenix, Globe and Mesa. Furthermore, two mobile units are used to provide preventive services to Arizona children during community events and at target school districts.
- **The Legacy Foundation** – Philanthropic organization that strengthens and supports community collaborations that focus on children, family and senior services. Additionally, this organization donates millions of dollars to non-profit organizations annually.
- **Saint Vincent de Paul Dental Clinic** – Comprehensive free dental clinic that provides treatment and preventive care to uninsured children and adults. This organization provides over 6,284 dental appointments per year and works with local schools to educate students on oral health.

A round table discussion yielded favorable results. Excitement and momentum was created to target specific districts, and schools using combined resources to identify the systematic approach to ensure all students within the school/districts (by phase) received dental preventive services. Future plans for implementation include education guides for facilitators, education for school nurses on recognizing dental emergencies, and combination of school events (back-to-school events, student assemblies) with clinical preventive dental services during events. Incentive strategies include gift cards for parents of students receiving dental preventive services, school-wide contests with prizes for students with proof of a dental encounter, and monetary grants for schools that promote oral health education.

Quantitative and Qualitative Outcomes

The quantitative outcomes are 46,585 closed dental gaps in care from the targeted population. Numerous collaborative outreach efforts originating from the collaborative have supported the outcomes thus far.

The qualitative outcomes have resulted from the following interventions:

- **Community Outreach Events (education/service)** – Several events were executed targeting members with gaps in care. Events were as follows: Dia De Los Ninos (Day for Children) and back-to-school health and safety fairs (Pima and Maricopa County). At these events, dental provider groups from the collaborative conducted screenings for both health plan and community members. Approximately 7,500 people received education at these events.
- **Member Outreach** – In addition to health outreach through the collaborative, provider partner Risas Dental enhanced member reach by launching a phone call campaign of 2,000 members (targeted list) to personally invite to dental outreach community events.
- **Media** – Risas extended outreach parameters through radio advertisement via a local radio show. The radio show promoted overall dental health and a back-to-school event.
- **Provider Outreach** – Lists of contact information for targeted members was sent to 500 in-network providers. These providers were encouraged to outreach these members and schedule a dental appointment. Additionally, fax blasts to 2,000 dental providers were sent to identify the collaborative goals, and to ask providers for help with outreach efforts through in-office interventions (apply services according to periodicity schedule, and call for appointments).
- **School Outreach Dental** – Dental outreach and education will begin in the fall. However, through this collaborative, district leaders have already been identified and added to the collaborative.

Location:

This program was a statewide effort, including all counties and an estimated 304 ZIP codes.

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AmeriHealth Caritas Pennsylvania and ProgenyHealth Care Coordination for Infants with Neonatal Abstinence Syndrome Secondary to In-Utero Opioid Exposure

Description:

The incidence of Neonatal Abstinence Syndrome (NAS) due to maternal opioid use during pregnancy continues to rise, and much of the cost burden is born by Medicaid. AmeriHealth Caritas Pennsylvania has experienced an increase of NAS in its NICU population similar to the national trend. ProgenyHealth noticed wide management variations and lengths of stay among NICUs and developed an evidence-based management guideline used to conduct care management for this often difficult-to-manage cohort.

This has resulted in an average of length of stay of 21 days for this population, which compares favorably to the consensus average of approximately 30 days as reported in the literature. Quality of care was maintained as evidenced by only a single readmission for further NAS treatment.

Abstract:

Illicit opioid abuse has reached epidemic proportions in the United States. It has been estimated that illicit drug use occurs in 4.4% of pregnant women, 16.2% among pregnant teens, and 7.4% among pregnant women 18 to 25 years of age. This has resulted in infants being born with opioid dependency. After delivery these infants begin to suffer withdrawal symptoms, termed neonatal abstinence syndrome (NAS). Based on a *JAMA* study from 2009, the NICU cost for an NAS admission is \$53,000 or over \$720M per year in aggregate, with nearly 80% attributed to Medicaid.¹ Additionally, a recent study published in the *Journal of Perinatology* demonstrated variation in hospital treatment of NAS resulting in wide variation in lengths of stay and hospital charges among 14 major US Children's Hospitals from 2004 -2011.² Increased length of stay is not only a cost-driver, but exposes the baby to hospital-associated morbidity, and can negatively affect the mother-baby dyad by delaying bonding. The incidence of NAS in the AmeriHealth Caritas Pennsylvania NICU population has continued to increase year after year, mirroring the national trend. It is now approaching 8% of total NICU admissions.

The goals of the program are to shorten the average length of stay for NAS cases thereby decreasing the associated inpatient costs by optimizing/standardizing treatment regimens, and to promote mother-baby bonding, while not adversely affecting clinical outcomes as measured by readmissions for NAS treatment.

Key Objectives:

- Control or reduce the per capita cost of care or increase efficiency
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.
- Promote maternal infant bond

Actions Taken:

Due to the wide inter-institutional variation in the management of NAS, ProgenyHealth sought to develop an evidenced-based treatment guideline for NAS. After a comprehensive, up-to-date literature review, ProgenyHealth in conjunction with its Medical Advisory Board, a group of nationally-representative, board-certified, practicing neonatologists, developed an NAS management guideline. This guideline is disseminated to participating NICUs to use as a clinical guideline and resource to assist them in the management of NAS infants. It is also reviewed with providers in NAS case discussions for the purpose of sharing evidence-based best practices to promote quality health care.

ProgenyHealth conducted a retrospective data analysis from its electronic database of all of AmeriHealth Caritas Pennsylvania's NICU patients with a diagnosis of NAS requiring pharmacologic treatment from 2007 through 2013 to assess the effect of its care management strategy on this population.

Footnotes

¹ Patrick SW, Schumacher RE, Benneyworth BD, Krans EE, McAllister JM, Davis MM. Neonatal Abstinence Syndrome and associated health care expenditures United States, 2000-2009. *JAMA* 2012; 307:1934-1940

² Patrick SW, Kaplan HC, Passarella M, Davis MM, Lorch SA. Variation in hospital treatment of neonatal abstinence syndrome in US Children's Hospitals, 2004-2011. *J Perinatol* 2014 Jun 12 doi: 10.1038/jp.2014.114. [Epub ahead of print]

Outcomes:

From 2007 through 2013, for the AmeriHealth Caritas Pennsylvania population of infants with NAS managed by ProgenyHealth, the average length of stay (ALOS) was 21 days. This compares favorably to consensus duration of approximately 30 days reported in the literature^{1,2} and represents a 30% reduction in ALOS. During this 6-year time frame, only one baby required readmission for treatment of NAS, supporting the clinical stability and readiness of infants at NICU discharge. These results also speak to the benefit of our well-established case management First Year of Life program, which has successfully reduced readmission rates. Case management supports this at-risk population by addressing parents' clinical concerns and by connecting them with available social support programs. Less time spent in the NICU translates to cost-savings for the health plan and supports the establishment of the mother-baby dyad. Of note, some of the infants were treated with a combined inpatient/outpatient medical protocol. When one major facility discontinued this approach due to lack of provider willingness, length of stay increased back to pre-program levels. Further development of a combined approach remains an opportunity that requires a coordinated effort between health plans and providers which can be facilitated by the type of programmatic approach that ProgenyHealth provides.

Location:

This program took place in Pennsylvania.

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About AmeriHealth Caritas Pennsylvania

AmeriHealth Caritas Pennsylvania, a member of the AmeriHealth Caritas Family of Companies, is a Medical Assistance (Medicaid) managed care health plan serving 26 counties in Central and Northwestern Pennsylvania. Headquartered in Harrisburg, Pennsylvania, AmeriHealth Caritas Pennsylvania is a mission-driven company dedicated to helping members get care, stay well and build healthy communities. For more information, visit www.amerhealthcaritaspa.com.

About AmeriHealth Caritas

AmeriHealth Caritas is one of the nation's leaders in health care solutions for those most in need. AmeriHealthCaritas operates in 16 states and the District of Columbia, and serves more than 6 million Medicaid, Medicare and CHIP members through its integrated managed care products, pharmaceutical benefit management services, behavioral health services and other administrative services. Headquartered in Philadelphia, AmeriHealth Caritas is a mission-driven organization with 30 years of experience serving low-income and chronically ill populations. For more information, visit www.amerhealthcaritas.com.

ProgenyHealth

ProgenyHealth delivers care management solutions to insurers and employer groups, managing the health care services provided to premature and medically complex newborns in the neonatal intensive care unit (NICU) after birth. ProgenyHealth's clinically driven program promotes appropriate NICU utilization, improves access to care, educates family members and reduces costs while maintaining the highest quality level of care.

Footnotes

¹ Kraft WK, Gibson E, Dysart K, et al. Sublingual buprenorphine for treatment of the neonatal abstinence syndrome: a randomized trial. *Pediatrics* 2008;122:e601–e607.

² Seligman NS, Salva N, Hayes EJ, Dysart KC, Pequignot EC, Baxter JK. Predicting length of treatment for neonatal abstinence syndrome in methadone-exposed neonates. *Am J Obstet Gynecol* 2008;199:396e1–e7

AmeriHealth Caritas Pennsylvania and AmeriHealth Northeast Cavity Free Kids: Oral Health Education for Preschoolers and Their Families

Description:

Cavity Free Kids is a Head Start-supported oral health education curriculum with the goal of implementing effective and creative ways to teach oral health to preschoolers and their families. Both children and adults learn about proper oral hygiene through a combination of demonstrations and fun, hands-on play-based activities, learning the best ways to prevent tooth decay. Since January 2014, 28 Cavity Free Kids events have been conducted throughout Northeastern and Northwestern Pennsylvania, providing oral health education to hundreds of members and their families.

Abstract:

Dental caries is the single most common chronic childhood disease — five times more common than asthma and seven times more common than hay fever. Children in low-income families suffer twice as many dental caries as adults, and their disease is far less likely to be treated. Poor oral health is related to poor performance in school, poor social relationships and lower success in later life. Knowledge is a powerful tool in combating these problems. Through early childhood education programs, Cavity Free Kids works to incorporate information and understanding about the importance of dental care into peoples' daily lives, and as a consequence, change behaviors and attitudes, leading to improved oral health.

Key Objectives:

- Improve the health of the population
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.
- Oral health education

Actions Taken:

AmeriHealth Caritas Pennsylvania partnered with dental-provider practices to hold Cavity Free Kids at a variety of locales, including Head Start centers, YMCAs, public schools, public libraries, shopping malls, and a Holiday Inn. AmeriHealth Caritas Pennsylvania-based community outreach specialists were trained and certified by the Pennsylvania Head Start Association as health educators. Our health educators then partnered with our local Head Start chapters to jointly provide oral health training to teachers, parents and children.

Cavity Free Kids provides early learning educators with user-friendly tools to incorporate five essential oral health concepts into classroom activities, home visits, parent education and family-fun nights. The five essential oral health concepts are:

- Let's Clean Our Teeth
- Get a Dental Check Up
- Why We Need Teeth
- What Hurts/Weakens Teeth
- We Can Keep Our Teeth Strong



The training material was prepared by the Washington Dental Service Foundation (www.cavityfreekids.org). Training topics included flossing and brushing demonstrations; acid attack demonstration; how much sugar is in an average daily meal; and a parent meeting on taking care of teeth. These demonstrations were accompanied by training activities for children. To better engage children and their parents, one health educator developed the idea of employing a tooth fairy theme, which has been very well received by children and their parents alike.

Outcomes:

From January 1, 2014, to the present, community outreach specialists and health educators (trained by the PA Head Start Association) have performed 28 Cavity Free Kids presentations throughout the 35 counties of Northeastern and Northwestern Pennsylvania. In two of the larger events (i.e., at the Cranberry Mall and Clarion Holiday Inn), 800 to 1,000 participants attended, including hundreds of AmeriHealth Caritas Pennsylvania members.

Location:

This program took place in 35 counties within Northeastern and Northwestern Pennsylvania.

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Select Health of South Carolina Collaborative Community Approach to Improve Asthma Medication Compliance

Description:

Select Health of South Carolina initiated a multi-pronged community outreach effort to First Choice members with asthma to increase coordination of care and decrease barriers to access of services, equipment and care. This outreach included targeted interventions to specific populations to address disparities within the asthma population, including members who self-identified Spanish as their primary language and those within the foster care system.

Abstract:

Because asthma complications can be prevented with proper use of and adherence to medication, Select Health works to ensure that all members with asthma fill their prescribed asthma controller medications. Using pharmacy data, Select Health identified members without asthma controller medication or with 50 percent or less asthma medication. A workgroup comprised of a representative from each department within Select Health evaluated members' geographic location, gender, ethnicity, preferred language and primary care provider, identifying Spanish language and foster child subset populations as groups with particular disparities.

Key Objectives:

- Control or reduce the per capita cost of care or increase efficiency
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.
- Reduce disparities in care of racial and ethnic minorities

Actions Taken:

Clinical support staff made outreach calls to inquire about and assist with barriers. Members were provided with community resources and assistance contacting First Choice care connectors/managers and their primary care provider as necessary. Calls were followed with mailed communications tailored to First Choice members' needs. The mailings provided information about transportation services and mileage reimbursement, mail order pharmacy service, asthma action plans and other community resources. The packages also included an "Every Day Matters – Breathe Easy" asthma bracelet and mirror/refrigerator cling as reminders of the importance of daily medication compliance.

Select Health also addressed well visits to enhance this intervention. Members with coordination of care issues were referred to care management. Members who could not be reached by phone were referred to health plan based- or community-based asthma educators who travelled to members' homes to meet with them in person.

In addition, Select Health contacted Spanish-speaking members to assist them with access to the plan's language line service, advising them about free language services and Spanish-speaking providers in the network. Foster care members received coordination of care services from their Department of Social Services case workers/health plan case managers and foster parents.

To further supplement these efforts, First Choice members were informed about and given assistance enrolling in asthma education camps hosted by the American Lung Association. Select Health sponsored several local events for the purpose of asthma education. Our asthma educator and community outreach specialist also outreached to school nurses, providing tools from the Centers for Disease Control and Prevention and the Environmental Protection Agency related to the management of asthma in schools.

Outcomes:

After implementing this community outreach effort, our Healthcare Effectiveness Data and Information Set (HEDIS®) asthma compliance rates improved across multiple measures and resulted in some of the best rates of compliance historically.

- Appropriate Use of Asthma Medication for ages 5 to 11 years: Compliance increased 3.3 percent, from 90.4 percent in 2012 to 93.4 percent in 2013.
- Asthma Medication Compliance (50 percent): Compliance increased 11.5 percent, from 51 percent in 2012 to 56.8 percent in 2013.
- Asthma Medication Compliance (75 percent): Compliance increased 13.6 percent, from 27.3 percent in 2012 to 31 percent in 2013.

There was also a statistically significant improvement in well visit compliance.

Location:

This program took place throughout the state South Carolina.

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Managed Health Services, Centene® Corporation

Early Periodic Screening, Diagnosis and Treatment (EPSDT) On-site Review and Education Program

Description:

Managed Health Services, or MHS, is committed to promoting preventive health screenings and improving the complete health of children enrolled in its health plans. The EPSDT On-site Review and Education program promotes quality and dynamic well-child care, appropriate well-child documentation habits and provider awareness of pediatric preventive care. Over the past three years, MHS has seen a sustained increase in child-related HEDIS measures.

Abstract:

With the high proportion of children in our population, our ability to impact the incidence of EPSDT and pediatric preventive well child exams is of vital importance to the overall well-being of our membership. Ensuring our members were receiving the necessary preventive care was imperative.

Further, MHS was not consistently performing as desired on all child-related HEDIS measures. In measurement year 2011, MHS scored below the 75th percentile for Adolescent Well-Care, Well-Child 0-15 months, Well-Child 3-6 Years and Lead Screening in Children. These contributing factors were identified during the HEDIS audit process. Some office visits submitted by providers were listed as a “well-child visit” but did not have the required documentation to count as a well-child visit. On the other hand, some office visit notes had the required well-child documentation but were not coded or billed as so. Further, lead screenings were being performed, but often times after the child’s second birthday, making the date of service not eligible for HEDIS.

Key Objectives:

- Improve the health of the population
- Enhance the patient experience of care, including quality, access, and reliability
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.
- Demonstrate accountability of Medicaid health plans, including fraud and abuse

Actions Taken:

The program has implemented ongoing processes to monitor compliance with the EPSDT program requirements and initiated interventions to promote substantial and sustained improvement over time. The key aspects of the program are on-site provider reviews and provider education. In addition, to improve our child-related HEDIS scores, we decided to review well-child billing and documentation, and missed opportunities for preventive care.

A Quality Improvement EPSDT Coordinator facilitates on-site reviews for at least 24 primary medical provider offices each year. Providers are randomly chosen and targeted based on HEDIS results, and large panel providers are prioritized for an annual EPSDT review. In coordination with Provider Relation Specialists, the primary medical providers are notified that an on-site record review will be scheduled. The Quality Improvement EPSDT Coordinator assesses EPSDT practices and documentation habits using a standardized audit tool. Preliminary audit results are reviewed with the provider office at the conclusion of the medical record review. Education is offered at this time. Model record-keeping aids, such as Bright Futures and other standardized documentation forms, are shared with providers as indicated. A comprehensive packet is mailed to the providers within 45 days of the audit by the Quality Improvement EPSDT Coordinator. The packet includes audit result letter, a copy of the completed audit tool and any appropriate education handouts. For any provider who’s overall audit score is below 80 percent, a follow-up on-site review is scheduled within nine months’ time. This allows time for the provider to implement interventions.

Outcomes:

Since 2011, over 165 on-site reviews have been conducted. Of those reviews, 27 providers were identified in need of a re-audit. As of August 2014, all of those providers have passed the re-audit. A handful of offices requested an EPSDT on-site review to help identify areas of improvement. For measurement year 2013, MHS reached above the 75th percentile for the HEDIS Adolescent Well Care and Well-Child 0-15 months measure and above the 50th percent for the HEDIS Well-Child 3-6 Years measure. Exact percentage increases are shown in the table below.

HEDIS Percentage by Measure			
Measurement Year	Adolescent Well Care	Well-Child 3-6 Years	Well-Child 0-15 months
2011	55.10 %	65.05 %	61.18 %
2012	54.30 %	67.55 %	65.12 %
2013	62.03 %	72.63 %	71.74 %

MHS has continued to see an increase in HEDIS Lead Screening in Children scores. The number of Medtox Lead screenings has improved from 1,394 in 2011, 1,961 in 2012 and up to 2,216 in 2013.

Location:

This program took place in Indiana.

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MDwise, Inc.

Everyone Needs Check-ups: An Initiative to Reduce Barriers to Care and Care Gaps and Improve the Health of MDwise Members

Description:

Everyone Needs Check-ups is a multi-faceted initiative that began in 2008 and has gained momentum over the years as it expanded to all areas of the health plan. The program started with a campaign that appeared on the MDwise website providing preventive care guidelines by age and gender and targeted postcards with these guidelines sent to all MDwise members. The campaign also appears on signage used at Outreach and Provider events, in provider materials and signage, advertising and website banners. As the program developed, the focus shifted to take a look at the planning and coordination of outreach events to meet Health Effectiveness Data and Information Set (HEDIS) goals, establish relationships with members, and otherwise increase access to care. The MDwise Outreach and Network Improvement Program (NIP) Team started working with providers and Federally Qualified Health Centers (FQHC), Community Health Centers (CHC), and large volume practices to create events targeting MDwise members who were in need of preventive health care services. The Network Improvement Program (NIP) team also offered their specialty of ensuring that the health centers billed for the services provided at the events in order to get proper credit for HEDIS. The MDwiseRewards program was promoted with this effort since MDwise members receive points for getting check-ups and other preventive care through this program, which results in gift cards to the member. Additionally, the members were informed that they'd also receive a bonus \$10 gift card at the event when they were being scheduled for their appointment. Backpacks filled with school supplies were provided at some events through the MDwise Tools for Schools program and MDwise's mascot, Ms. Bluebelle, was present at many of the events. MDwise members were educated on the health plan including the myMDwise member portal on the website. At events that were also open to the community, uninsured individuals that were encountered were provided with resources to apply for health insurance.

Abstract:

According to a focus group done with physicians and dentists by Washington University Center for Health Policy, non-compliant /undependable patients was listed as a top medical challenge with Medicaid patients. MDwise's experience, as most managed care organizations and physicians report, is no different. MDwise has historically promoted to its members seeing their doctor for preventive care. This program was designed to place even more emphasis on preventive care and use expanded tactics to promote the message and provide opportunities for non-compliant MDwise members to get annual check-ups and health screenings outside of normal doctor office business hours.

Key Objectives:

- Enhance the patient experience of care, including quality, access, and reliability
- Improve the health of the population
- Control or reduce the per capita cost of care or increase efficiency

Actions Taken:

In the past year, the following initiatives were in place. Some of these initiatives have been in place for several years:

- 1) Developed an over-arching campaign theme "Everyone Needs Check-ups" with preventive care information that appeared on the MDwise website, signage and materials.
- 2) Created targeted direct mail postcards with preventive care schedules were mailed to all MDwise members. The postcards were customized by age/gender. Over 200,000 postcards have been sent to MDwise households each year since 2008.
- 3) Provider educational materials were developed by the NIP team and distributed to provider's offices. These materials include the W15 flyer for 0-15 months measure and Well-Child First poster, which provides specific procedure codes for EPSDT/Well-Care, Preventive/Well-Care and Sick Visit Plus EPSDT, and each year's full HEDIS performance measures with billing codes poster.
- 4) The Outreach and NIP teams establish planning sessions with appropriate individuals at the provider offices to initiate and discuss ENC event details, work flow, processes, best practices, resources, and expectations. The NIP team presents, reviews, and explains HEDIS and quality data during the initial meeting to determine which HEDIS measures to target during the ENC event.



- 5) The Outreach and NIP teams provide ideas and suggestions to the ENC planning committee on how to reach members, advertise event, and how to plan for the event and the teams provide and explain to provider office/scheduler the talking points for an ENC Day, highlighting the incentive offered, importance of coming into the doctor, and promote MDwise outreach.
- 6) The NIP team provides HEDIS reports to the ENC planning committee, along with other ad hoc lists of HEDIS and quality information as requested by the committee.
- 7) The NIP team conducts a data pull of non-complaint members for provider's offices on specific HEDIS measures to guide the planning of an event.
- 8) The Outreach team partnered with provider's offices, FQHCs and CHCs planned and hosted Outreach events to provide expanded access to care. The events were customized to member's needs in the targeted areas. The events were held at times that are convenient for the member, which are typically evenings and weekends. Some events were held for an entire week to ensure the most coverage possible. All of the events were promoted throughout the communities with flyers, posting on the MDwise website, local publication calendar alerts and grass roots efforts to spread the word about the events. The health plan Delivery System, Outreach team and/or the provider's office staff contacted members with care gaps directly to set-up appointments.
- 9) Incentives were offered to increase member attendance at the events. These included points towards a gift card for the MDwiseRewards program and backpacks with school supplies. MDwise Rewards is also promoted on the MDwise website, member newsletter, direct mail postcards, flyers, provider office pieces, etc. Preventive care is the overarching focus of the MDwiseRewards program.

Outcomes:

MDwise created several MDwise Member Events across the state in the past year to carry out the Everyone Needs Check-ups initiative.

- 1,826 MDwise members have completed preventive care appointments from Aug of 2013 to date through ENC events — including well-child visits, LDL screenings and other quality measures.
- 3,124 MDwise members were scheduled to receive their check-ups through ENC events; therefore the attendance rate was 58.5%, which is slightly lower than 2013's attendance rate of 61%. This statistic represents events that were held to date in 2014, which were mostly held between April and August.
- Each member and their families received direct member education on MDwise benefits, how to stay enrolled and were able to get answers to questions they have regarding their health coverage.

- The MDwise outreach and NIP team has forged strong relationships providers, FQHCs and other key partners to expand opportunities for members to complete preventive visits and provide education on the MDwise Health Plans.

FQHCs in Central Indiana

- 140 non-compliant members who had not received their well-child visits came to a single Everyone Needs Check Up event in partnership with IU Health Family Medicine Residency in Central Indiana. A total of 240 non-compliant members were invited, with a similar attendance rate with all of our events. We also offered additional information about MDwise specific programs, such as MDwiseRewards, SafeLink, ER use, and MDwise special programs.
- MDwise and HealthNet have had events at multiple HealthNet health centers in Central Indiana in 2013. Out of the 238 non-compliant members that were invited, 186 members received their well-child visits. We also have offered additional information on bicycle safety, nutrition, reading, physical activity, and dental health at these events. All of the MDwise members who attend the events were educated on myMDwise and how to redeem MDwiseRewards at these events.

Provider groups in East Central Indiana

- 216 non-compliant members who had not received their well-child visits
MDwise and MDwise Hoosier Alliance worked with provider offices and community health centers to organize and hold seven ENC events in 2013. Out of the 371 non-compliant members that were invited, 216 members received their well-child visits. The outreach team also educated 440 MDwise members on how to sign-up for the myMDwise and how to redeem MDwise Rewards at these events. At selected sites, free dental screenings were provided to all children that attended.
- 210 non-compliant members who had not received their well-child visits
MDwise teamed up with MDwise Hoosier Alliance, Select Health Network, providers, FQHCs and CHCs on 13 ENC events. Out of the 334 MDwise members who were scheduled to receive their preventive care, 210 received their well-child visit. The outreach team also educated 88 members on the MDwiseRewards Program and signed up 80 MDwise members on the MDwise Portal at these events.

Location:

The educational pieces were distributed or mailed statewide and/or available on the website to all MDwise members and providers. MDwise and the health centers that collaborated on Outreach events conducted the Everyone Needs Check-ups initiative in the following communities:

- | | |
|--|---|
| ■ Michigan City, Indiana (LaPorte County) | ■ South Bend, Indiana (St. Joseph County) |
| ■ Anderson, Indiana (Madison County) | ■ Terre Haute, Indiana (Vigo County) |
| ■ Mishawaka, Indiana (St. Joseph County) | ■ Fort Wayne, Indiana (Allen County) |
| ■ Evansville, Indiana (Vanderburgh County) | ■ Plymouth, Indiana (Marshall County) |
| ■ Indianapolis, Indiana (Marion County) | ■ Delphi, Indiana (Carroll County) |
| ■ Kokomo, Indiana (Howard County) | ■ Bedford, Indiana (Lawrence County) |
| ■ Gary, Indiana (Lake County) | ■ Knox, Indiana (Starke County) |
| ■ Logansport, Indiana (Cass County) | ■ Linton, Indiana (Greene County) |
| ■ Peru, Indiana (Miami County) | ■ Seymour, Indiana (Jackson County) |

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Health Partners Plans (HPP)

Healthier YOU! Baby Partners Program

Description:

The Baby Partners program was designed to help educate pregnant Health Partners Plans (HPP) Medicaid members about the importance of getting proper prenatal and postpartum care. Baby Partners program participants receive:

- Case management services that include telephonic-based education and information about pregnancy, childbirth and child care after delivery
- Home visits for high-risk pregnancies as needed
- Member incentive where members may receive up to \$100 for completing an early prenatal visit, receiving dental care and having a postpartum visit
- Referrals for domestic violence support, depression counseling, quit smoking programs and transportation
- Doula support (prenatal and postpartum) for members who lack social support or require breastfeeding education or may need childbirth coaching
- Follow-up care for mom and baby after delivery
- Help finding a pediatrician
- A 24-hour breastfeeding helpline, staffed by certified breastfeeding counselors

In 2012, Finity Communications was awarded a Health Care Innovation Award designed to lower costs and improve the health and care of Health Partners Plans members. One of the ways HPP used the grant was to enhance its existing Baby Partners program, by incorporating real-time reporting and measurement into the program.

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Abstract:

Using evidence-based guidelines, the Baby Partners program strives to optimize the health outcomes of Health Partners Plans pregnant members and to promote the importance of preventive health care. The program helps members understand how their baby develops during pregnancy and the ongoing care required for a healthy outcome. It also enables case managers to maintain regular communications with pregnant members so that they can answer questions, provide information and resources and respond to special needs in a timely fashion. Interventions are member specific in order to address barriers to care, as well as behaviors that may potentially jeopardize the outcome of the pregnancy.

Key Objectives:

- Improve the health of the population
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.
- Utilize new innovation and technology to improve member health outcomes, while maintaining quality and reducing costs

Actions Taken:

Our Health Care Management team developed an incentive program that rewards members who schedule needed checkups, while staying in contact with their Baby Partners case manager throughout their pregnancy. This initiative was also designed to improve HEDIS measures in the areas of prenatal and postpartum care, as well as dental screenings for pregnant members.

Through a partnership with acknowledged industry leaders in prepaid card and transaction technologies, Baby Partners launched the new incentive program in 2012. Through the program, members are given a restricted gift card good for purchases such as diapers, lotion, shampoo, milk, and medicine at participating stores. Members can earn up to \$100 loaded onto the card. Upon completion of each of the following doctor visits, the cards are credited with \$25:

- A prenatal visit within the first trimester or within 42 days of enrolling in a HPPs Medicaid plan.
- Completion of a dental screening visit (anytime throughout the pregnancy and up to 60 days post-delivery)
- Postpartum visit within 21 to 56 days
- Members receive an additional \$25 after completing all three visits.

If a member completes any of the above appointments within the specific timeframe, yet loses contact with Health Partners Plans, she will receive a letter acknowledging the appointment. The letter will also inform her that she must speak with a Baby Partners case manager in order for her card to be credited. Once the member calls, the card is loaded with the correct dollar amount.

Through the Health Care Innovation grant, members were also able to register for the new member portal that includes pregnancy specific content. The portal offers a personalized pregnancy experience that evolves based on stage of pregnancy and tracks their progress towards completing the Baby Partners rewards program. It also features interactive tools, games and movies to promote a healthy lifestyle during and after pregnancy.

Outcomes:

We completed our first analysis of the Baby Partners program that includes the data collected from the Health Care Innovation Grant-funded reporting. The results are as follows:

- Participants were included in the analysis if they had a delivery from July 2012 to June 2013 and earned an incentive on the gift card
- There was a total of 1,105 participants
- We saw an average cost difference of babies born to participants vs. non-participants of \$437.38 per-member per-month (PMPM)
- This equated to a savings for the first 3 months post-delivery for babies born to participating mothers of approximately \$1.5M
- \$92K was spent on incentives and about \$1,500 on engagement efforts. Thus, the net savings for the first three months post-delivery for babies born to participating mothers is approximately \$1.4 million.
- For participants, the odds of delivering a low weight baby was lowered by 14% and had a 20% higher postpartum office visit rate
- Compliance to preventive care were higher among participants, even with non-incentivized activities such as pediatric visits

Location:

This program took place in the following counties: Bucks; Chester; Delaware; Montgomery; and Philadelphia.

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HealthPlus Amerigroup, a WellPoint Company

Keeping Kids in School Asthma Education Program

Description:

The Keeping Kids in School Asthma Education Program uses an innovative approach to promote asthma awareness and control among children, parents, teachers and adults in underserved communities in New York City. The program consists of three components: School-based interactive classroom education for students in grades 3-6; parents/adults asthma workshops and Annual Asthma School Poster Contest & Awards Ceremony. Since the launch of the program in 2001, almost 58,000 children in NYC public elementary schools and over 18,000 parents/adults have participated in the Keeping Kids in School Asthma Education Program.

Abstract:

Asthma, the most common chronic childhood disease, affects as many as 7 million children in the United States (National Health Interview Survey, 2008). This makes it the leading cause of absence from school. More than 1 million NYC residents- including 400,000 children suffer from asthma. Not only does asthma needlessly claim the lives of close to 3,500 Americans and over 200 New Yorkers each year (NYSDOH, 2013), the disease is also the leading cause of missed school and hospital stays for children in NYC.

In New York City, the greatest burden is among children from poor, minority communities. In an effort to raise awareness about asthma (to all children), reduce disparities in care of racial and ethnic minorities and improve the quality of life for children, families, and communities in NYC, HealthPlus Amerigroup developed the Keeping Kids in School Asthma Education Program. Committed to promoting healthy lifestyles in NYC communities, the asthma education program is extended to all residents of the communities served by the plan, regardless of membership in the plan.

Key Objectives:

- Improve the health of the population
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.
- Reduce disparities in care of racial and ethnic minorities

Actions Taken:

Dedicated resources committed by the health plan: one full-time Asthma Educator dedicated to the school-based program, to coordinate and implement classroom education sessions at NYC public elementary schools; a multi-lingual and culturally diverse team of Community Health Educators that provide parent/adult asthma workshops at schools, health centers, FQHCs, WIC Offices, Head Start programs, community-based organizations and health plan offices. This team of Health Educators also provides health promotion programs on children's and women's health, as well as prevention and control of chronic diseases.

Forged strong collaborative partnerships with city and social agencies, asthma coalitions and sports organizations: NYC Department of Education to implement asthma classes at NYC public elementary schools, gain support of the Office of School Health & Office of School Wellness Programs, and provide access to health insurance for uninsured children. Partnership with NYC Department of Transportation- Air Quality & Education and Outreach Division to expand venues for asthma awareness and joint community health initiatives, NYCDOT co-sponsorship of annual asthma school poster contest and development of annual Air Quality Awareness calendar displaying winning artwork. Partnerships with NYC Department of Health and asthma coalitions facilitate joint community interventions as well as citywide distribution of annual asthma calendar. Partnerships with sports organizations and celebrities increased program engagement and enjoyment for children and their families, and facilitated venues to hold school poster contest awards ceremony (i.e., CitiField with the NY Mets for various years).



Outcomes:

Since the launch of the Keeping Kids in School Asthma Education Program in 2001, almost 58,000 children in NYC public elementary schools have received asthma education via 2,320 classroom sessions, and over 18,000 ethnically and culturally diverse parents/adults have been reached via multi-lingual workshops. On average, 20 public elementary schools citywide and over 3,000 students participate in the annual school poster contest. Since 2001, over 1,000 posters have been submitted by 235 schools for the annual contest displaying children’s asthma awareness through art. Winning posters are showcased in NYC Air Quality Awareness Calendar in collaboration with the NYC Department of Transportation, and calendars distributed to all program participating schools, city and social service agencies, health centers and health plan employees (which are displayed in workstations).

Impact assessments (questionnaires) conducted with participating schools, community partners, health plan members and workshop attendees, show high satisfaction with the Keeping Kids in School Asthma Education Program, and increased knowledge on asthma.

Location:

This program took place in NYC (Brooklyn, Queens, Manhattan, Staten Island and the Bronx) and Nassau County, Long Island.

**Keeping Kids in School Asthma Education Program
Classroom Education (Grades 3-6)**

School Year	# of participating schools	# of classroom sessions	# of student attendees
2001-2002	11	65	1503
2002-2003	8	68	1049
2003-2004	27	213	5331
2004-2005	31	234	5682
2005-2006	30	263	6380
2006-2007	31	245	5435
2007-2008	36	296	7004
2008-2009	34	221	5925
2009-2010	31	174	4649
2010-2011	24	140	3919
2011-2012	20	127	3,250
2012-2013	25	148	4220
2013-2014	24	126	3400
Total		2,320	57,747

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Health Partners Plans (HPP)

Oral Health Initiative

Description:

Since dental care is an essential element of primary care for children, the Oral Health Initiative was developed to provide members with the ability to receive a physical well-care exam and a dental prevention exam on the same day at the same place. We identified three Federal-Qualified Health Centers (FQHC) — Delaware Valley Community Health (DVCH), Greater Philadelphia Health Action (GPHA) and Spectrum Health Services. Combined, they have seven sites that offer both medical and dental services at the same location. We identified 3,000 members across the three FQHC locations that met the criteria for outreach and coordination of care.

Abstract:

In the US, approximately 53 million children and adults have untreated tooth decay in their permanent teeth. Much of this problem is preventable. Tooth decay remains one of the most common chronic diseases of childhood. Therefore, we targeted children ages 2-20. By taking a proactive approach we are hoping to help combat tooth decay early.

The Oral Health Initiative is designed to increase dental screenings and access to preventive services for our pediatric at-risk population. Oral health impacts physical health. Additionally, there are significant cost benefits of preventive services versus restorative services. Our program attempts to close the “dental care gaps” of our members who have not seen a dentist since 2013. The initiative is also designed to encourage collaboration between medical and dental providers. Conference calls and site visits are conducted with the FQHC’s Chief Medical Officer and dental providers to discuss and coordinate participation and implementation of the program.

Key Objectives:

- Improve the health of the population
- Enhance the patient experience of care, including quality, access, and reliability
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.



Actions Taken:

There are several components that make our Oral Health Initiative a success. They include:

- Financial incentives for members and providers who participate.
- Promoting healthy eating by giving \$25 ShopRite gift cards to members who complete the dental screenings. They also receive lunch bags with literature about healthy eating and good oral hygiene.
- Appointment scheduling assistance. We perform targeted three-way telephone outreach to close gaps in care by coordinating dental appointments with providers and members via follow up calls and rescheduling appointments. To date, a total of 3314 calls have been placed and 541 appointments have been scheduled.
- Chopper Check. In partnership with the St. Christopher's Foundation for Children, a mailing is sent to our members ages 3-9 who have not had a dental visit in the prior year. We conducted five Chopper Check events in 2014. Approximately, 200 young members have been seen at the events, with 100 mailing in proof of having received a dental screening.
- Identification of pediatric members at risk of tooth decay. Through our vendor, Avesis, we identify pediatric Medicaid members who are at high risk for serious future dental disease, based on having a sibling that had a significant amount of dental services due to excessive decay. We obtain a list of 1,030 members that had over \$1,000 of dental work in 2013 (excluding certain claim codes and orthodontics). The HPP Health Care Economics department then attempted to link the children on the list to family members under 21 years old. This list showed 1,132 members that had the same subscriber number and 85 members that had the same phone numbers but not the same subscriber numbers. This may mean that all of the identified children may have a sibling that has had high cost restorative dental care.
- Collaboration with Head Start programs in our service area to share data for enrolled children who are in need of dental screenings.
- Automated Televox calls to remind members when they are due or overdue for a dental screening.
- 15 "Dental Muppet Shows" that promote good dental health for children.
- A designated dental hotline for members and providers.

Outcomes:

The Oral Health Initiative started July 2014. As of August, 19, 2014:

- 279 calls have been placed
- 135 members have been reached
- 96 appointments have been scheduled
- 128 dental screenings have been completed
- Monthly teleconference calls are held with the FQHCs to evaluate progress, address barriers and prepare and discuss member care gap reports
- We conduct quarterly reviews of the dental rates of targeted members to determine if additional outreach is needed

Location:

This program took place in Philadelphia.

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Centene® Corporation

Start Smart for Your Baby® Texting Program



Description:

The Start Smart For Your Baby® (SSFB) Texting Program is a component of our comprehensive Start Smart For Your Baby Care Management program that was created in 2008. The Texting Program was rolled out in January 2012 and aims to improve maternal and infant health by providing timely health information, resources and reminders to members during their pregnancy and continuing six months after birth. Specifically, the program's goals are to encourage breastfeeding and increase prenatal, postpartum and infant well-child visits for our Medicaid members.

Abstract:

In 2010, we determined breastfeeding initiation rates among many of our health plans were lower than the national average of approximately 75%.¹ Increasing these rates was important because of the benefits breastfeeding has. Studies have shown breastfeeding helps protect babies from infections such as earaches, coughs, colds, and diarrhea. It also helps protect against diseases later in life. Adults who were breastfed as babies have less tendency to become overweight as well as a lower chance of getting diabetes, asthma, childhood leukemia and some other cancers. Moms who breastfeed also have less chance of getting ovarian cancer, breast cancer, and diabetes.² We also saw prenatal and postpartum visit rates were lower in the Medicaid population. In response, the Start Smart For Your Baby Texting Program was developed to communicate the benefits of breastfeeding, share other prenatal and postpartum health tips and send reminders about doctor visits and certain health plan benefits to our members who are pregnant or have just delivered. With the digital divide closing across all ages and socio-economic groups, we find that online and texting services are increasingly effective in reaching and engaging our target population.³⁻⁴

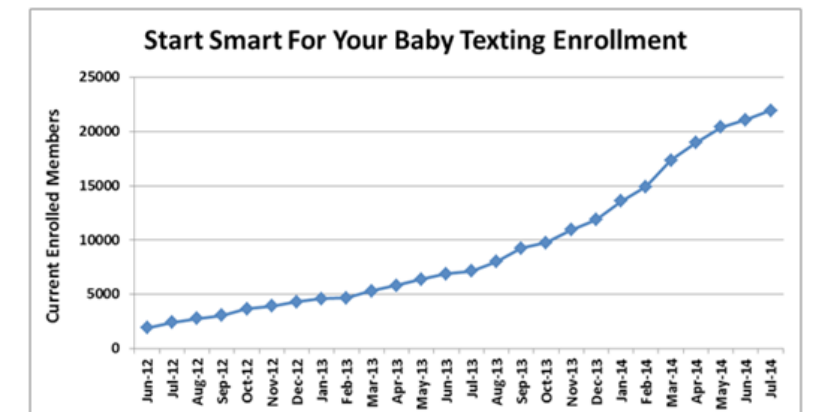
Key Objectives:

- Improve the health of the population
- Increase breastfeeding rates, prenatal, postpartum, and well-child visit rates among our member population.
- Educate our members who are pregnant or have just delivered on healthy prenatal and postpartum care for them and their baby

Actions Taken:

We developed a thorough and comprehensive text campaign to target our members who are pregnant or have just delivered and who agreed to participate in the program. Members may opt out of the text campaign at any point by texting back STOP. A concurrent email campaign with more detailed information is also available to members. All text messages and emails are individually timed to each member's due date or baby's date of birth so information is received when it is most relevant. Members receive one text message every two weeks during pregnancy through six months postpartum. We worked closely with obstetricians, pediatricians, and clinicians to determine which information was most important to send at each interval.

The text messages include critical information about a variety of important topics, including talking to your doctor during prenatal visits and scheduling postpartum visits. We also remind them of well-child visits, immunizations, healthy nutritional habits for pregnancy, tips for feeling better during pregnancy, baby feeding tips, and the benefits and importance of breastfeeding. As we will show, we had impressive success with our Texting Program to increase breastfeeding and HEDIS rates for members in the program. The program has been well-received with 94% of members who responded to a question at the end of the program finding the texts somewhat helpful or very helpful.



Outcomes:

Over the life of the program, more than 476,700 text messages have been sent out to over 37,000 different members across 16 health plans, and over 24,700 Texting Program participants have delivered babies. Nearly 22,000 members are enrolled in the program.

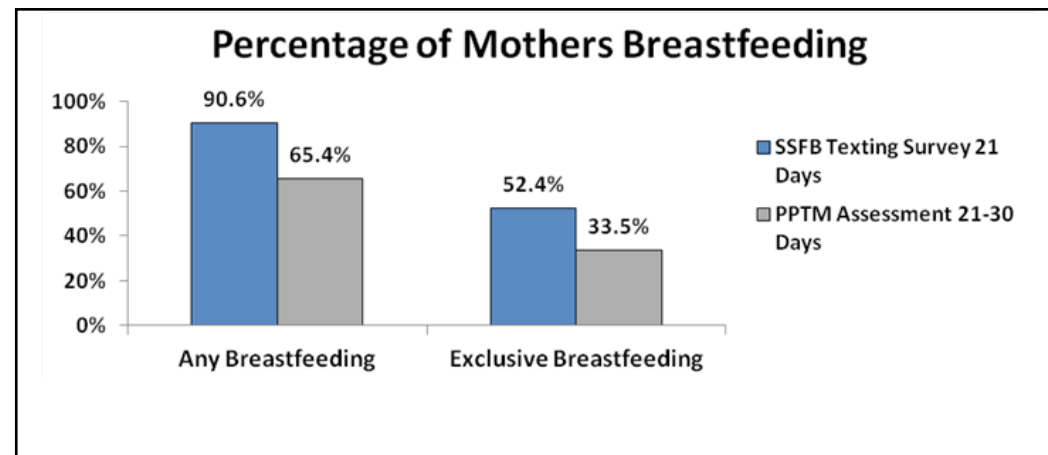
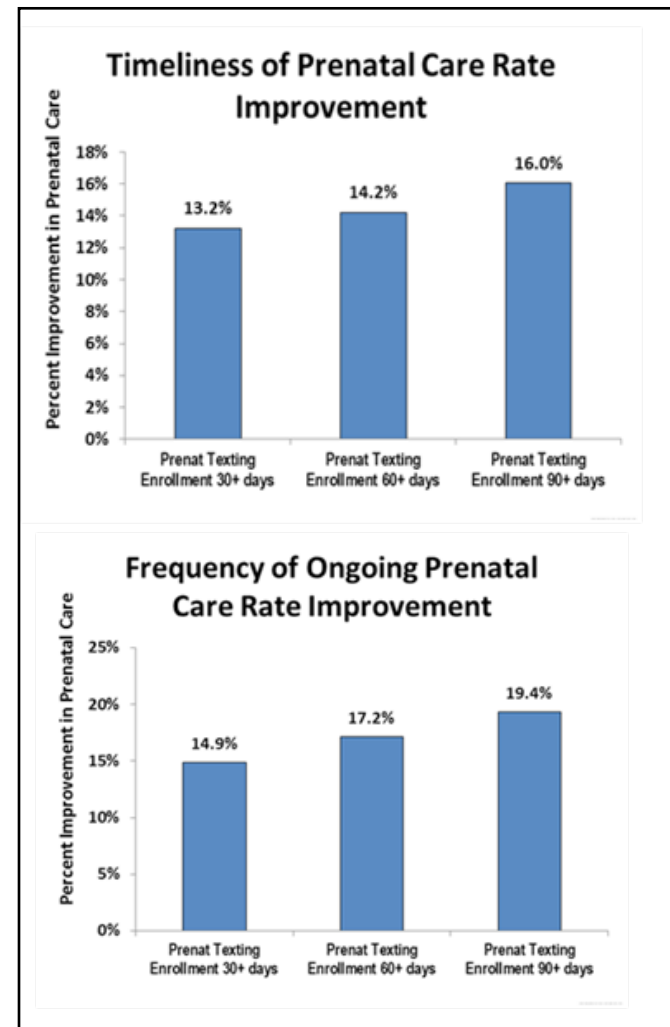
One goal of the texting program is to improve prenatal visit compliance. We compared the HEDIS rates for timeliness of prenatal care and ongoing prenatal care for members participating in the Texting Program with the same HEDIS rates for the overall member population. HEDIS rates for timeliness of prenatal care were 16.0% higher ($p < 0.01$) and HEDIS rates for ongoing prenatal care were 19.4% higher ($p < 0.01$) for those in the Texting Program at least 90 days during the prenatal period compared with members not in the program. In addition, longer participation in the program was correlated with higher rates in both prenatal care metrics ($p < 0.01$).

The Texting Program also incorporates an optional survey to assess the program's effect on member breastfeeding rates. To date, over 2,000 members have completed the survey. Compared with a control group of members who completed postpartum assessments, 25.2% more breastfeeding survey respondents (90.6% vs 65.4%) maintained some amount of breastfeeding at 21 days post-delivery ($X^2 = 331.3$, $p < 0.001$). Furthermore, 18.9% more breastfeeding survey respondents (52.4% vs 33.5%) were exclusively breastfeeding at 21 days post-delivery compared with the control group ($X^2 = 118.4$, $p < 0.001$).

Members in the Start Smart For Your Baby Texting Program had improved HEDIS rates and higher initiation and maintenance of exclusive breastfeeding. We continuously strive to improve the program by requesting feedback from members and engaging healthcare providers to identify opportunities for additional communication. The Texting Program has been well-received by our members, and 94% of members who responded to a question at the end of the program found the texts somewhat helpful or very helpful. Further,

most members who deliver during the program participate for at least two months, suggesting our Texting Program is valuable to our members. Centene Corporation is constantly evaluating innovative approaches, including the Start Smart For Your Baby Texting Program, to engage members and convey important and relevant information to impact health behaviors and improve quality of care.

We believe this program made a difference in the lives of our Medicaid members because we educated them on the benefits of breastfeeding, how to have a healthy pregnancy and how to remain healthy postpartum. We found many of our members did not know or understand the benefits of breastfeeding; therefore, explaining the benefits to the member will encourage the member to do what's right.



Location:

This program took place in the following: California, Kansas, Missouri, Illinois, Georgia, Indiana, Mississippi, Ohio, South Carolina, Texas, Washington, and Wisconsin.

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Buckeye Health Plan, Centene® Corporation Substance Abuse in Pregnancy Program

Description:

The Substance Abuse in Pregnancy Program reaches out to pregnant members who abuse opiates, alcohol and other drugs. Case managers work with the member, obstetrician, primary care provider and behavioral health providers to develop a collaborative treatment plan from pregnancy through the postpartum period. The hallmark of the program is a nonjudgmental, trust-based approach that enables case managers to truly connect with the member and understand the needs of her and her family. Once rapport is established, the treatment team guides the member toward counseling and supports medication-assisted treatment with buprenorphine (Subutex) or methadone.

Abstract

Drug abuse in pregnancy is a significant problem in the United States, with severe consequences for both a mother and her infant. National data indicates that in 2011, 5.9% of pregnant women aged 15-44 abused drugs during pregnancy.¹ Research has found that the number of pregnant women using opiates at the time of delivery has increased almost fivefold from 2000 to 2009.² The number of infants diagnosed with Neonatal Abstinence Syndrome (NAS) has tripled in the same time period, contributing to increased morbidity such as respiratory problems and low birth weight.² Importantly, infants diagnosed with NAS were more likely to be on Medicaid (78.1% vs 45.5%; $P < .001$).² The US Centers for Disease Control has cited related data from a Washington study, stating that those dying of drug overdose are more likely to be on Medicaid, specifically that "the age-adjusted rate of death was 30.8 per 100,000 in the Medicaid-enrolled population, compared with 4.0 per 100,000 in the non-Medicaid population."³

The Substance Abuse in Pregnancy Program was piloted in Ohio by Buckeye Health Plan. Ohio has been greatly affected by opioid abuse. The table below shows the increasing rate of infants diagnosed with NAS and covered by Buckeye Health Plan:

Yearly Incidence per 1,000 Newborns-2004-2013

	2004	2005	2006	2007	2008	2009	2010	2011	2012	Jan-Oct 2013
Newborn Members	1,042	1,762	3,337	5,610	5,905	6,098	6,121	5,666	5,873	4,392
NAS Newborns Enrolled First Year of Life	5	5	4	13	13	18	29	33	67	62
Incidence per 1,000 Newborns	4.8	2.8	1.2	2.3	2.2	3.0	4.7	5.8	11.4	14.1

Increasing rates of NAS lead to more NICU admissions and longer length of stays, as well as higher incidence of acute and chronic health problems. These factors greatly increase health care costs and put greater stress on already vulnerable families. Women who test positive for street drugs at the time of delivery are also more likely to have their infants removed from their custody by the children's division of state social service agencies.⁴

Footnotes

¹ CDC National Immunization Survey, 2010 provisional rates: http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm

² Office on Women's Health. (2014). *Why is breastfeeding important*. Retrieved from: <http://www.womenshealth.gov/breastfeeding/breastfeeding-benefits.php>

³ Gates, A., Stephens, J., Artiga, S. (2014). Profiles of Medicaid Outreach and Enrollment Strategies: Using Text Messaging to Reach and Enroll Uninsured Individuals into Medicaid and CHIP.

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⁴ Liang, J. (2014). Text Messaging is an Effective Outreach Strategy for Enrolling the Uninsured in Medicaid and Health Insurance.

Retrieved from: <http://www.mobilecommons.com/blog/2014/04/text-messaging-is-an-effective-outreach-strategy-for-enrolling-the-uninsured-in-medicaid-and-health-insurance/>

Key Objectives:

- Improve the health of the population
- Control or reduce the per capita cost of care or increase efficiency
- Improve quality of care in perinatal care

Actions Taken:

The Substance Abuse in Pregnancy Program uses data from member or health care provider Notifications of Pregnancy, claims data and provider referrals to identify pregnant women who are using harmful substances during pregnancy. This data is combined into a report that lists members who will be prioritized for outreach by an integrated treatment team. The treatment team consists of case managers from the Start Smart for your Baby Program and Cenpatco Behavioral Health (a Centene subsidiary company), as well as primary care providers, obstetricians and other specialists. Medical and behavioral health case managers work together to address the needs of the whole person, engaging the member on many levels. The trust-based case management approach encourages the member to participate in a personalized plan that helps her overcome addiction and improve the likelihood of a healthy pregnancy and an infant that does not suffer from withdrawal.

The Substance Abuse in Pregnancy Program partners with state addiction programs and encourages counseling and medication in addition to intensive outpatient or inpatient addiction treatment if needed. Case managers assess the member's readiness to change and focus on moving her through the stages of change related to addiction treatment. Basing interventions on readiness to change helps ensure that the member is met with appropriate interventions that challenge but do not overwhelm her. Medication-assisted treatment with Subutex or methadone can replace the need for dangerous prescription or street drugs and prevents the pregnant member from going into withdrawal, which can be dangerous for the fetus. Subutex is particularly encouraged, as it has been shown to reduce the rates of infants with NAS and also NICU length-of-stay.^{5,6}

Outcomes:

In the first six months of the pilot program, 22 members have enrolled in the program and 13 have delivered. Retention rate until delivery for enrolled program members is 100% thus far, excluding those who left the health plan. Preliminary data shows that neonatal inpatient length-of-stay is reduced to an average of 13 days among infants delivered to mothers enrolled in the Substance Abuse in Pregnancy Program. Comparatively, the average inpatient length of stay for NAS infants in Ohio ranged from 20.1 in 2008 to 15.9 days in 2011.⁷ Additionally, five-out-of-nine members who were enrolled in the substance abuse program with Buckeye Health Plan at the time of delivery had infants who were NAS free. Future efforts will concentrate on identifying and enrolling more members who are dealing with substance abuse.

Location:

This program took place in Ohio.

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Footnotes

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² Brauser, Deborah. Number of Infants Born Addicted to Opiates Triples. *Medscape Multispecialty*. <http://www.medscape.com/viewarticle/763285>. Published May 4, 2012. Accessed August 5, 2014.

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⁷ Massatti, R., Falb, M., Yors, A., Potts, L., Beeghly, C. & Starr, S. Neonatal Abstinence Syndrome and Drug Use Among Pregnant Women in Ohio, 2004–2011. Ohio Department of Mental Health and Addiction Services. <http://www.healthy.ohio.gov/~media/HealthyOhio/ASSETS/Files/injury%20prevention/NAS%20Report%20FINAL.ashx>. Published November, 2013. Accessed August 12, 2014.

UnitedHealthcare Community Plan of New York

Using Music to Promote Well-Child Visits in the Hasidic Community

Description:

How do you improve health in the Hasidic community while having a great time? Simple — call Uncle Moishey and the Mitzvah Men! This popular children's entertainer has a strong following in the Hasidic Jewish community and a desire to see the Hasidic community benefit from key interactions with their health care providers. Partnering with a community-based organization that offered to host Uncle Moishey concerts for members and families of members 3-6 years of age, the UnitedHealthcare Community Plan (UHCCP) of New York began to collaborate in an effort to meaningfully improve the rates of well-child visits in the Hasidic population.

The events are organized and arranged with a heavy focus on cultural sensitivity. More specifically, the concerts are held during specific, culturally focused times of the year. These include Hanukkah and Lag B'Omer, and offer two special celebrations for the families involved. Based on cautious planning and careful execution, both concerts were sold out and feedback from the members, providers and community has been extremely positive.

Abstract

UHCCP-NY has a large portion of Hasidic members in the Borough Park section of Brooklyn. When looking at the rates of well-child visits within the 3-6 year age range, UHCCP was not satisfied being under the 50th percentile. Understanding that the population in the Borough Park area is made up almost exclusively of Hasidic Jews, a new and innovative approach was required. It was also understood that the unique cultural characteristics of the members in this community could lead to health disparities. For instance, families are very large, often there are over five children in a family; moreover, parents are not able to take the time to bring their children to the doctor outside of accidents or illness. Parents often rely on the advice of other community members and neighbors to guide their health care decision making rather than a doctor. In turn, misinformation being spread through the community was noted as a concern.

The goal of having the concerts was to help focus parents on the value of bringing their children in for well visits. The feeling was as this task was accomplished, it would lead to the establishment of a trusted relationship with a primary care provider. In turn, they would be given concert tickets for successfully seeing a doctor and completing the well visits. The hope is that once parents bring the child for a visit when they are healthy, the doctor will have the opportunity to explain the value of continuing to do so each year.

Key Objectives:

- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.
- Reduce disparities in care of racial and ethnic minorities

Actions Taken:

Parents of members who were identified as not having an annual well visit (per HEDIS specifications) in the three ZIP codes of Borough Park Brooklyn were sent a letter informing them of the concert, and what needed to be completed to receive a free ticket. An attestation form was included on the letter; members saw the provider for a well visit, the provider stamped the attestation that a well visit was completed, and the parent brought the letter to the community-based organization partner in exchange for tickets to the show.

Outcomes:

We had over 3,100 people (including members, families and friends) in attendance for the two 2013 shows! Specifically, in 2013 the concerts generated 312 provider visits which were confirmed in claims and related to multiple gap-in-care closures. At the time of this submission, the rate of well-child visits (ages 3-6) for 2013 increased almost two percentage points from 2012 and it is expected to be greater than the 50th percentile for the state. The expectation is to increase these numbers year-over-year. The 2013 concerts included invitation mailings to 4,319 members for the December 2013 concerts.

Location:

This program took place in Brooklyn, New York.

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Health Plan Innovations to Improve Health Care Results

Medicaid health plans are leaders in working to maximize the value of health care services. Health plans are working hard to understand the health risk factors of Medicaid beneficiaries and to improve adherence to treatments. They are also committed to finding new and innovative ways to deliver care, for example, by encouraging patient-to-patient interaction in group visits, improving language access, and teaching staff and health care providers to be culturally competent. The following 13 innovations demonstrate how health plans help to improve services and improve results of health care interventions.

Select Health of South Carolina

A Multifaceted Approach to Increase Well Visits

Description:

Annual well-visit adherence, especially among 12- to 21-year-olds, presents a very challenging care gap among the South Carolina Medicaid population. Therefore, in 2013, Select Health of South Carolina implemented a multifaceted strategic approach to increase annual well visits for our child and adolescent members.

Abstract:

Annual well visits are important check-ups that allow the primary care provider (PCP) to monitor development, give immunizations and catch health problems early. For adolescents in particular, well visits give health care providers the opportunity to help teenagers who are at risk for many preventable health problems. Counseling and treatment can help young adults avoid or recover from a number of problems including addictive behaviors like alcohol abuse, smoking and drug use; eating or mental disorders; sexually transmitted diseases and pregnancy.

In South Carolina, there has been an increasing challenge in making headway to improve the rates of children and adolescents who receive annual well visits. While these preventive health check-ups promote physical and mental health, they are a highly underutilized benefit in South Carolina. Therefore, the South Carolina Department of Health and Human Services prompted a statewide focus on well visits and challenged all Medicaid plans to improve the rates of compliance for well visits.

Key Objectives:

- Improve the health of the population
- Enhance the patient experience of care, including quality, access, and reliability
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.

Actions Taken:

For this initiative, Select Health used a collaborative approach across departments to achieve improved well-visit rates. Our Community Outreach team coordinated with high volume provider offices to assist in scheduling appointments for plan members. They called members ages 3-6 and 12-16 years to remind them of needed well visits and assisted with transportation information. In addition, low-performing counties/providers (Georgetown County and Colleton County) were specifically targeted for education and assistance with appointment scheduling. In Columbia, SC, our annual Jump-Start Back-to-School event also promoted well visits. Members were allowed to register for a free book bag and school supplies if they scheduled a well visit with their primary care provider prior to the event.

In addition, letters were sent to all non-compliant members offering a \$10 Subway gift card reward for completion of a well visit by the end of 2013. The outreach letters were also translated in Spanish and sent in the language preferred by the member to increase engagement. The letter included a form to be signed by the provider indicating the well visit was complete and the date of service, along with a postage-paid envelope. A toll-free fax option was also added to the form to increase the ease with which members could return the form.

In June 2013, Select Health launched its First Choice Fit® adolescent well-visit campaign starring Marcus Lattimore, former University of South

Carolina star running back and current San Francisco 49er, as a celebrity spokesperson. An interview discussing Lattimore's proactive health strategies, including well visits, appeared in the summer issue of our member newsletter that reached more than 130,000 SC households. Two online videos of this interview were posted on our website, providing an intimate perspective of Lattimore's thoughts on the importance of staying First Choice FitS. In addition, 19,871 First Choice members ages 17 to 21 received a personalized telephonic message from Lattimore emphasizing the importance of well visits. The campaign's telephonic outreach was re-launched in the fall to 17,818 adolescents who had still not yet seen their doctor to connect them with a First Choice representative who helped schedule a well visit. Furthermore, the First Choice Fit campaign featuring Marcus Lattimore received more than \$129,000 in free press spanning local, state and national media including MSNBC, serving to further elevate the key messages for being First Choice Fit: eating right, exercise, and annual well visits with a primary care provider. Marcus also used his social media platforms (Facebook, Twitter) to promote these key messages. Photos and other items personally autographed by Marcus were used as a way to incentivize members for completing well visits.

For providers, information about well visits and appropriate coding was included in the electronic newsletter and fax-blasted. Providers were educated about the need to complete well visits as opposed to the limited sports physical many students receive to play sports. Providers received lists of non-compliant members in June 2013 to begin proactively scheduling appointments. Providers received early notification of the outreach and member rewards and were able to use this in scheduling appointments as an aid to reduce no-show rates.

Outcomes:

This multifaceted strategic approach to increase annual well visits significantly improved rates as seen through our Healthcare Effectiveness Data and Information Set (HEDIS®) results.

- Adolescent well visits improved from 39.9 percent in 2012 to 48.7 percent in 2013. Specifically, adolescent well visits increased from 45 percent to 53.3 percent in Georgetown County and from 35.8 percent to 39.9 percent in Colleton County.
- Well-child visits for ages 3-6 years increased from 60.5 in 2012 to 64.1 percent in 2013.

Location:

This program took place throughout the state of South Carolina.

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Keystone First

Breathe Easy Start Today (BEST) Asthma Program

Description:

The BEST asthma program is a collaborative initiative between Keystone First and its network providers, developed to improve medication adherence and provide hands-on education to members with asthma with the aim of reducing asthma-related emergency room and inpatient admissions. Working with a pharmaceutical service supplier, Keystone First empowers providers with the capacity to dispense asthma medication at the members' point of service (POS,) and supports — through reimbursement and vendor-assisted train-the-trainer instruction — provider education of members concerning the proper use of the members' own asthma devices, as well as rescue and control inhalers. Refill medications are delivered directly to the patients' homes prior to the refill due date.

Abstract

Adherence to asthma medications among affected individuals remains low (reported non-adherence rates range from 30 percent to 70 percent)¹, and up to three-quarters of total asthma-associated costs may be due to poor asthma control. Additionally, improper inhaler technique results in poor asthma control, and is associated with more frequent hospitalizations in children, especially in underserved populations. Conversely, improved medication adherence will often lead to improvements in asthma control and quality of life. Keystone First has invested considerable resources over the past two years in improving asthma control, increasing medication adherence, and reducing the hospitalization rate of its members.

The BEST asthma program supports medication adherence by:

- Providing access to asthma medication and supplies onsite at the physician's office.
- Allowing patient therapy to start immediately, as the patient receives the prescribed medication and supplies (i.e., inhaler, spacer, and mask) at the POS without having to go to a pharmacy.
- Putting a refill in the patient's hands near the refill due date without requiring member action.
- Billing Keystone First directly for the medication and supplies, as well as any provider-conducted demonstration and/or evaluation of the patient's ability to properly use the approved asthma supplies.

Key Objectives:

- Improve the health of the population
- Enhance the patient experience of care, including quality, access, and reliability
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.

Actions Taken:

Keystone First arranged for a pharmacy service supplier to supply participating provider offices with an automated unit consisting of a secured medication stock cabinet (fully stocked with asthma medication and supplies), computer system, prescription label-maker, and barcode scanner (Figure 1). To dispense medication or supplies, the patient's prescribing information and medication directions are logged into the computer system, the cabinet automatically unlocks and the UPC code on the item is scanned to verify dispensing of the product. A prescription label meeting all federal and state regulations is printed and secured to the item (Figure 1 callout boxes). Finally, the provider e-prescribes or faxes a prescription to the pharmacy service supplier for the items dispensed from the stock cabinet, triggering a bill to Keystone First and updating the inventory list so the cabinet can be resupplied. The pharmaceutical service supplier is reimbursed directly by Keystone First for any prescriptions written by the provider.



Figure 1: KOPPS Automated Unit with Medication Stock Cabinet with computer system and prescription label-maker highlighted.

Thus, the patient receives the asthma medication and supplies while still in the physician's office, along with any education and training on the use of the supplies. Upon request, a respiratory educator from the pharmacy service supplier goes to the provider's office to "train the trainer" using the proven teach-back method, where the patient or guardian demonstrates use of the supplies to ensure proper technique and understanding. The pharmacy service supplier also contacts the patient four to five days before a refill is due ("pre-refill calls"), and hand-delivers the refill medication to the patient's home.

Outcomes:

There are currently 22 office sites in Keystone First's Southeastern Pennsylvania service area (Philadelphia, Delaware, Bucks, Berks and Montgomery counties) participating in the BEST asthma program. Thirteen cabinet units have been distributed to participating practices; the remaining practices have elected to use their own secured cabinet spaces. Since the program's inception in April 2013, 1,896 Keystone First members have received asthma prescriptions from the BEST program. About 400-500 pre-refill calls are made weekly by the pharmaceutical service supplier. Fifty-two percent of participating members were age 6 or under and 86 percent were age 12 or under. Over the past six months, a total of 3,667 asthma prescriptions and devices have been dispensed, including:

- 1,239 rescue inhalers (e.g., albuterol sulfate)
- 649 corticosteroids (e.g., fluticasone propionate and budesonide)
- 95 long-acting beta agonists (e.g., fluticasone propionate plus salmeterol combination)
- 486 valved holding chambers (VHCs)
- 1,197 VHC masks
- 1 vial of sodium chloride

Cost data from participants with 6-month pre-intervention and 6-month post-intervention (allowing for a 30-day grace period post-engagement) reported a 54.4% decrease in inpatient admission costs and an 8.7% decrease in emergency room visit costs.

Location:

This program took place in Philadelphia, Delaware, Bucks, Berks, and Montgomery counties in Pennsylvania.

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Footnotes

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Figure 2: VHC with mask, rescue inhaler, and control inhaler (from left to right)

Because of the high degree of self-management required for asthma control and the greater degree of complexity of inhaler administration over simple pill consumption, the asthma population is particularly susceptible to poor medication adherence. Patients with asthma are typically supplied with a VHC and mask, and rescue and control medications along with their corresponding inhalers (see Figure 2). Providers often give their patients cursory instructions on how to use these supplies, so patients often must refer to drug and device instructions and labels that patients with poor health literacy may find difficult to follow. The BEST asthma program encourages providers to educate members at their point of service concerning the proper use of asthma supplies and medication. Specifically, the provider trains the member on using his/her own asthma VHC, and rescue and control inhalers. The member is properly fitted with a mask, which comes in three sizes, that is then secured to the VHC. The patient is then taught how to secure the appropriate inhaler to the inhaler port on the VHC, followed by administration of an inhaler dose. Patients with asthma are susceptible to inadvertently taking rescue medication instead of controller medication, risking poor management of asthma and hospitalization. To minimize this risk, stickers are secured to the inhaler; a green sticker for the control inhaler suggesting daily use, and red sticker for the rescue inhaler suggesting conditional use during an asthma attack. Both inhaler devices contain a dose meter. When contacted by the pharmaceutical service supplier, the member is asked to read out the number on the inhaler to calculate the time when resupply is necessary, as well as determine the member's level of medication adherence. This information is relayed back to the provider and Keystone First for further member follow-up when necessary.

Select Health of South Carolina

“Can We Talk?” Language Services Campaign

Description:

In 2013, Select Health of South Carolina launched a statewide initiative to reduce language barriers between First Choice plan members and health care providers. The “Can We Talk?” campaign was designed to increase member and provider awareness and utilization of free telephonic interpretation services available to First Choice members in more than 200 languages 24 hours a day, seven days a week.

Abstract:

Guaranteeing members have access to quality health care services in their preferred language is a primary concern of Select Health. Therefore, the plan regularly evaluates the provider network’s capacity to deliver linguistically appropriate services to ensure that language needs are being met for First Choice members. In 2012, Select Health of South Carolina conducted a Member Experience with Language Services Survey as well as a Provider Network Cultural Assessment to gauge the quality, availability and accessibility of language services offered to Limited English Proficiency (LEP) plan members.

While findings indicated that the plan is meeting the member’s language needs overall, both the member and provider surveys reinforced that further education was required concerning language services offered to First Choice members. More specifically, results pointed to a lack of awareness concerning Interpretalk®, the plan’s telephonic interpretation service with 56.78 percent of surveyed members reporting they did not know that the plan offered free Spanish language services. In the 2012 Provider Network Cultural Assessment, it was determined that 52 percent of provider offices used family members or friends to interpret for patients; 30 percent of those used minors to interpret. Therefore, we realized the need to focus on education related to the provision of appropriate language services to both members and providers to ensure the quality of the health care encounter.

Key Objectives:

- Enhance the patient experience of care, including quality, access, and reliability
- Reduce disparities in care of racial and ethnic minorities

Actions Taken:

The ¿Can We Talk? program was designed as a multi-faceted educational language services campaign, with targeted interventions for Select Health of South Carolina associates, First Choice members, First Choice providers and community stakeholders to enhance the awareness and accessibility of free telephonic interpretation services offered by the plan.

Most notably, Select Health instituted a new policy to include a preferred language field on member identification cards. This allows our providers to quickly identify a member’s preferred language and arrange language services if necessary. To supplement this effort, members identified as Spanish-speaking were mailed language services wallet cards, with instructions in Spanish and English on how to access free language services through Select Health. Members also received information in their quarterly member newsletter and on the website. Also, ads and articles about free language services were placed in Spanish-language publications throughout the state.

For providers, Select Health disseminated desktop displays to keep at their practice. These displays allowed members to point to their native language and request language services. Providers also received regular articles related to language services in the electronic newsletter and on the website. In addition, ¿Can We Talk? information was added to the provider trainings held quarterly around the state.

Outcomes:

To measure the success of ¿Can We Talk?, Select Health assessed Interpretalk’s telephonic interpretation utilization rates for 2012 to establish a benchmark. Prior to the campaign, First Choice found that plan members used Interpretalk® a total of 519 times in 2012, utilizing 18 languages for a total of 6,066 minutes of interpretation service.

In 2013, usage of Interpretalk® more than doubled, with a total number of 1,070 calls, utilizing 23 languages for a total of 12,721 minutes of interpretation service. This represented a 106-percent increase in total usage of Interpretalk®.

Location:

This program took place throughout the state of South Carolina.

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WellPoint, Government Business Division

Chronic Illness Intensity Index (CI3) Case-Finding Algorithm

Description:

The Chronic Illness Intensity Index (CI3) is a predictive modeling algorithm that assists our case and disease management teams in prioritizing members for these programs. The CI3 List uses a clinical filter to determine members that would be most significantly benefitted through case management, then prioritizes them into five intervention groups using predictive models; the CI3 score uses demographic, diagnostic, and pharmacy data to quantify how “sick” or complex a member is, and for the very highest risk members the Likelihood of an Inpatient Admission (LIPA) model gives likelihood of admission in the next 60 days. Every member, every month is scored and these prioritization scores are coupled with extensive clinical and utilization data and are provided to the clinicians in a user-friendly format.

Abstract:

This tool was developed to assist in the prioritization of members for case and disease management programs. Given large and very diverse populations, Amerigroup wanted a way to identify those members most in need of intervention, stratify them into the appropriate risk groups, and prioritize them in order to connect members most in need of services to the appropriate clinical resource. Previous case-finding methods were inconsistent across the company and did not reliably refer members with preventable future events. The CI3 algorithm was the result of clinical and analytic teams partnering to deliver an efficient solution and build proprietary models that could help impact Medicaid members most in need of management.

Key Objectives:

- Improve delivery of benefits
- Prioritize members for outreach and enrollment into clinical programs based on need

Actions Taken:

Since initiation of this tool our CM and DM teams use it to target their outreach to members based on those with the highest scores in targeted areas such as risk score and likelihood for inpatient admission score. It gives us a consistent approach to attempt engagement of those members most in need of care management services and reduce duplication of effort by identifying members for specific programs based on CI3 scoring.

Outcomes:

The CI3 is very effective at stratifying members based on their future risk. The LIPA model, which was built internally showed an AUC (area under the curve) of 0.79 and was the best predictor of IP admissions compared with other potential methods (p<0.001). Studies completed at implementation showed that, using a common effectiveness of care management on total medical costs, the CI3 solution increased ROI on Case and Disease Management by 35%. The top 3 risk groups include the top 2% of the population, which accounts for 23% of the resource utilization:

CI3 Group	Description	% of Population	Resource Utilization
Group 4	Highest and most complex risk	0.1%	3%
Group 3	High and complex risk	0.6%	8%
Group 2	Moderate to high risk	1.4%	12%
Group 1	Low to moderate risk	21%	42%
Group 0	None to Low Risk	77%	35%

We regularly evaluate the CI3 Algorithm as well as Case and Disease Management and utilize these findings to improve both the algorithm and the way these members are managed. Studies have found that after being managed for at least 90 days, members used health care resources more efficiently and required less emergent care, thus reducing costs while improving health outcomes. Overall, managed members demonstrated a 39% reduction in non-emergent ER visits. A separate study showed that managed high-risk members had a median savings of \$510 PMPM while un-managed controls had a median savings of \$73 PMPM.

Location:

This program took place in all Amerigroup markets: New York, New Jersey, Florida, Georgia, Tennessee, Louisiana, Texas, Washington, Kansas, Nevada, and Maryland.

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UnitedHealthcare Community & State Clinical Toolkit

Description:

The Clinical Toolkit (also known as Auto Fill) is set of web-based and offline tools to: streamline the completion of state-required assessments, care plans and forms; schedule and track member appointments; capture electronic signatures; and create reports by auto-archiving data completed through designed forms. This tool helps care managers spend more time on member care and less time filling out paperwork. Early results indicate time savings of up to 50% when using the Clinical Toolkit to complete state-based forms, which can equate to potential FTE savings of 5% to 10%.

Abstract:

Each state Medicaid Program requires multiple forms or assessments to be completed on a periodic basis (quarterly, annually, etc.) for Medicaid long-term care members. Each form, completed in the member's home, is designed to meet special requirements of the state, federal government, or health plan. Currently each form, most of which have similar information, is completed by hand and/or data is re-entered in the system, leading to hours of manual effort and usage of resources for form archives. The process also opens up the possibility of typos, errors and data loss.

Key Objectives:

- Control or reduce the per capita cost of care or increase efficiency
- Improve delivery of benefits
- Demonstrate accountability of Medicaid health plans, including fraud and abuse

Actions Taken:

The New Mexico health plan deployed the Clinical Toolkit application on a pilot basis to approximately 10 care managers in the summer of 2013. Initial pilot results indicated time savings of up to 50% when completing state-based forms. In May 2014, the New Mexico plan deployed the tool to over 350 care managers and staff. The tool was developed internally and was designed so if a care coordinator needs to complete five forms, then each repeated field only requires data entry once. For example, if "First Name" and "Last Name" are required on all five forms, the fields will be automatically populated as soon as they are entered on the first form. The form fields that are previously completed will be populated on the newly scheduled forms and can be easily updated. The tool requires attestation for all new data entries, which ensures data integrity. Each completed form is auto archived online and can be reviewed and audited by clinical management for compliance and outcomes improvement. The data extracted from the forms can be tracked for population health trending which provides analysis tools for population health management. It is also used to fulfill and comply with the state of New Mexico contract requirements.

Outcomes:

Early pilot results indicate a reduction in time spent completing forms by at least 50%. The tool has enabled easy scheduling of the appointments, helping coordinators to better manage their workload and schedule. The tool also has extended offline capability, which enables care managers to collect data during home visits and sync the data once back in the office. Digital signature capture has created efficiencies over manual signature capture. Finally, the tool has reporting capabilities on all data elements entered, which enables the health plan to meet extensive reporting requirements from the state.

Location:

This program took place in New Mexico.

Contact:

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Horizon NJ Health

Drug Utilization Review of Potentially Inappropriate Medications in the Elderly

Description:

Horizon NJ Health has a comprehensive Retrospective Drug Utilization Review (DUR) program which provided targeted interventions for elderly patients who filled potentially inappropriate medications (PIMs) according to criteria established by the American Geriatrics Society. As of July 2014, Horizon NJ Health had over a 90 percent reduction in the use of PIMs for these elderly members.

Abstract:

According to the American Geriatrics Society, older adults continue to be prescribed PIMs despite evidence of limited effectiveness and being associated with serious problems such as delirium, gastrointestinal bleeding, falls and fractures. The elderly population represents an increasingly higher proportion of the New Jersey Medicaid population and correspondingly, the overall Horizon NJ Health enrollment. In an effort to improve the pharmaceutical management of elderly members, Horizon NJ Health has implemented a Retrospective DUR program which provides targeted interventions for those patients who have filled potentially unsuitable medications. The purpose of this specific DUR program was to recommend and evaluate the rate of discontinuation of PIMs that were filled by elderly members.

Key Objectives:

- Improve the health of the population
- Improve quality of care in a specific clinical area, e.g. prenatal care, diabetes, asthma, etc.

Actions Taken:

In January 2014, Horizon NJ Health targeted members who were 65 years or older and had received at least one fill of a possibly unsuitable medication based on a six-month retrospective pharmacy claims review. Primary care providers (PCPs) were targeted through outreach letters with an enclosed list of their patients who were identified as receiving a PIM that should be avoided according to the American Geriatrics Society 2012 Beers Criteria Update Expert Panel. PCP letters included a table in addition to a brief description of which drugs or drug categories should be avoided in those patients aged 65 years or older. Outcome measure included the rate of discontinuation of PIMs.

Outcomes:

Horizon NJ Health initially identified 552 elderly members who were receiving PIMs. There were subsequently 361 letters mailed to PCPs with patient enclosure lists. The top medications prescribed were cyclobenzaprine, hydroxyzine, glyburide, megestrol and promethazine. Six months after the initial mailing, about 95 percent of the members were no longer receiving PIMs.

Location:

This program took place in New Jersey.

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Goold Health Systems, an Emdeon Company

Goold Pharmacy Care Management

Description:

Goold Health Systems, an Emdeon Company, has initiated a Pharmacy Care Management program for a Medicaid population in a rural state to improve clinical outcomes, abate costs, and improve member's quality of life and satisfaction with their healthcare. These interventions, performed by pharmacists who work closely with our physicians are targeted to members who are prescribed certain high-cost medications. The key unique aspect of this program is that it is payor based and not provider based as many other specialty drug management programs are. Potential patients are identified for the program in real time when they are about to initiate treatment with a high cost medication at the time of prior authorization. A weekly report is generated based on paid claims to identify other potential intervention opportunities. Our clinical staff comprised of pharmacists and physicians then work with the prescribers and members to be sure that evidence-based best practices are being followed and that the treatment and dosage chosen is the most cost-effective. Once the treatment is approved, the program then focuses directly on the member. Telephonic interventions are utilized to provide in-depth counseling on proper medication storage, administration, expectations of treatment, as well as recommendations to aid treatment to decrease the possibility of side effects as well as to assess for other deterrents to adherence. In the first nine months of the program in this single rural Medicaid population, Pharmacy Care Management has enrolled over 580 patients that are followed regularly through analysis of pharmacy claims data and further lab and chart notes reviews as necessary. PCM has also detected and intervened in over fifty unique cost-savings situations that have resulted in a direct cost avoidance of over \$1.7 million for the payor. Metrics regarding adherence, patient satisfaction, quality of life assessment, medical costs, and clinical outcomes are being tracked and will be available for reporting later this year.

Abstract:

The number of new, often high-cost, biologic and specialty medications continues to rise exponentially, creating a challenge for many payors. These novel high cost medications are expected to account for over 50% of drug expenditures by 2018. In many cases, no alternative therapies are available. These regimens require more intense monitoring — first for the overall appropriate use by the prescribers for the correct diagnosis, dose and patient selection characteristics and secondly for the appropriate individual use by the member to achieve optimal results.

Compliance is a core factor in achieving optimal treatment outcomes with the use of these high-cost medications. Adherence issues are a substantial treatment limiting challenge in all populations but are often further compromised in the Medicaid population. Medication specific intervention beyond the approval of a prior authorization or prescription claim is increasingly important to realize the value of these high cost medications.

Key Objectives:

- Enhance the patient experience of care, including quality, access, and reliability
- Control or reduce the per capita cost of care or increase efficiency
- Increase accountability of Medicaid providers, including fraud, waste, and abuse



Actions Taken:

Beginning in October 2013, a Pharmacy Care Management pharmacist compiled a list of patients actively prescribed a high-cost medication (defined as those medications costing more than \$3000/month average wholesale price). The members were first assessed for appropriateness of therapy in terms of their age, sex, and diagnoses, followed by review of the actual regimens inclusive of dosage and duration. Lastly, and most importantly, the member and regimen were reviewed to assess overall adherence measured through Medication Possession Ratios. Any discrepancies or questions were handled through telephone interviews with the patient and/or provider, as well as collection of prescription images and supporting chart notes when necessary. In the PCM program, the pharmacist enrolls new patients when a Prior Authorization request is submitted for a targeted medication, or through a weekly High-Cost New Users report generated by prescription claims data. When necessary, prescribers are advised to select more cost-effective therapies or adjust medication doses for the safety of the patient. Adherence issues are addressed by counseling the patient and further follow-up with the prescribers when necessary.

The PCM program is also addressing issues of medication waste. After reviewing prescription claims for medications ordered by providers' offices it was noted that some medications were ordered and never administered to the patient — for example Mirena IUDs that were never inserted or Remicade injections that were never administered. The program works with practices to assist in returning these otherwise unused products to the manufacturer/pharmacy and reverse prescription claims accordingly.

The program has developed client-specific reporting. The results of the program are made available to the client on a quarterly basis including details of interventions made as well as measurements of cost abatement and adherence data of the enrolled population.

Outcomes:

As of July 2014, Pharmacy Care Management has enrolled 583 unique patients utilizing 84 different high-cost medications. Interventions with these patients and/or their prescribers included 175 for direct patient education regarding medication, 41 for questioning an inappropriate dose or duration of therapy, 16 related to medication waste or billing errors, and 77 for addressing significant adherence deficits. Of over 300 unique interventions made, 50 have resulted in direct cost abatement for the payor through decreasing inappropriate dosing, opting for a more cost-effective regimen at therapy initiation, and discontinuing therapies that have been continued without reason amongst others. These interventions have abated over \$1.7M.

Preliminary data suggest that within three months after initial program intervention our population experienced decreases in all measured areas of aggregate spend — inclusive of number of hospital admissions, total spend for hospital in-patient services, total number of emergency room visits, and total spend for emergency services. The program continues to collect adherence data via calculation of Medication Possession Ratios for members enrolled prior to and after interventions and aims to increase overall patient adherence.

Location:

This program took place in Maine.

Contact:

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WellCare Health Plans, Inc.

HealthConnections: My Family Navigator

Description:

My Family Navigator was created in an effort to provide case managers and field workers a readily available database where information about community based programs and services in 15 states can be accessed. With the help of CommUnity Liaisons, information about social service organizations, including the organization type, funding source, services offered and service area, are identified and entered into the database on an on-going basis. Currently My Family Navigator holds information for more than 30,000 organizations.

Abstract:

Due to the recent economic crisis, social service programs have been identified as an important link to health outcomes. Public assistance agencies that offer social service programs such as transportation, affordable child care, financial assistance and so on, are important in closing the gaps in the delivery of healthcare. WellCare's goal in the creation of My Family Navigator is to provide a streamline method for case managers and field workers to easily access social service programs in a given community.

Key Objectives:

- Improve the health of the population
- Enhance the patient experience of care, including quality, access, and reliability
- Control or reduce the per capita cost of care or increase efficiency
- Improve delivery of benefits

Actions Taken:

My Family Navigator began in 2011. Six CommUnity Liaisons were hired in September 2013 to collect information on social service organizations for the state of Illinois, Georgia and New Jersey. Since then, 19 CommUnity Liaisons have been hired to help build the database to expand information available on social service organizations to eight states. The hope is to continue this growth and eventually maintain information in My Family Navigator for 15 states.

Outcomes:

The My Family Navigator database has exponentially grown since its start in 2011. To date, the database holds more than 30,000 organizations, representing over 1.2 million services. The ability for case managers and field workers to provide members with immediate information about local organizations and activities pertaining to their individual needs has proven to be an invaluable and essential tool, resulting in over 4,800 social service referrals. The growth in number of social services entries available for reference, and the resulting number of referrals shows the efficacy and the need for My Family Navigator in the stride towards providing members with an enhanced experience of care.

Location:

My Family Navigator currently contains social service information for California, Florida, Georgia, Illinois, Kentucky, Missouri, New Jersey, and Louisiana, and is soon expected to include information for South Carolina, Tennessee, Mississippi, and Arkansas.

Contact:

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NurseWise

Improving HRA Collaboration and Results

Description:

NurseWise and a health plan client saw the need to improve the completion rates on Health Risk Assessments (HRAs) for the health plan's Medicaid population. Historically, the completion rates had been below 50%. Through collaboration, improved contact information, enriched quality improvement practices, and an enhanced training program, the results have shown great improvement and continue to advance. The goal was to be above the required 50% completion rate. For the first four months of 2014, the lowest the completion rate has been 58% and the highest completion rate has been 82% — a more than 30% improvement of previous year.

Abstract:

The health plan client receives an annual review from an External Quality Review Organization (EQRO) and the completion rate of the HRAs is one of the performance measures. The EQRO looks at the completion rate for members who are new to the plan, as well as the completion rate of the annual reassessment. The health plan asked NurseWise to participate in an improvement process to increase the completion rates. Through analysis, we were able to identify barriers to completing HRAs including accuracy of member contact information and member willingness to spend the time required to complete the entire length of the assessment.

Key Objectives:

- Improve the health of the population
- Enhance the patient experience of care, including quality, access, and reliability
- Control or reduce the per capita cost of care or increase efficiency

Actions Taken:

Working collaboratively with the health plan, NurseWise set upon a course to improve our completion rate of HRAs for Medicaid members. Through refocusing the team and working to improve member contact information, we were able to produce greatly improved results.

Due to the length of the HRA, it was often difficult for the NurseWise team to get health plan members who were willing to fully complete it. In defining member engagement strategies and communication skills to promote members' willingness to spend the time on the phone regarding their health care, NurseWise developed a skill-based training plan. Doing that enabled us to more accurately project the staff time involved in successful completion. By working with the NurseWise Workforce Management team, we were able to implement robust staffing strategies to identify exactly how many people are needed on the team to complete the HRAs properly based upon the file size. As part of the training program, the team was given guidance and resources to help them get members to complete the HRA. The monitoring and quality checks used include:

- Actively engaging with the files through audits that are performed internally every day;
- Implementing a coaching form that is used to give staff precise ways that they can improve in the future; and
- Sending daily reports to management to ensure that all levels of the organization are engaged and aware of status.

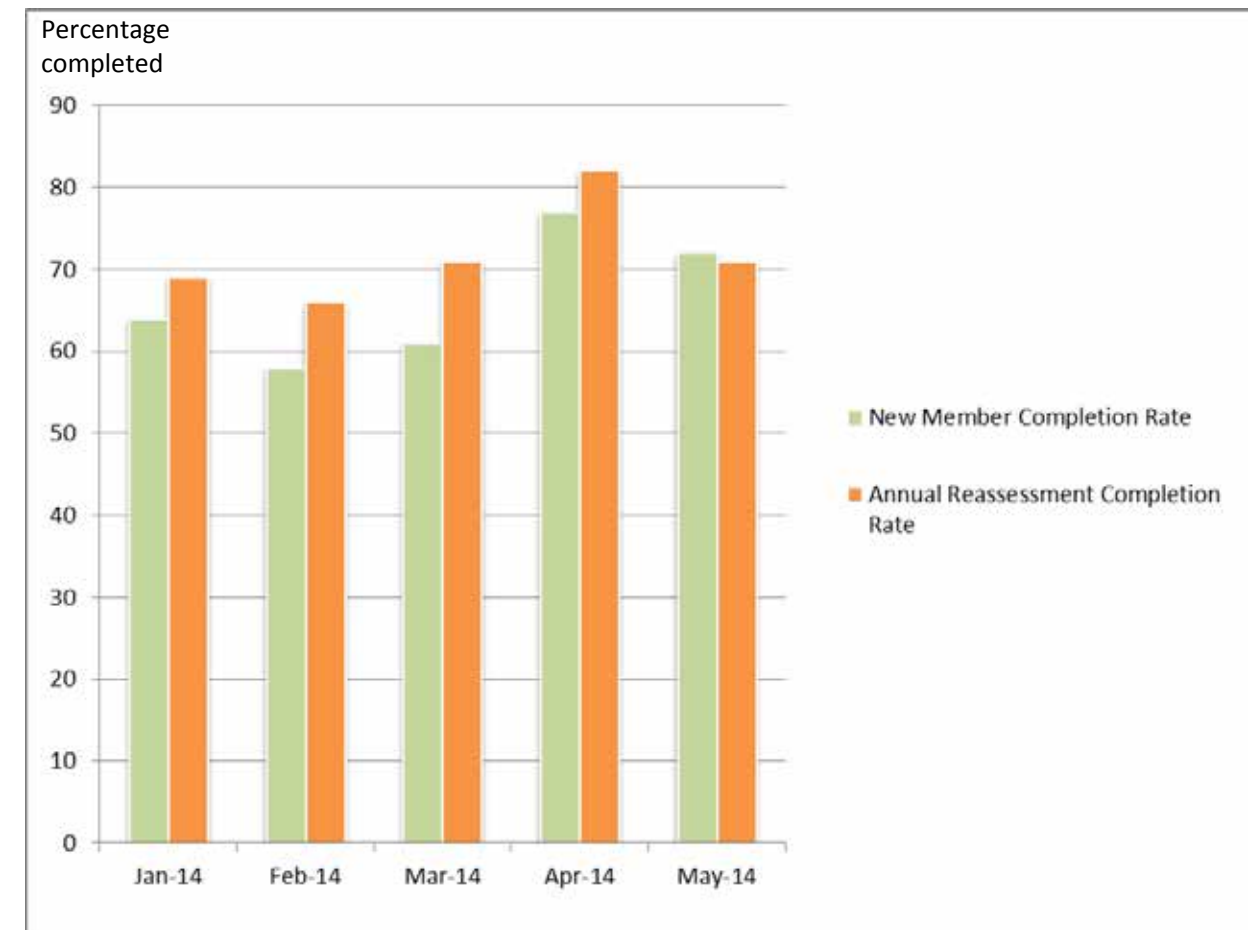
While member engagement, training and staffing were part of the program enhancements, one of the areas that drastically needed improvement was the accuracy of the member file. More than 50% of the time, the contact information provided to the outreach team was incorrect. Using a multi-pronged approach, we were able to get better contact information for the members — which ultimately translates into better completion rates. The efforts NurseWise used to better the contact info were:

- Implementation of patented online searching resources;
- Telephonic outreach to Primary Care Providers, and most importantly; and
- The creation of a proprietary interface with pharmacy benefit claims so that when prescriptions are refilled, the NurseWise files are updated with the correct member contact information.

Outcomes:

It might seem hard to believe that a simple phone call could change the course of someone's life. But from warding off diseases by recognizing probability at an early stage to ensuring medication issues are identified, a health risk assessment performed by NurseWise's experienced clinical professionals can unearth more information than one would ever think possible. We proactively connect with the health plan's members to learn about their current state of health and to educate them about health risks and preventative measures. This not only helps members manage their own health, it also gives the health plan early indicators to possible health issues before they magnify, and provides a smooth and timely referral to the health plan case manager. We also educate members regarding the availability of the nurse advice line, connectivity with their PCP and other health plan support services.

As exemplified by the chart below, the completion rates are continuing to show momentum. Historically, the completion rates had been below 50%. Through collaboration, improved contact information, enriched quality improvement practices, and an enhanced training program, the results have shown great improvement and continue to improve each month. The goal was to be above the required 50% completion rate. For the first four months of 2014, the lowest the completion rate has been 58% and the highest completion rate has been 82% — a more than 30% improvement of previous year.



Location:

The health plan client is located in Wisconsin. NurseWise serves clients across the entire United States.

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AmeriHealth Caritas Pennsylvania

Members-Only Block Scheduling Coupled with Education Substantially Reduces Gaps in Care

Description:

Health plan members in large medical provider practices identified as having significant gaps in care (GIC) for recommended screenings are invited to participate in a provider- and health plan-led “AmeriHealth Caritas Pennsylvania Screening Day” with members-only block scheduling to complete their recommended screenings. AmeriHealth Caritas Pennsylvania staff is available during the event to assist in member processing, health education, answering questions and disseminating gift cards upon completion of screenings.

Abstract:

GIC for recommended medical screenings are a significant concern in the Medicaid population, resulting in less preventive care and potentially more remedial care, weaker provider/patient communication and lower Healthcare Effectiveness Data and Information Set (HEDIS) scores for health plans. Beginning in January 2013, the member screening initiative has targeted members with significant GIC for recommended screenings, including HEDIS-based cervical and breast cancer and chlamydia screenings, and A1C (diabetes) and LDL (cholesterol) monitoring, as well as adolescent well-child (AWC) visits.

Key Objectives:

- Improve the health of the population
- Improve delivery of benefits
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.

Actions Taken:

Large medical provider practices with multiple members identified as having significant GIC for recommended screenings (typically 50 or more patients with GIC) are consulted by the health plan to discuss the importance of addressing GIC and ways to collaborate in eliminating GIC. With state approval, the practice — with health plan support — then hosted an “AmeriHealth Caritas Screening Day” with allocated appointment slots (ranging from 25–100 appointments) exclusively for AmeriHealth Caritas Pennsylvania members to complete recommended screenings. AmeriHealth Caritas Pennsylvania’s Quality Improvement staff mailed an event flyer to all members on the GIC list and then followed-up with phone calls to schedule the providers’ appointments. Once all the slots were filled, a reminder appointment flyer was sent to the member, including a reminder call during the week of the event.

The community health educator and the assigned community outreach specialist remains at the event for the entire day to assist with the flow of active members, provide health education, answer questions from the medical staff and members, and disseminate gift cards to members upon completion of screenings.



Outcomes:

The 2013 participation rate for members with GIC in this program was 68 percent, higher than the average participation rate for similar AmeriHealth Caritas Pennsylvania programs (60 percent). During the six screening events conducted in four cities in the second half of 2013 (Table 1), 260 appointments were scheduled and 178 gift cards were disseminated to members for completed screenings. Moreover, 199 HEDIS-based GIC screenings were performed.

Table 1: Screening Events Completed

No.	Practices	City, Pennsylvania	Date
1	Southeast Lancaster Health Services	Lancaster, PA	July 2013
2	Berks Community Health Center	Reading, PA	August 2013
3	Berks Community Health Center	Reading, PA	September 2013
4	Dr. Sotomayor Medical Practice	Reading, PA	December 2013
5	St. Luke’s Southside Medical Center	Bethlehem, PA	December 2013
6	Sacred Heart Hospital — Pediatrics Dept.	Allentown, PA	December 2013

Table 2: Number and Types of HEDIS-based GIC Screenings

HEDIS-based GIC Screening	Total Number
Cervical	66
Chlamydia	21
A1C (diabetes)	29
LDL (cholesterol)	19
Adolescent Well-Child Visits	64
Total	199

Location:

This program took place in the following Pennsylvania counties: Lancaster, Reading, Bethlehem and Allentown.

Contact:

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AmeriHealth Caritas Family of Companies

[Keystone First, AmeriHealth Caritas Pennsylvania, Select Health of South Carolina, and PerformRx]

Multifaceted Interventions Improve Medication Adherence in Patients with Chronic Conditions

Description:

In 2013, the organization set a goal to increase medication adherence, as measured by the proportion of days covered (PDC), by 5 percent in three health plan affiliates [Keystone First, AmeriHealth Caritas Pennsylvania and Select Health of South Carolina] for four medication classes:

- Asthma controllers
- Oral hypoglycemics
- Antihypertensives
- Statins

Abstract:

Medication nonadherence is one of the most challenging issues in managing patient health. The Agency for Healthcare Research and Quality (AHRQ) reported that 20–30 percent of medication prescriptions remain unfilled. On average, 50 percent of medications for chronic disease are not taken as prescribed, and medication nonadherence has been estimated to cost the U.S. health care system \$100 – \$289 billion annually in direct costs¹. When chronic conditions are suboptimally treated, disease symptoms and complications worsen, leading to increased utilization of health care resources.

AmeriHealth Caritas' medication adherence program was designed to improve medication adherence for members in four medication classes and three health plan affiliates, and determine the effect that improved adherence may have on physician office and emergency department utilization, as well as hospital inpatient admissions (not reported here).

Key Objectives:

- Improve the health of the population
- Control or reduce the per capita cost of care or increase efficiency
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.

Actions Taken:

AmeriHealth Caritas' medication adherence program was designed to improve medication adherence for members in four medication classes and three health plan affiliates, and determine the effect that improved adherence may have on physician office and emergency department utilization, as well as hospital inpatient admissions (not reported here).

Table 1: Sampling of Plan-specific and Enterprise-wide Interventions

Global	Intervention	Scope
Global	Develop staff-, provider-, and member-oriented promotional and educational material around medication adherence.	Enterprise-wide
	Use of on-hold messaging for generic medication reminders.	Enterprise-wide
	Enhance medical management platform to have an interventions "pop-up" widget on members being tracked.	Enterprise-wide
	Create "care gaps alerts" to notify providers and care management staff of members missing a refill.	Enterprise-wide
Targeted	King Of Prussia Pharmacy (KOPP) Consignment Program for asthma controllers.	Keystone First
	Outreach and reminder calls for members who consistently miss refills.	Enterprise-wide
	Notification to primary care providers of members in their panel with low PDC scores.	Enterprise-wide

The study period ran from January 1 to December 31, 2013.



Outcomes:

The data from 19,751 participating members in three health plans were analyzed in this study (3,417 AmeriHealth Caritas Pennsylvania; 10,702 Keystone First; and 5,632 Select Health of South Carolina). The baseline characteristics were comparable among all three plans regarding gender (59%–63% females), care management (≥ 94% not previously under care management), and risk stratification (~25% evenly split among four risk quartile groups). Regarding age demographics, participating Select Health of South Carolina members < 18 years of age were over-represented (38% vs. 17% – 23%), while those 40 – 64 years of age (47% vs. 60 – 63%) and ≥ 65 years of age (0.02% vs. 2%) were under-represented, compared to AmeriHealth Caritas Pennsylvania and Keystone First.

Medication adherence rates in 2013, as measured by adjusted PDC (excluding members who did not have PDC data in December 2013), met or substantially exceeded our AOP goal of 5 percent increase in comparison with the rates in 2012, both overall and when stratified by medication class (Figure 1) or health plan (Figure 2). The adjusted percentage increases of PDC rates for the four medication classes were:

- Asthma controllers — 5.2%.
- Oral hypoglycemics — 22.4%.
- Antihypertensives — 24.1%.
- Statins — 25.5%.

The overall percentage increase of the adjusted PDC rate for all medication classes was 18.4 percent. When stratified by health plan, the percentage increases of the adjusted PDC rates were 23.8 percent for AmeriHealth Caritas Pennsylvania; 22.4 percent for Keystone First; and 6.7 percent for Select Health of South Carolina.

Location:

This program took place in Pennsylvania and South Carolina.

Contact:

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Figure 1

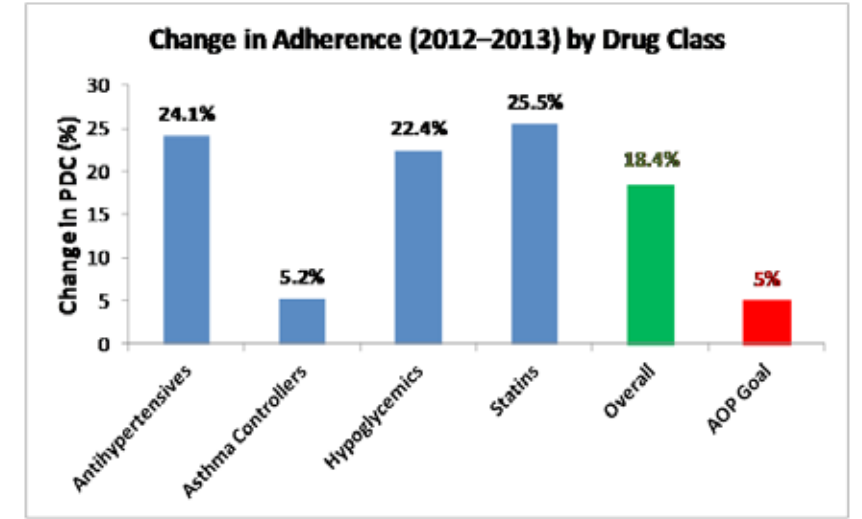
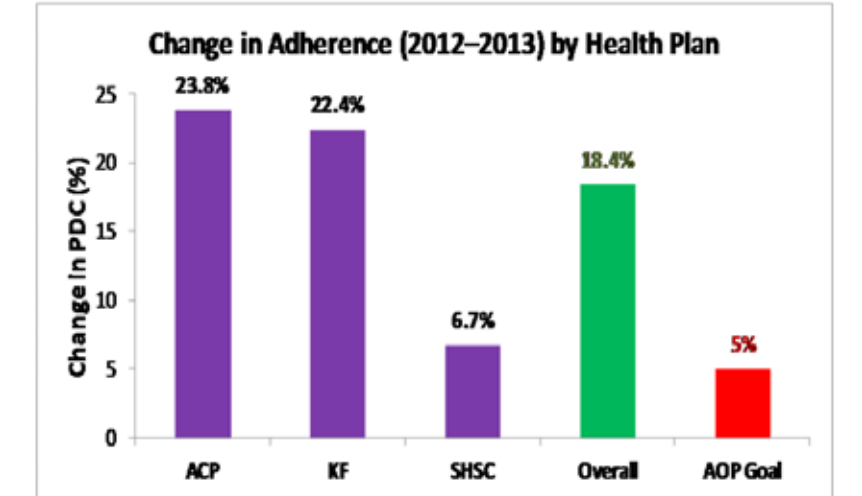


Figure 2



Annual Operating Plan (AOP); AmeriHealth Caritas Pennsylvania (ACP); Keystone First (KF); Select Health of South Carolina (SHSC)

Footnote

¹ Viswanathan M, Golin CE, Jones CD, Ashok M, Blalock SJ, Wines RC, Coker-Schwimmer EJ, Rosen DL, Sista P, Lohr KN. Interventions to improve adherence to self-administered medications for chronic diseases in the United States: a systematic review. *Ann Intern Med.* 2012 Dec 4;157(11):785-95.

Nurtur®/Centene® Corporation

Poverty Competency Training for Member-Facing Staff

Description:

Nurtur is dedicated to providing distinctive training programs to help drive member engagement. We cannot make a positive difference in members' health status if we cannot engage them. Nurtur works with a predominately low-income population — one that has historically presented a challenge to effectively engage. As healthcare professionals, we believe that we can help these individuals if we could simply make contact with them. Our preconceived ideas of poverty often prevent us from effectively communicating with our members.

People living in an impoverished state often have a different set of priorities than individuals who have never experienced living in daily crisis. Poverty continues to be a real issue in America. According to the Current Population Survey (CPS), 2013 Annual Social and Economic Supplement (ASEC), in 2012, 15 percent of the population, or 46.5 million people, were living in poverty; 21.8 percent of them were children under the age of 18. Since a large portion of the members we serve live in poverty, Nurtur developed a unique Poverty Competency Training course for our member-facing staff. Nurtur employees receive the following benefits:

- Deeper understanding of poverty, its history, and causes
- Awareness of one's own attitudes and beliefs about poverty and the poverty population
- Recognizing poverty types and the corresponding effects
- Understanding that people are likely making the best choices they can based on their worldview
- Understanding oral culture and relational styles of giving and receiving information
- Skills for better communication across poverty barriers

Nurtur is deeply committed to communicating the importance of understanding those in poverty in order to better engage and help them achieve a healthier status.

Key Objectives:

- Improve the health of the population
- Enhance the patient experience of care, including quality, access, and reliability
- Reduce disparities in care of racial and ethnic minorities

Actions Taken:

Cultural sensitivity and disparity has been a topic of interest and often required training for employees across all organizations. Specific training on poverty — understanding its history and causes, people's preconceived attitudes and beliefs, the types of poverty and communicating effectively across poverty barriers — has been lacking. Nurtur conducted an intensive search for a stellar training course that would enhance our understanding, communication and engagement of our members.

In early 2013, Nurtur created its Poverty Competency Training program based on the principles gleaned from Donna Beegle's, EdD, Poverty and Coaching Institute's two-day course. We used the tools and training we received and applied them to fit a more condensed training program. The resulting 3.5-hour training included the use of poignant videos, authentic audio messages as recorded by Nurtur staff, activities, and lecture presentations. Although well-received, the course length was consistently listed as the sole negative comment on feedback surveys. The initial training has been reduced to three hours while maintaining multimedia and content integrity.

The ensuing frank discussions that result from the video, activities and presentation demonstrates our unique worldview on poverty. Often, participants share their own experiences having come from an impoverished background; some remain stalwart in their belief that people take advantage of the system. Regardless, staff leave with a deeper appreciation of the extreme hardships that our members experience on a daily basis, such as why finding transportation to the local food pantry is more important than being present for a scheduled health coaching call, and although they cannot make a difference in the lives of all, celebrate making the difference to even one!



Every part of the presentation was outstanding or excellent I felt. The presenter was speaking from experience, really conveyed the needs and concerns of people living in poverty and made a lasting difference in my perception of poverty and my desire to become involved in a positive way in the lives of others. Already today I have had an opportunity to empathize and give encouragement to a member with financial problems that could impact her health. The presentation definitely increased my sensitivity to this issue and my motivation to become positively involved."

– Nurtur Health Coach

"Awesome presentation; learned a lot on how to relate to my members in a more empathetic manner."

-Bridgeway Case Manager

"Excellent training session! I was amazed at the difficult decisions that families in poverty must make. I now have knowledge and insight that I did not have before. Thank you so much!"

– Nurtur Employee

"The information was presented well. It was very insightful and introduced me to various reasons as to why someone may not be achieving their health-related goals that I did not previously consider."

- Nurtur Employee

Outcomes:

Nurtur's Poverty Competency Training program was presented to more than 250 member-facing staff as well as executive leadership. The mandatory program is offered quarterly for new employees, and an annual Poverty and Health Literacy Refresher course was implemented at the start of 2014; to date, 206 Nurtur employees have attended.

Due to the overwhelmingly positive reception from Nurtur employees and leadership, Poverty Competency Training was offered free of charge to all Centene Health Plans. Training was provided to member-facing staff at a number of Centene subsidiary health plans, such as Absolute Total Care, Bridgeway, CeltiCare, Coordinated Care (twice), Louisiana Healthcare Connections, Managed Health Services-Indiana, New Hampshire Healthy Families as well as to Centene's Member Connections Reps. Nurtur trainers presented on-site (except in two instances) to approximately 400 employees. In addition, Nurtur trainers provided training materials to the respective Health Plan trainer in order that the Health Plan may share to staff going forward.

Location:

Nurtur has made this training available to employees at its offices located in Farmington, CT; Dallas, TX; Baton Rouge, LA; and Tempe AZ. Additionally, the training was offered to all Centene health plans. Participating health plans have included those located in Arizona, Indiana, Louisiana, Massachusetts, New Hampshire, South Carolina, and Washington. Numerous remote employees from Nurtur and Centene also participated.

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UnitedHealthcare Community & State Sickle Cell Outreach

Description:

A member outreach campaign including claims analysis, nurse phone calls and clinical marketing materials to connect members with a sickle cell specialist. The specialist will be able to evaluate whether the member is a good candidate for the medication hydroxyurea (HU), which has been shown to significantly reduce the incidence of sickle cell crises, hospitalizations and ER visits.

Abstract:

About 3,200 members across all UHC Health Plans have a sickle cell diagnosis and approximately 30% of these, or roughly 1,000, are candidates for HU. HU is an inexpensive medication that can significantly reduce the frequency of sickle cell pain crises. Improving hydroxyurea adherence among members with sickle cell disease will enable our members to live healthier lives and lower health care costs via reduced ER visits and hospitalizations. In fact, our Healthcare Economics team conducted analysis indicating that good compliance with hydroxyurea can yield \$2,000 PMPM healthcare cost savings. The first step in supporting the use of hydroxyurea for these members is to connect them with a sickle cell specialist, usually a hematologist, or sickle cell center of excellence.

Key Objectives:

- Improve the health of the population
- Control or reduce the per capita cost of care or increase efficiency
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.

Actions Taken:

Using claims analysis, the health plans first identified members with sickle cell disease. Next, a referral list was created by identifying sickle cell centers of excellence, as well as providers experienced in hydroxyurea administration. A 15-page color educational booklet was developed by our Clinical Marketing team to help members learn more about how to stay healthy with sickle cell disease.

Once the referral lists and materials were created, we enlisted the expertise of our high-touch call team staffed with registered nurses to make outreach phone calls. During the calls, the nurses asked members if they needed help finding a specialist to better manage their sickle cell disease. If the member needed assistance, the nurse would refer the member to a specialist nearest to the member's home. The nurse also offered to conduct a three-way call during the outreach to schedule the appointment with the member still on the line. Educational materials were also offered during the call, and any member interested in receiving these materials was mailed the 15-page educational booklet immediately following the completion of the outreach campaign. In Tennessee, we conducted a post-outreach survey to gather feedback, which included questions such as, "How many new things did you learn about sickle cell disease by reading the Living Well with Sickle Cell booklet?"

Outcomes:

Impact to HU Utilization: In Maryland, 13 more members were prescribed HU after campaign completion, an increase of 33%. For the more recent Tennessee and Louisiana outreaches, the impact of HU prescriptions has yet to be determined. However, below are some preliminary results:

- In Tennessee, eight members responded to a post-outreach survey. 100% indicated the educational sickle cell booklet: (1) provided useful information; and (2) was easy-to-understand. Seven-out-of-eight members learned one or more new things after reading the booklet.
- In Louisiana, we identified 20 members during outreach calls who requested additional assistance managing their disease. All of these members received follow-ups from nurse case managers.

Location:

This program took place in Maryland, Tennessee, and Louisiana.

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Helping People Help Themselves

Health plans recognize that health care is a partnership, and patients have to be engaged in both prevention and treatment. Plans have implemented many initiatives to empower beneficiaries to take charge of their health. They also create incentives to support people in making healthier choices. The following eight submissions, presented in alpha order, focus on methods health plans took to help their members/beneficiaries make the most out of the health care.

UnitedHealthcare Community Plan of Tennessee Bringing People Together to Overcome Chronic Conditions (Stanford Model Classes)

Description:

Feeling alone after being diagnosed with a chronic condition is a commonly encountered issue faced by many Americans challenged by illnesses like diabetes. UnitedHealthcare Community Plan of Tennessee (UHCCP-TN) has partnered with the Tennessee Department of Health and the University of Tennessee (UT) Extension Services to offer our members the Stanford Model, six weekly, group-style educational sessions that promote self-management and a teaming approach to combat chronic conditions. Both the "Taking Charge of Your Diabetes" and "Living Well with Chronic Conditions" programs are: being used to increase member understanding related to their conditions; increasing member support by feeling included in a group; closing gaps in care; and creating healthy lifestyle changes.

Abstract:

The goal of this initiative is to increase member engagement, provide disease-specific education, and empower members. As a result, members are better able to self-manage their chronic condition(s) resulting in improved quality of life for the member and reduced episodes of inpatient ED visits and/or hospital stays. The Health Plan conducted focus groups in each of the three state regions to better understand how to motivate members to make lifestyle changes. The focus groups took time, but significantly helped to meaningfully understand the specific behaviors needed to better manage the participant's chronic conditions.

Based on the feedback from the focus groups, the Health Plan sought opportunities to bring groups of members with similar diagnoses together for educational sessions and peer support. In order to keep members in the comfort of their own communities, the Health Plan partnered with local Health Departments and the UT Extension to offer the Stanford Model Classes. These classes are conducted by certified trainers employed by either of the two host agencies.

Key Objectives:

- Improve the health of the population
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.
- Improve member self-efficacy

Actions Taken:

The action taken was extracted from the member focus groups and was tied to specific member wants, needs and desires. The Health Plan partnered with two state organizations that were receiving federal grant funding to support population health and in turn, the Stanford Model Classes. Together, a system was crafted to increase potential member participation by increasing convenience. More specifically, the classes are offered across the state. When a class is set up, the Health Plan provides targeted outreach to invite members identified with chronic conditions who live within a 15-mile radius of the class location. They provide a small incentive to members who successfully complete the course; in addition, they collect individual member surveys that detail lifestyle changes and care gap closures that have resulted after attending the entire course. In turn, the Health Plan can continuously improve the courses and innovate based on member feedback.

Outcomes:

We collect and monitor several data points. We look at both our engagement rates and our graduation rates. A member is considered to have graduated from the course if they attend at least four of the six classes. At graduation, per state guidelines, we can count these graduates as educational face-to-face visits. A major focus is on the self-reported data provided in the surveys that we designed for the end of the course. We are expecting and experiencing increased year-over-year growth based on member-suggested course improvements, word of mouth, and new member engagement strategies.

In 2013, we had a total of 41 classes. We had 65 members who attended at least one class and a total of 42 who actually graduated (attended at least four of the six classes). In 2014, we have had a total of 47 classes year-to-date. A total of 34 of those classes have ended and 13 of those classes are still ongoing, so no outcome data is available on those as of yet. We have had a total of 52 members who have attended at least one class and a total of 35 of those graduated. We are currently averaging two closed gaps in care and three lifestyle changes for each of our graduates from these courses.

Location:

This program took place in Tennessee (all three regions).

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Meridian Health Plan

Calling All Members! Welcome Calls to Engage Members in Their Health



Description:

Each and every member enrolled with Meridian Health Plan receives a welcome call. This allows us to welcome them to managed care, explain their benefits, connect them with community resources, verify member demographic information, and conduct a health risk survey. Each member is explained their benefits and is provided with an opportunity to ask questions. Our outreach team refers members to programs offered, and assists with setting up their first PCP visit. We utilize this call to explain the importance of their medical home, and to provide important information about recommended services. In 2013, Meridian dialed 354,657 welcome calls. Meridian consistently ranks among the highest performing plans with quality and access to care measures. Welcoming all members has proven to make a difference in the lives of our members, as well as our outcomes, exceeding NCQA's 90th percentile in Customer Service, and exceeding 75th percentile for Access to Care.

Abstract:

Meridian Health Plan recognizes that members newly enrolling in the plan need education and assistance in order to understand their benefits and effectively access health care and plan services. This process is particularly important for members who are new to managed care or previously did not have health insurance coverage. Often times, members are unsure of their effective date, the plan benefits, or how to access them. In early 2014 Meridian enrolled over 62,000 new members under Michigan's Medicaid expansion program. Many of these members were new to health insurance coverage and needed assistance in accessing Plan programs such as Disease Management, Care Coordination, Nutrition, and Smoking Cessation to support the Healthy Behaviors they agreed to work on as a condition of the new Healthy Michigan program.

Key Objectives:

The objectives of the program are to:

- Educate new members on plan benefits and how to access plan services
- Conduct a Health Risk Assessment to screen members for programs such as Care and Disease Management
- Engage members in their health management by stressing the importance of establishing a medical home and assisting members in making an appointment with their primary care physician

In working to achieve these objectives, Meridian strives to achieve the following goals:

- Improve the health of the population
- Enhance the patient experience of care, including quality, access, and reliability

Actions Taken:

As the largest Medicaid Health Plan in Michigan, Meridian has a large number of new enrollees each month. During implementation of Healthy Michigan, the state's Medicaid expansion population, Meridian was onboarding up to 20,000 new enrollees within a given month. In order to reach all new members with welcome calls, the Plan uses an auto-dialer system combined with a Welcome Call alerts within its managed care system (MCS).

When Meridian receives the monthly enrollment file from the State, a red "W" alert is populated within its managed care system (MCS) which is displayed on the member demographic screen to inform staff of each newly enrolled member. This alert is not removed until the member receives a welcome call. These welcome calls are completed if a member calls into the Member Services Department, or when reached through the outbound auto-dialer call. Welcome calls are always completed by a live staff member.

The outbound dialing system, Presence, is used to complete outbound welcome calls. Presence retrieves phone numbers from MCS based on the call campaign logic and dials out at random. Presence filters out incorrect phone numbers and calls going to voicemails, only connecting answered calls so that Meridian staff members have the most effective use of their time. If the system reaches a member's voice mail, previously recorded voicemail messages are left, asking for the intended call recipient to call the plan back. By using an auto-dialer system, Member Services staff is able to spend all their time talking with members rather than manually dialing members.

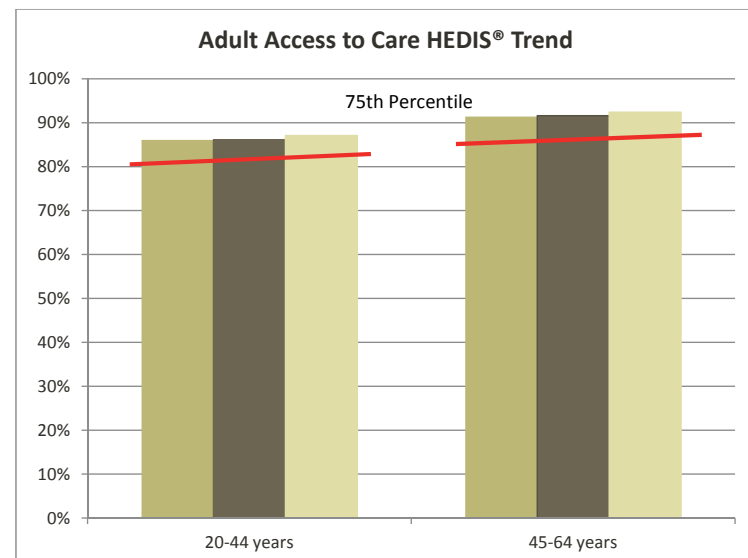
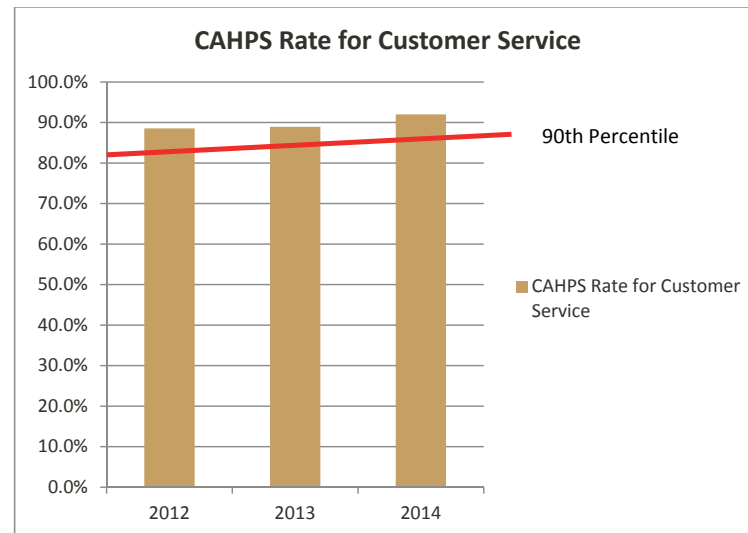
Outcomes:

In 2013, Meridian performed 354,657 welcome calls using its Presence auto-dialer system and connected in person with 75,761 households. In addition, the following referrals and assistance was provided:

Assistance/ Referral	Number in 2013
Office Appointment Scheduled	8,097
Smoking Cessation Program Referral	1,879
Pregnant Member Reached	6,251
Behavioral Health Referral	1,399
Dental Information Provided	9,647
Benefit Education Provided	75,761
Total Welcome Calls	354,657

Meridian measures success with welcome calls using the CAHPS survey results for the customer service questions as well as rates of the HEDIS Access to Care measures. As indicated at right, Meridian has exceeded NCCA's national Medicaid 90th percentile in Customer Service ratings in 2013 and 2014.

In the area of Adult Access to Care, Meridian has consistently performed well exceeding NCCA's national Medicaid 75th percentile in both age categories. (See graph at bottom right.) In 2014, Meridian also exceeded the 90th percentile in Adult Access to Care for ages 45 to 64.



Location:

This program took place in the following: Michigan, Illinois, and Iowa.

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Keystone First, AmeriHealth Caritas Partnership

Empowerment Tour: 40-Day Journey to Better Health

Description:

The Health Ministry provides underserved communities with a safe, supportive, and faith-based setting in which to learn about their health and receive health screenings. Participants are introduced and encouraged to change their eating and exercise behaviors by using the Daniel Fast, a Bible-based program that promotes eating fruits, vegetables, and whole foods during the 40 days of Lent. From February to March of 2013, we partnered with three area churches in underserved communities of Philadelphia to provide a series of faith-based health education programs and screening events to Keystone First members and nonmembers alike over a six-week period.



Abstract

In various formal and informal surveys, Philadelphia — the 5th most populous city in the United States — has consistently ranked among the unhealthiest cities for its size,^{1,2} and the unhealthiest county in the state of Pennsylvania³. A 2008 CDC study ranked Philadelphia as the 5th unhealthiest city out of the 20 largest metropolitan areas in the United States⁴. An unhealthful lifestyle is the sum total of a combination of factors, including an adverse physical environment, socioeconomic factors, poor clinical care, and unhealthful behaviors. In order to address the complexity of factors resulting in an unhealthful lifestyle and to engage the attention of an underserved population, a holistic wellness-based approach with unique and stimulating programming is required.

Since the Health Ministry was launched in 2000, more than 15,000 minority men and women across three states have received potentially life-saving screenings, including mammograms, blood pressure and cholesterol testing, and screenings for depression through this program. The program goals include:

- Promoting health education, health literacy, and preventive health care among underserved communities.
- Increasing knowledge of diseases.
- Improving screening behavior and readiness to change.
- Reducing risk associated with diseases and symptoms of diseases.
- Engaging Keystone First and community members in proactively managing their health.
- Reducing unnecessary hospitalizations/emergency department visits.
- Reducing the potential costs associated with emergent/urgent care.
- Promoting and encouraging medication adherence.
- Collecting data on shopping habits, nutrition knowledge and food choices.
- Partnering with sponsors and other interested parties, including the Drexel University School of Public Health, the American Diabetes Association, the American Heart Association, YMCA, ShopRite, Enterprise Kitchen, Zipongo, Coca Cola, Pfizer, ShopRite, and Walgreens.

Key Objectives:

- Improve the health of the population
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.
- Reduce disparities in care of racial and ethnic minorities

Footnotes

¹ The 10 Most Unhealthy Cities in America. MOVOTO blog. 2013. <http://www.movoto.com/blog/top-ten/most-unhealthy-cities/>
² Woehr M. The Least Healthy Cities to Live in the U.S. http://www.ehow.com/info_8193269_least-healthy-cities-live.html
³ RWJF/University of Wisconsin Population Health Institute. 2013 Rankings: Pennsylvania. County Health Rankings & Roadmaps. http://www.countyhealthrankings.org/sites/default/files/states/CHR2013_PA_0.pdf
⁴ Hughes E, Kilmer G, Li Y, Valluru B, Brown J, Colclough G, Geathers S, Roberts H, Elam-Evans L, Balluz L. Surveillance for Certain Health Behaviors Among States and Selected Local Areas – United States, 2008. MMWR, Dec. 10, 2010, 59(SS-10).

Actions Taken:

Keystone First members were targeted for participation through care gaps using hypertensive and diabetic criteria. The community was engaged through mapping and partnership collaboration. Three churches with primarily African-American constituents were selected as host sites due to their locations. The six-week program featured:

- Pre- and post-health screenings (offered no charge on the first and last dates of the program) for blood pressure, blood sugar (HbA1c), cholesterol, weight (BMI), and more.
- Prayer, fellowship, and music.
- The “Daniel Fast” and healthful eating.
- Interactive sessions on stress, heart health, diabetes, nutrition, exercise, and why medication adherence matters.
- Cooking demonstrations and food sampling.
- Motivational speakers and celebrities.
- Member incentives, like gift cards, raffles, and more.
- Sign-up for Zipongo’s Text Message program using mHealth technology, a mobile health application that encouraged shopping for whole foods by incentivizing cost through grocery store discounts.

In addition to hosting workshops designed to prevent and manage chronic conditions (e.g., breast cancer, diabetes, obesity, stroke and hypertension, heart disease, stress, and depression), speakers also focus on exercise, smoking cessation, proper nutrition, healthy lifestyles, and emotional and mental well-being. At all workshops and events, the Health Ministry program offers individual health assessments and screenings provided by a team of physicians and nurses. Health assessments examine each participant’s level of physical activity, diet and other lifestyle choices. Each participant also receives a healthy living guide featuring articles written specifically for the Health Ministry by medical experts and health professionals. The guide focuses on prevention, awareness and education to help participants and their families make informed health decisions.

Outcomes:

From February to March of 2013, 609 Philadelphia residents living in underserved communities, including 348 Keystone First members (57 percent) expressed interest and registered in the 40-Day Journey Empowerment Tour in three area churches. Within this population, a total of 278 people (members and nonmembers) participated in the program; 108 were Keystone First members with diabetes and/or hypertension and 81 (75 percent) members attending at least two sessions. At almost every weekly event, over 100 people attended a session and participants reported high rates of satisfaction and positive feedback concerning the program.

For the present analysis, 1,341 total health screening results were collected from the 108 Keystone First members. Several notable positive outcomes after six-month follow-up included:

- A 13 percent drop in total cholesterol in participants in two of the churches.
- A 10 percent drop in overall blood pressure among participants in one of the churches.
- An average weight loss of 6.2 pounds among those participants who lost weight.
- An average 1.4 inch loss in waist circumference.
- A 27 percent average reduction in BMI among those who received a pre- and post-screening.

Among all three churches, 70 participants lost a combined total of 434 pounds of weight. Finally, participants also increased their awareness of nutrition content in foods and their willingness to try healthier foods and substitutes. One-hundred fifty-four members participated in Zipongo’s Text Message program; out of the 69 (45 percent) respondents to a survey, 97 percent replied that texts were very helpful.

Location:

This program took place in Philadelphia, Pennsylvania.

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UnitedHealthcare Community Plan of Arizona It’s All About me* (Member Empowerment)

Description:

UnitedHealthcare Community Plan of Arizona’s me* program is a member-centric, goal-oriented program designed to empower members, in our UnitedHealthcare Community Plan long-term care product, to live happier and healthier lives through goal-setting. Case managers and their members set the member’s personal goals together, track progress on a regular basis and celebrate successes. The program has spun off to other opportunities to empower members, such as through workshops we created called Abilities Workshops. These workshops are opportunities to provide members with information to lead healthier and happier lives. This health plan is the largest Arizona Medicaid (AHCCCS) payer, while serving members covered in the largest geographic areas for the Arizona Long Term Care Services (ALTCSS) program. The plan has over 30 years of experience serving the needs of the Medicaid population.

Abstract

Long-term care members quite often lose the desire or capability to pursue goals or dreams after a life-changing injury or illness. Many are placed into long-term care settings. This can lead to feelings of unhappiness and reduced self-worth. Our members quite often talked about desires, without the ability to follow through. UnitedHealthcare Community Plan staff wanted to do something to make a real difference in the lives of the members they serve.

So the employees of UnitedHealthcare Community Plan developed and implemented me* with the goal to have members and staff think more about member empowerment. For the member, me* means “what goals do I have?” and “what will make my life better and make me happier and healthier?” For the staff, me* means “what specifically can I do to help my member meet his or her personal goals?” Employees show members, their families, providers and facility staff that empowering individuals by providing resources to meet their goals will in turn improve each person’s quality of life and engagement in their community.

Key Objectives:

- Improve the health of the population
- Enhance the patient experience of care, including quality, access, and reliability
- Improve delivery of benefits

Actions Taken:

The primary action was in creation of the program itself. The program construct entails:

- Goal setting for every member – discussion with case managers and documented for progress. The goals that members establish can be as simple as learning to knit, volunteering or moving to a home in the community.
- Case management tracking of goals with regular follow-up with members on progress
- Case managers support of the member to help remove obstacles to achieving goals
- Local resource directory comprised of names of resources to help members with such things as employment, housing, transportation, education and volunteer opportunities
- me* resource team to support all case management staff with questions or barriers that may arise in their day-to-day work with our members in the community. The team helps find solutions to barriers to goal success, such as locating options and obscure resources to meet the most unique care needs of the members.
- Reintegration specialists help members with goals to move home, and who have more complex discharge needs, reintegrate into their communities. The reintegration specialist possesses knowledge of the community resources and is equipped to address obstacles through creative care planning activity.
- Provider education in me* and the member’s goals, often resulting in provider engagement in the member meeting their goals
- Provider collaboration meetings to share ideas about engaging members in achieving goals
- Celebrations when members reach their goals
- Annual member Abilities Workshops to bring resources and services to members to help them achieve their goals
- Staff newsletter highlighting the monthly me* success stories
- Scrapbook of member success stories to share with agency providers and members. It is a way to honor the hard work and accomplishments, and has received positive feedback of pride and fulfillment from those who view it.

Outcomes:

- 100% of the members are evaluated and encouraged to develop a personal goal that is meaningful to the member.
- 100% of the members have a personal goal established in their care plan.
- About 25% of our members annually achieve the personal goals they set, with the assistance of their case managers. Some are short-term goals (e.g., purchasing a sewing machine), while other goals are accomplished over a longer period (e.g., college degree). Whether in the short or long term, our dedicated case managers empower members to remain focused on accomplishing the goals they have set for themselves.
- Trickle-down effect: By highlighting success stories with all staff, they understand how better to empower their members. This has led to other departments, such as provider services, hosting and coordinating events with our providers to better support those who care for our members.

Location:

This program was initiated across the State of Arizona, and is being adopted by UnitedHealthcare Community Plans throughout the country.

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HAP Midwest Health Plan

Knowledge Sharing and Tool Management for a Better Tomorrow

Description:

In 2012, HAP Midwest Health Plan developed a web-based system in-house for use by enrollment and customer services staff. This system integrated information from various sources, such as, weekly, monthly Medicaid plan enrollment data and remittance advice received from the State of Michigan, authorizations, claims from trading partners, pharmacy claims and internal member and customer service databases. The Enrollment group uses this system to enroll and dis-enroll members, maintain member information, check eligibility in real-time or in batch mode, change primary care physician, request and generate ID cards, enter memos and alerts, and upload and attach emails and documents. Customer Services staff can view and update member details, enter and update alternate contact information, add and maintain customer log entries, communicate with member and or responsible party and generate transportation requests. Managers are able to assign tasks to enrollment and customer services staff. The alerts also show when members are in need of services that are HEDIS related and if there is a gift card incentive for the member to complete these needed services too. Upon login, staff can view and respond to their assigned tasks that correlate to the ensuring the quality of communication occurs between the health plan and the member for required services through the prompted alerts. This system serves as a communication tool between two groups.

Abstract:

HAP Midwest Health Plan worked to address a need for efficiency in enrollment and customer services, and reduction in processing times through the use of this single point of access to quality information in real time. Through this program, an increased data quality was addressed to contribute to HEDIS measures, as well as an investment in the productivity from this tool. Features were also added to read and respond to messages and feedback from the users of the new HAP Midwest Health Plan websites and to manage access, pins, website content and disease information for a more streamline communication process between the website users and the health plan. All of these main points outlined were in an effort to reconcile the issues related with the quality of data and imperative nature of real time information within the system.

Key Objectives:

- Control or reduce the per capita cost of care or increase efficiency
- Improve delivery of benefits

Actions Taken:

The system serves as a dashboard and central repository of knowledge and information eliminating the need to login to different systems and look up different resources. It serves as a workflow communication tool automating and managing manual processes. HAP Midwest Health Plan realized a number of benefits from this project that increased the efficiency of processing transportation requests by electronically faxing, auto-filling the member demographics on the request form, and providing auto populated total miles for each trip. These improvements have enhanced the quality and accuracy of our transportation process.

Outcomes:

These improvements listed below have enhanced the quality and accuracy of HAP Midwest transportation process which resulted in the following accomplishments for the 700 transportation requests processed monthly.

- 1.5 minutes less processing time per call resulted in an additional 17.5 hours per month for customer representatives to focus on special projects
- The electronic faxing function has eliminated duplicate transportation requests which have increased the accuracy of reporting, billing, and service to our customers.
- The ability of the system to electronically notify management on a daily basis of the capacity of the transports allows us to utilize our resources to enhance efficiency of the scheduling with numerous vendors

Other improvements include a member screen that lists any preventative medical needs for the members and are populated as an alert to remind the customer service representative when conversing with the member on the phone. The customer service representative is able to tell the member what medical appointments may be needed, and if there are incentives attached to the completed appointment. This increased the health plan's outreach efforts to make sure members stay healthy and in compliance with MDCH quality standards of care. The alerts also show when members are in need of services that are HEDIS related and if there is a gift card incentive for the member to complete these needed services, too. These improvements are in relation to an increase in HEDIS scores and better health outcomes, as well as an increase in member satisfaction.

Location:

This program took place in Southeastern Michigan.

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MDwise, Inc.

MDwise Community Advisory Councils

Description:

MDwise, as a state-wide health plan, hosts Community Advisory Councils across the state. These Councils are comprised of a broad coalition of community organizations that serve a significant number of MDwise members across all Indiana Medicaid programs. The primary goals of the Councils are:

- 1) To help MDwise better understand the unique needs in each geographic and cultural region
- 2) To learn which strategies that have proven successful in meeting local needs
- 3) To get local input into how MDwise health-focused programs are designed and rolled out
- 4) To obtain feedback from participants about what MDwise is doing well and what we can improve upon
- 5) To allow participants time to network and share information with one another

Abstract:

As a health plan that is contractually mandated to serve the entire state geographically, MDwise is challenged to serve extremes in terms of cultural dimensions. We serve areas that are extremely rural and extremely urban, with unique cultural diversity in both settings. We did not have a forum where we could get input and feedback from our constituents about how well we were meeting the local needs of members and providers. Through the councils, we are able to discuss various challenges and barriers to care in order to understand the community and tailor quality improvement efforts. We are also able, through the councils, to communicate valuable information about MDwise to assist our community partners in better understanding what MDwise programs are available to serve our members and their communities.

Key Objectives:

- Enhance the patient experience of care, including quality, access, and reliability
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.
- Reduce disparities in care of racial and ethnic minorities

Actions Taken:

The Community Advisory Councils began with a pilot program in Northwest Indiana in 2010 and have expanded to seven regions across the state in 2014. Each regional council meets two times each year with an average of 10-12 attendees at each meeting. Feedback is collected from participants through an evaluation at each meeting and trended over time in order to measure the success of convening these councils. What we have found is positive responses over time, with high percentages of participants reporting that they have had an above average to excellent experience and learned something new that they could utilize in their work in the community.

Some of the topics discussed in 2013 included: Culturally and Linguistically Appropriate Services (CLAS), HEDIS and CAHPS, Affordable Care Act and the MDwise Marketplace, medication adherence, family planning and asthma and diabetes tools.

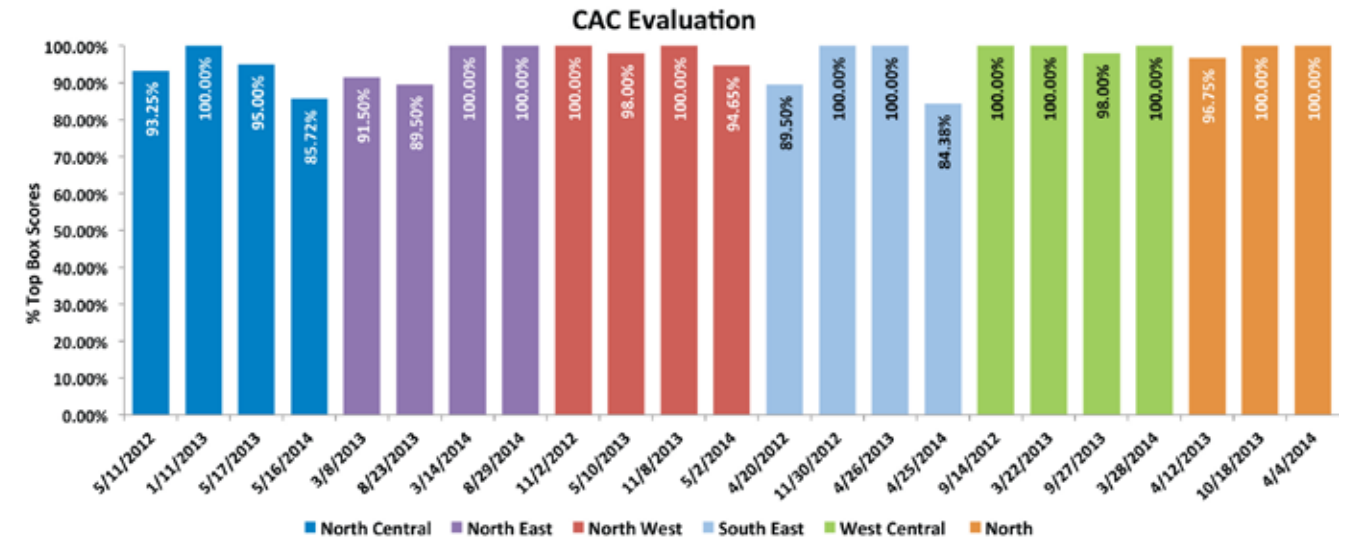
We classify and communicate key findings to:

- State Medicaid staff
- MDwise Delivery Systems for follow-up on issues related to providers
- MDwise departments for consideration and action
- Research and responses back to the group

Outcomes:

Examples of where the Community Advisory Councils have provided valuable input in 2013 and 2014 include, but are not limited to: regional information that was used in MDwise's Culturally and Linguistically Appropriate Services work; insights and feedback that were communicated to Medicaid staff as the Presumptive Eligibility Program for pregnant women in Indiana was being revised; and assisted in the development of a reference guide for asthma and diabetic supplies.

We attempt to measure participant satisfaction with program content at each meeting through an evaluation. The chart below depicts the "top box" scores, or those that indicated above average to excellent (scores 4 and 5) on a 5-point scale.



Location:

This program is available throughout the state of Indiana.

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Description:

In the MDwiseREWARDS program, members can earn REWARDS points for actions that range from completing a health risk screening with health plan staff to getting an annual physical exam or annual diabetes testing. MDwise currently has identified 14 activities for which members can earn points, and is adding two additional activities in the fall of 2014. Points expire one year from the date that they were earned. Members are able to view reward options available to them and select their reward online or through customer service. Points are structured so that a member must complete at least one important action in order to earn the first tier of rewards. The program was officially made available to MDwise membership in April of 2011 and has continued to show steady growth through 2014.

Redemptions in the initial year suggest that only a small percentage of our membership was aware of or took advantage of the program. We have seen increases over time as additional messaging has been introduced to members and providers about the program. MDwise always sees a spike in activities and redemptions when targeted postcards are mailed to member households. The messaging emphasizes “free” and clarifies how members can find out more about the REWARDS program. We continue to trend over time to evaluate the impact of various communications and thus far have continued to see a sustained increase in overall awareness month over month from previous year data.

Abstract

The REWARDS program was designed to incentivize members to make positive health choices, develop loyalty to MDwise as a health plan and positively impact quality measures such as HEDIS. We also hoped REWARDS would serve as an incentive for members to complete the state’s required Health Risk Screener. MDwise incentivizes members to sign up for the member portal, which requires provision of an email address, to enhance communication efforts with members. We sought to develop a unique program that would be appealing to our members and would be easy to understand and implement.

Key Objectives:

- Improve the health of the population
- Improve delivery of benefits
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.

Actions Taken:

MDwise processes and tabulates member points based on eligibility, claims received and other pertinent data feeds. Members are able to view their points, how they earned them and redeem them for a gift card, online through the MDwise member portal (requires sign-up). Members without access to a computer or the Internet can inquire and take action through MDwise customer service. MDwise offers a variety of gift card choices, values equal to \$10, \$30 and \$50, depending on the number of points the member has earned and wants to redeem.

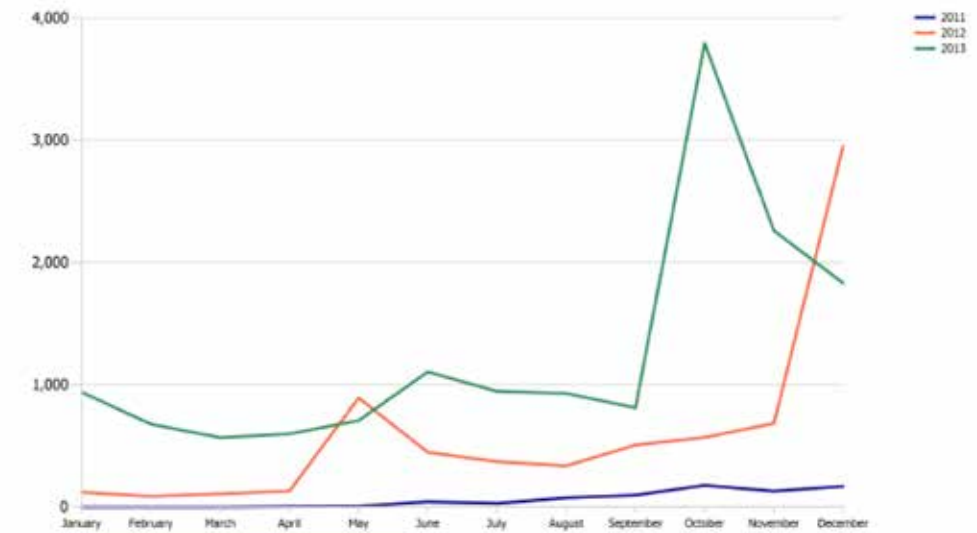
The program is communicated to members in a number of ways. Annually, MDwise sends out a specific mailing to each member household about the REWARDS program. The ways in which we communicate this program in other member materials such as the quarterly newsletter and other notices that are distributed have increased over time. We have developed informational tools for provider offices, so that providers can promote this program and encourage wellness behaviors their MDwise patients. Our customer service and case management staff use the program as a tool to encourage members to complete Health Risk Screenings and to comply with needed screenings such as LDL, mammograms and cervical cancer, as well as prenatal/postpartum appointments.

The outreach department has also employed the use of iPads at community events to assist members with enrolling in myMDwise portal, where members can check and redeem their MDwiseREWARDS points. In 2014, 39,780 MDwise members were signed up for myMDwise portal compared to 9,877 to members in 2011. This is a 302.75% increase in portal sign up since the MDwiseREWARDS program started.

Outcomes:

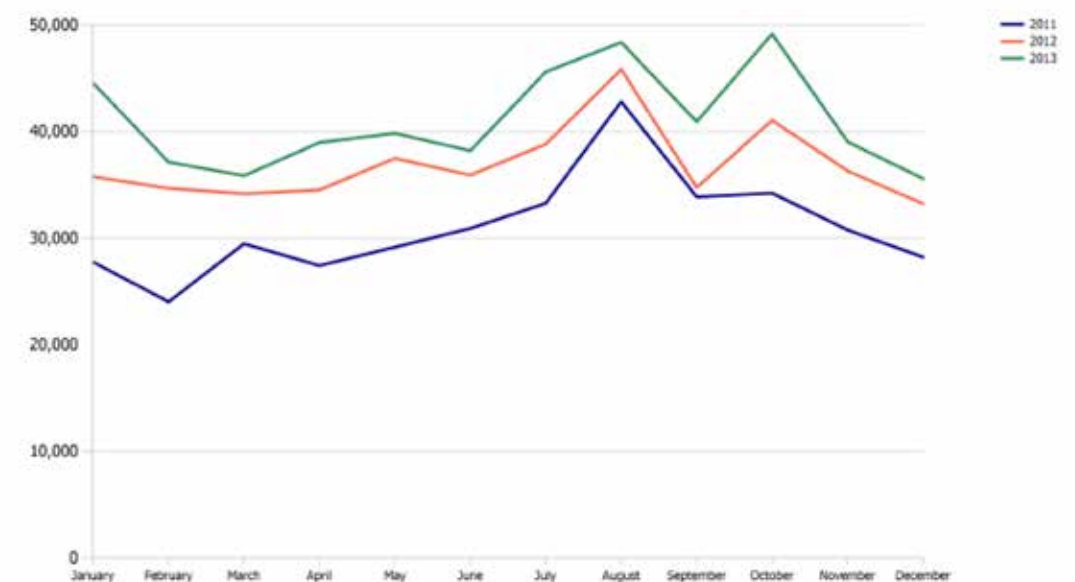
We have seen a steady upward trend in the number of redemptions over time as the following chart indicates. Targeted mailings about the program occurred in May and December of 2012 and October 2013 to every member household. Spikes in redemptions can be seen as a result.

Redemptions by Month by Year



We also wanted to see whether the REWARDS Program motivated members to seek care and positively impact our HEDIS measures. The following depicts an increase in REWARDS’ activities that earn points:

Reward Events by Month by Year



In an attempt to look further at the efficacy of the REWARDS program, we looked at the total number of pregnant women in our HEDIS denominator for the postpartum measure. We then looked at the number of redemptions in 2013 versus 2014 and found that more pregnant members took advantage of the REWARDS program in 2014.

	HEDIS 2013		HEDIS 2014	
	Count	%	Count	%
PPC Denominator	11,679		12,050	
With Redemption	694	5.94%	1,238	10.27%
Without Redemption	10,985	94.06%	10,812	89.73%

We then calculated a postpartum rate for both the redeeming and non-redeeming groups. We can see that the member's engaged in the REWARDS program had a higher rate of postpartum visits.

	HEDIS 2013			HEDIS 2014		
	Members with PPC exam	Members with NO PPC exam	Postpartum Rate	Members with PPC exam	Members with NO PPC exam	Postpartum Rate
Members that redeemed points for a gift card	500	194	72.05%	834	404	67.37%
Members that did not redeem points for a gift card	6,833	4,152	62.20%	6,306	4,506	58.32%
Difference in rates between groups			9.84%			9.04%

We then calculated a postpartum rate for both the redeeming and non-redeeming groups. We can see that the member's engaged in the REWARDS program had a higher rate of postpartum visits.

	HEDIS 2013	HEDIS 2014
Well Child 0-15 months (W15)	65.21%	71.05
Well Child 3-6 years (W34)	69.34	76.89
Adolescent Well Care (AWC)	50.85	58.88
LDL-C Screening (CDC)	66.24	69.53
Breast Cancer Screening (BCS)	35.54	40.42

While REWARDS was not the only intervention that was used to impact these rates, it played a strong part in motivating members to seek care. In regards to gift selection, the overwhelming first choice selected by members at the \$10 level has been a Subway gift card. At the \$30 level, a discount department store card was the most popular choice.

Location:

This program is available to MDwise members throughout Indiana.

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UnitedHealthcare Community Plan of Kansas UnitedHealthcare – Empower Kansans

Description:

UnitedHealthcare created the Empower Kansans program to evaluate and fund the implementation of innovative programs that provide support to persons with disabilities in their pursuit of meaningful employment. These employment opportunities align with both an individual's capabilities, as well as an individual's personal aspirations as it relates to employment. A committee consisting of community leaders, representatives from disability organizations and advocacy groups, state employees and others was created to consider and evaluate proposals for funding, which totaled \$1.5 million over three years.

Abstract:

Persons with disabilities experience a higher unemployment rate than their non-disabled peers. According to the Department of Labor's Office of Disability Employment Policy's website, labor force participation for persons with disabilities is at 19.3%, while persons without disabilities have a 69.3% participation rate. Many persons with disabilities want to work, but are facing various personal and systemic barriers. UnitedHealthcare encourages a holistic approach in support of our health plan members, which includes addressing the need for supports that assist individuals to obtain and maintain employment. When people gain employment, they are able to benefit financially, socially and generally experience an increased quality of life. A 2010 study by the Kessler Foundation and the National Organization on Disability (NOD) found that individuals with disabilities are more than twice as likely to live in poverty and have limited access to transportation. Therefore, they are less likely to socialize. (2010 GAP Survey of Americans with Disabilities)

Key Objectives:

- To develop programs that leverage existing community resources, consider expansion of current innovative programs and evaluate and implement new pilots and programs to support individuals in their pursuit of competitive, integrated employment, particularly programs that may be scalable to benefit larger populations.
- To support a commitment to a holistic approach to health care, including improving outcomes related to employment of persons with disabilities.
- To engage with key stakeholders with a broad base of expertise and experience regarding employment of persons with disabilities, and consider innovative practices supporting employment first initiatives.

Actions Taken:

1. Development of the Empower Kansans Advisory Committee, with key stakeholder representation, to inform program development and focus of funds.
2. Dissemination of Request for Proposal (RFP) targeted at employment of persons with disabilities (CY2013 & CY2014).
3. Review of proposals by committee and clarifications of outcomes with applicants: Received eight proposals as a result of the first RFP. Received 18 proposals as a result of the second RFP. Increased response and improved quality of proposals. A third RFP is scheduled for August 2014.
4. Grant Awards
 1st RFP: Five (5) projects awarded funds totaling \$264,000;
 2nd RFP: Seven (7) projects awarded funds totaling \$455,000

Outcomes:

The first five grantees are currently in the fourth quarter of their year-long grant cycle. All grantees are on target to complete their proposed activities, and some will exceed their identified outcomes for people with disabilities becoming employed. One grantee, Cottonwood, Inc., proposed facilitating integrated employment for at least five job seekers previously working in non-integrated settings. They are using a peer group/job club model to generate interest and provide job readiness training. By the end of the third quarter, this grantee reported five individuals with intellectual and developmental disabilities who have obtained integrated employment in their community. In addition, they are actively supporting job development activities for 14 additional job club members.

A second grantee, Assistive Technology for Kansans (University of Kansas), proposed providing digital training/iPad workshops to individuals with disabilities in three Kansas communities. The workshops were designed to support skills needed in competitive and integrated employment settings. Participants completed a work/learning plan that reflects their employment interests. For example, employment tasks could include learning to complete online job applications or search for jobs that match your skills online. Many of the workshop attendees are now employed, more than the original target.

Location:

Programs have focused supporting individuals or addressing barriers to employment in the following targeted locations in the state of Kansas, although beneficiaries of the funding may live in other locations as well: Kansas City (Kansas), Johnson County, Miami County, Wyandotte County, Beattie, Wichita/Sedgwick County, Hutchinson, Stafford, Dodge City, Medicine Lodge, Pratt, Waterville, Topeka, Pittsburgh (Kansas).

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Prevention and Wellness

Medicaid health plans have developed diverse programs to reach Medicaid beneficiaries and engage them in healthier behaviors. This section includes Best Practices illustrating both community-based and individually targeted strategies. From smoking cessation programs to increasing access to healthy foods, health plans are reaching out to beneficiaries to improve health and health care services. The following 10 case studies are presented in alphabetical order.

MDwise, Inc.

“Advising Smokers and Tobacco Users to Quit” — Postcard and Call Intervention

Description:

The purpose of the outreach was to remind adult MDwise members of the tobacco cessation benefits and services available to them. In order to emphasize the CAHPS question and attempt to impact a positive response, we designed the postcard so that it mirrored the CAHPS question. We also implemented an automated call that reinforced the message as well.

Abstract

MDwise has struggled to improve the CAHPS score on “Advising Smokers and Tobacco Users to Quit” with one of our adult coverage programs that includes pregnant women and low income families. Indiana is ranked as the 6th highest smoking state in the United States. Because of a high smoking rate among Medicaid members, the state Medicaid agency makes the CAHPS scores for doctors “Advising Smokers and Tobacco Users to Quit”, a Pay for Outcomes (P4O) measure for its health plans. The state Medicaid agency withholds money from capitation and based on pre-determined measures, MDwise can earn that money back based on performance. “Advising Smokers and Tobacco Users to Quit” has been part of the P4O program for three years. Internal data shows approximately 120,000 of these members have not had a dental exam in over 12 months.

Key Objectives:

- Improve the health of the population
- Enhance the patient experience of care, including quality, access, and reliability
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.

Actions Taken:

MDwise developed, and improved a postcard and automated call message to reach members prior to the annual CAHPS survey time. The purpose of the outreach was to remind adult members of the tobacco cessation benefits and services available to them. The first attempt was made in 2012 with little impact. We made changes to the postcard and the call script in 2013, incorporating information about cessation aids that were available, as member services indicated this was their top question from members about tobacco cessation. We also re-worded the message on the postcard to mirror the CAHPS question, letting members know that their doctor advises them to quit. We were hopeful that this message would be more impactful. Postcards and calls were conducted with MDwise members 18 years and older, one per household.

Outcomes:

In the past, the MDwise Smoke-free program has had lower satisfaction and participation scores. These numbers reflect the steady and increased CAHPS scores.

For the automated calls we had consistent results over time. The following is our percent of successful contacts:

2012	2013	2014
72%	75%	74%

MDwise's CAHPS scores for "Advising Smokers and Tobacco Users to Quit" are as follows:

CAHPS Score 2012	CAHPS Score 2013	CAHPS Score 2014
68.6	72.8	74.9*

**Significantly higher than 2012 score; All significance testing is performed at the 95% significance level.*

Our outreach messages just prior to survey time appear to have impacted the score, resulting in a better outcome in 2013 and better yet in 2014.

Location:

This program was available to MDwise adult members within the state of Indiana.

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Centene® Corporation

Breast Cancer Screening Member Mailer and Proactive Outreach Manager Outreach Pilot

Description:

The Breast Cancer Screening Member Mailer and Proactive Outreach Manager Outreach Pilot program targeted female Medicaid members between the ages of 50–74 who had not received a mammogram screening in the previous two years as of November 2013. We conducted a randomized controlled trial to evaluate the effectiveness of this pilot program and found that those receiving the outreach were subsequently more likely to have a breast cancer screening than a control group that received no outreach.

Abstract

Breast cancer is the most common cancer among women in the United States. Mammograms every two years are recommended for women ages 50-74 years as a way to lower the risk of dying from breast cancer.¹ There are barriers, however, to meeting this recommendation. The Komen website indicates lack of access to care (for example, access to mammography centers or access to transportation to those centers) and lack of awareness of breast cancer risks and screening methods among potential barriers to breast cancer screening.²

Key Objectives:

- Test the effectiveness of a newly designed member mailer
- Test the effectiveness of the current Proactive Outreach Manager
- Test the effectiveness of a combined outreach approach of member mailer plus Proactive Outreach Manager
- Increase breast cancer screening rates among noncompliant Medicaid members

Actions Taken:

To address these barriers among our Medicaid members, we developed an outreach pilot that included creating a new member mailer and using an existing Proactive Outreach Manager telephone script to encourage mammogram screening. Members who completed a mammogram were rewarded with a gift card that could be used for health purchases. We chose to pilot this outreach strategy in one state. Each mailer was designed to address the barriers listed above by providing facts about breast cancer risks, information about mammogram screenings, a toll-free number for health plan transportation services, incentive information and a list of three mammography centers. To determine which centers would be listed on each member's mailer, we examined our Medicaid claims for mammograms and selected the three centers with the highest number of claims for each county in the pilot area. The member's county of residence was then cross-referenced to determine which centers would appear on each mailer. This approach guided members to mammogram centers that were nearby and also likely to accept their insurance. The Proactive Outreach Manager campaign called each member with an automated message that encouraged the member to schedule and complete a mammogram.

To evaluate the impact of these outreach strategies, we conducted a randomized control trial among members in the pilot area's target population. Eligible members were randomly assigned into four groups: Group A received the mailer only; Group B received the Proactive Outreach Manager call campaign only; Group C received both the mailer and call; and Group D served as a control group and received no outreach materials. The rate of completed mammograms for the 120 days following outreach was compared for the three intervention groups versus the control group using chi-square analysis.

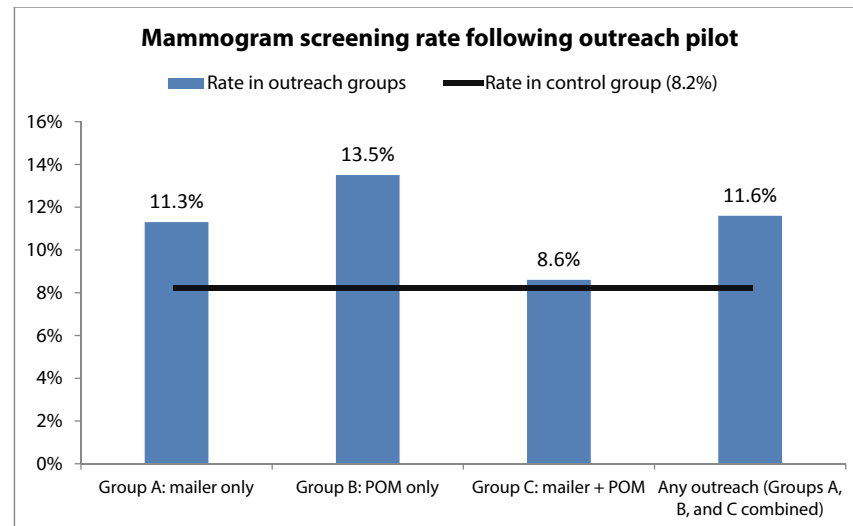
Footnotes

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² Komen, Disparities in Breast Cancer Screening. <http://www5.komen.org/BreastCancer/RacialEthnicIssuesinScreening.html>

Outcomes:

A total of 632 members were eligible to participate in this pilot study: 221 were randomly selected for Group A; 221 for Group B; 126 for Group C; and 64 for Group D. Members who lost eligibility during the follow-up period were excluded from the analysis, as were those who did not answer calls or have voicemail, leaving results for 501 members for assessment of outcomes (79.3% of those originally included). Following the outreach pilot, mammogram rates were considerably higher in Group A (mailer outreach, 11.3%) and Group B (Proactive Outreach Manager outreach, 13.5%) than in the control group (no outreach, 8.2%). The rate for the combined outreach (Group C) was similar to that in the control group. We also observed that the screening rate for all outreach groups combined was greater than for the control group (11.6% vs. 8.2%). Due to the small sample size, the improved screening rates for the outreach groups were not statistically significant relative to the control group.



Our results suggest that a mail or telephone outreach strategy that includes screening reminders, accurate information about breast cancer risks and screening methods, transportation support, and member-specific options for screening sites may positively impact the rate of mammograms among previously non-compliant Medicaid members. Based on these promising results, the outreach program has been expanded to include a larger population across more states. We hope that a larger study population will allow us to detect statistically significant impacts on mammogram screening rates in the future, as well as gain a better understanding of which outreach approach — mailers, Provider Outreach Manager calls, or a combination — is most effective.

Location:

This program took place in Florida.

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Select Health of South Carolina

Eye Exams for Members with Diabetes: An Approach to Improve Access, Compliance and Engagement

Description:

The plan identified a need among our members with diabetes for improved access to and compliance with vision exams. Using a multi-faceted approach, we conducted an in-depth analysis to identify barriers to vision care. Using these findings, we strengthened provider and member engagement through multiple points of education, improved primary care and specialty communication and coordination, and we conducted targeted interventions to underserved populations, including a mobile option where possible. We also included a member incentive and facilitated care coordination and communication between our primary care providers and vision care providers, including ophthalmologists and optometrists.

Abstract

People with diabetes are at an increased risk of developing eye diseases that can cause vision loss and blindness. However, these risks can be reduced substantially with annual dilated eye exams. Using annual Healthcare Effectiveness Data and Information Set (HEDIS®) data, Select Health identified that less than 40 percent of our members who have diabetes received an eye exam in 2012. The plan set the goal to increase First Choice member and provider awareness of the importance of the annual dilated eye exams, thereby increasing the number of members with diabetes receiving annual screenings for diabetic retinopathy.

Early in 2013, a multi-disciplinary workgroup determined ways to improve this important component of comprehensive diabetes care. We reached out to First Choice providers and members in various low-performing counties to identify and collaborate to mitigate barriers. We identified a multitude of barriers that needed to be addressed to increase compliance with this measure.

- Providers were confused about the benefit and unaware that vision exams were covered. As a result, many were not referring members to a vision care provider.
- Members were also unsure of the benefit. In some cases, members failed to show up for appointments with vision care providers for fear they would have to pay for the exam. When members did show up for appointments, they often failed to tell the vision provider they had diabetes.
- Lack of understanding about the benefit trickled down to the state's transportation provider, and in some cases, the transportation request was denied, assuming the service was not covered.
- There was a lack of coordination between the vision care provider and the primary care physician. In many cases, the results of completed vision exams were not sent to the primary care physician.
- In some rural areas, there was very limited access to vision care or long-distance access, resulting in higher gas costs or longer rides with the transportation service. There was a clear need to improve education and engagement, strengthen care coordination and target interventions to improve access in rural areas.

Key Objectives:

- Improve the health of the population
- Enhance the patient experience of care, including quality, access, and reliability
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.

Actions Taken:

Select Health educated primary care physicians and vision care providers through provider electronic newsletter articles, fax blasts and face-to-face contact. We provided relevant information related to clinical guidelines, covered services and coding, outlining the coverage of the eye exam service for our members with diabetes, the overall low rates of compliance with this important standard of care and appropriate coding of services to avoid inappropriate denials. We addressed care coordination, the importance of primary care physician referrals to vision care providers and the need to establish internal protocols to assure the results of the vision exam are recorded on member medical records. The Medicaid transportation broker also received clarification that vision exams are covered services and that transportation for these services should not be denied. The broker's management team also received training materials for staff. New questions were added to their workflow to better identify those seeking medical rather than vision screening services. In addition, we established a protocol for a biannual review of this education with the primary care physicians, vision care providers and transportation staff. We also worked with vision care providers to reach out to members due for a vision exam. Providers worked in tandem with the First Choice outreach team on calls and coordinated results with primary care offices.



Centene® Corporation

Fluvention® Texting Program: Improving Influenza Vaccination Rates through Text Messages to SafeLink® Phones

Description:

The Fluvention Texting Program uses a fast and effective communication medium — text messages to SafeLink phones — to tell members about the importance of influenza, or flu, vaccinations. The use of SafeLink phone numbers is a cost-effective way to reach a large set of members through free text messages. This program aims to increase the number of members receiving annual flu vaccinations.

This study establishes text messaging as an effective medium to quickly reach members and motivate them to get vaccinated: The flu vaccination rate was 10.5% for those who received any text messages compared with 9.3% for those that did not receive text messages, showing a significant impact of sending text messages ($p < .05$). This program has made a difference in the lives of members by providing continual reminders about the importance of flu vaccinations and letting members know where to receive them. Additionally, members who are vaccinated as a result of this program offer protections to others who live and interact with them. Thus, this program's benefits extend beyond the member and helps protect the population.

Abstract

Influenza and influenza-like illnesses are responsible for over 200,000 hospitalizations and 36,000 deaths in the average flu season.¹ Vaccination is the best defense as it decreases influenza-associated hospitalizations and medical costs,²⁻⁴ prevents influenza-related deaths,⁵⁻⁶ and results in a gain of quality-adjusted life-years.^{5,7} The flu vaccine is recommended for pregnant mothers and anyone over the age of 6 months.¹ To reach such a broad population, we explored the use of an innovative and rapid medium for health communication. Text message, or short messaging service, has proved to affect behavior change in preventive health initiatives⁸⁻¹² Most Americans (90%) own a cell phone and 80% use their phones to send and receive text messages.¹³ Text messaging offers a cost-effective way to communicate important health information with the potential to reach a wide variety of people over a vast geographic area. This study aims to add to the literature around the effectiveness of using text messages to increase influenza vaccination rates in the Medicaid population.

Key Objectives:

- Improve the health of the population
- Increase communication directly with members in a more effective way
- Educate patients to make informed decisions about seeking care

For members, mobile dilated eye exams were offered in rural/disparity areas. By working with a local provider with a mobile Retasure vision unit, members were able to have services performed onsite at diabetes-focused community health fairs. Results were then coordinated with the member's primary care physician.

Members also received education through phone calls and mailings. Mailed materials included specific information related to the coverage and importance of eye exams. In addition, a county/region-specific vision care provider directory was mailed to all First Choice members who have diabetes. Members received this directory based on the region where they live to make it easier for them to identify in-network vision care providers nearest to them. This was also shared with primary care providers to assist with increasing referrals. Calls went out to members in known areas of disparity to mitigate barriers. Referrals were also made to care management and community resources were offered. The plan also assisted members by funding applications to community agencies for eyeglasses if they weren't covered in their benefit structure.

Outcomes:

In 2012, only 40.1 percent of members with diabetes were compliant with a needed dilated eye exam. Due to our efforts, the rate of members receiving this important exam increased to 50.7 percent. This demonstrates a 26-percent increase in member compliance. Improved rates were also identified in many disparity areas. These efforts began in 2013 and are expected to continue to improve in 2014 with this ongoing strategy.

Location:

This program took place throughout the state of South Carolina.

Contact:

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Footnotes

¹ Centers for Disease Control and Prevention. Influenza: The Disease. Available from: <http://www.cdc.gov/flu/about/disease.htm>

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¹² Stockwell, Melissa S., Elyse Olshen Kharbanda, Raquel Andres Martinez, Celibell Y. Vargas, David K. Vawdrey, Stewin Camargo. Effect of a Text Messaging Intervention on Influenza Vaccination in an Urban, Low-Income Pediatric and Adolescent Population. *Journal of American Medical Association*. 2012; 307 (16): 1702-1708. *Epidemiologic Review*. 2010; 32(1): 56–69. doi:10.1093/epirev/mxq004.

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Actions Taken:

Centene's records were used to determine Medicaid members in its health plans who had a SafeLink phone as of September 2013. SafeLink Wireless is part of Lifeline, a federally regulated program that provides members with a free, basic phone that includes 250 minutes per month. Centene extends this program and provides members with health plan calls and free unlimited inbound and outbound text messages. Members who had a SafeLink phone were randomly assigned to one of three intervention groups to test the impact of frequency of messages sent: Group A received 12 text messages; Group B received seven text messages; Group C was the control group and did not receive any text messages. The text messages contained the health plan name and phone number, encouraged members to get a flu vaccine, helped dispel myths about the flu and flu vaccine, and provided members with information on where to obtain the flu vaccine. An external vendor programmed and tested all texts. Text messages were sent to members throughout the flu season (October-March). Each member could opt out of the campaign at any point. After receiving a claim verifying that a member received his/her flu vaccine, we removed the member from the texting schedule. At the end of the campaign, intervention Groups A and B received evaluation text messages, regardless of whether or not the member received a flu vaccine. The evaluation helped determine whether the text program was helpful in the decision to get a flu vaccine and accounted for self-reports of the flu vaccine as members may have received the vaccine in a location that claims data does not capture.

We conducted univariate chi-square analyses to determine the association between the Fluvention Texting Program and likelihood of getting a flu vaccine in the 2013-14 flu season. We conducted multivariate logistic regression to examine the predictors of getting a flu vaccine, and included race, intervention group (# of texts), any amount of texts received, gender, member geography, pregnancy status and flu vaccine in the previous flu season.

Outcomes:

We evaluated outcomes for 11,906 members (8,734 in the two intervention groups; 3,172 controls). Overall, 1,211 members (10.2%) received a flu vaccine over the course of the intervention. Members who received text messages (either Group A or Group B) had a flu vaccine rate of 10.5% compared with 9.3% of members in the control group. Vaccination rates within each intervention group were as follows: Group A-10.3%; Group B-10.7%; Control-9.3%. When compared with the control group, members in Group B (seven text messages) had a statistically significant higher vaccination rate (10.7% vs. 9.3%) ($p < .05$). Differences in flu vaccine rates were evident across the four health plans in the program. Wisconsin was the only plan that had a statistically significant higher flu vaccine rate in both intervention Groups A and B compared with the control (10.6% vs 12.3% vs. 6.22% respectively) ($p < .05$). Furthermore, multivariate logistic regression revealed that the only significant predictor of getting a flu vaccine in the current flu season was receipt of a flu vaccine in the previous season. Members who received a flu vaccine during the previous season (2012-13) were seven times more likely to obtain a flu vaccine during the current flu season (2013-14) than members who did not get a flu vaccine in the previous flu season ($p < .001$) (aOR=7.11, 95% CI=6.24-8.12).

Qualitative analysis revealed that over half (52.7%) of members that responded stated that the text messages were helpful in their decision to get a flu vaccine (Figure 1). The most common reasons given by members who did not receive a flu vaccine were: afraid of getting sick (39%), do not like shots (28%), do not have time (28%) and that it is not easy (5%). Our results suggest that the study population generally found the text messaging campaign to be helpful. The results also indicate that intervention B, which sent fewer texts, was more effective than intervention A, which sent more texts. In addition to limiting the number of texts sent, future campaigns should focus on dispelling the myth that the flu vaccine makes you sick. Outreach to members in future campaigns should also differ based on receipt of the flu vaccine in the last flu season. Finally, evaluations should be sent to members of the control group to get a true picture of the actual vaccination rate, which may not be accurately reflected in claims data.

Location:

This program took place in Illinois, Mississippi, Ohio, and Wisconsin.

Contact:

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WellCare Health Plans, Inc.

HealthConnections: LINK Up Illinois, Farmer's Market Initiative

Description:

Harmony Wellcare has established a partnership with Experimental Station (LINK Up Illinois program) to increase access to healthy foods for low income populations. Incentives to purchase fruits and vegetables will be available in 17 farmers markets throughout Cook County for both Harmony and non-Harmony members, allowing measurable results to be attained on the economic benefits for the small business Farmers Market, as well as community members.

Abstract:

Urban and rural areas are faced with issues associated with access to healthy foods and the ability for low income families to afford healthy foods. The creation of farmers markets in these communities has provided thousands of families access to healthy food items; however, many of these families rely on LINK benefits which require the use of EBT (Electronic Benefit Transfer) systems not readily available at farmers markets. WellCare's partnership with Experimental Station aims to promote a healthy lifestyle in these communities by funding incentive programs which allow families to double purchases made at local farmers markets.

Key Objectives:

- Improve the health of the population
- Control or reduce the per capita cost of care or increase efficiency
- Improve delivery of benefits
- Reduce disparities in care of racial and ethnic minorities

Actions Taken:

Wellcare's funding for Experimental Station's LINK Up Illinois program will initiate an incentive program at 16 farmers markets in Cook County to utilize Harmony WellCare Double Value Coupons, which will match LINK consumers up to a dollar amount. This incentive will allow an increase in purchases of fruits and vegetables, thereby promoting a healthier community.

Outcomes:

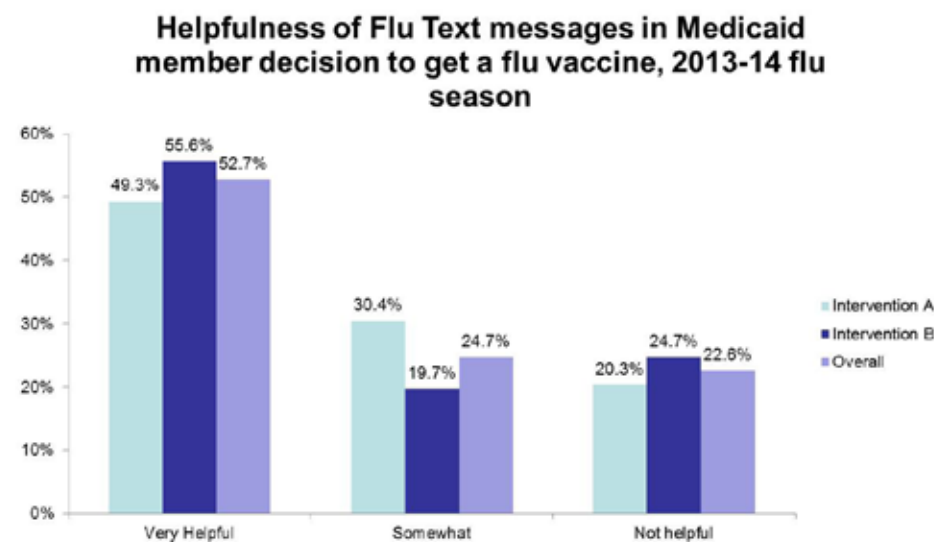
In 2011, LINK Up Illinois served more than 2,000 families by training and funding 20 Illinois farmers markets. This number exponentially increased in 2012 when funding increased to 38 markets, serving over 6,000 families which projected a 300-400% increase in purchases of healthy foods. Evaluation of surveys distributed to customers utilizing the farmers market incentive showed that 76% of customers shopped at the farmers markets because of the Double Value Coupon Program; 85% said that they purchased and consumed more fresh fruits and vegetables as results of this program as well. On July 15, 2014, WellCare began use of Harmony WellCare Double Value Coupons at 17 markets in Cook county which will run until January, 15, 2015. A continued rise in purchases of fruits and vegetables, and economic growth in the community is expected in comparison to last year's standings.

Location:

The program is currently being implemented in Cook County, Illinois until January 15, 2015. WellCare plans to monitor the economic benefits within the community during this time period.

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HAP Midwest Health Plan

Helping People Vaccinate Against HPV

Description:

The program was created in order to raise awareness among providers and members about the importance of HPV vaccination. The program was also created to increase HPV HEDIS outcomes. HAP Midwest Health Plan initiated a HPV project in the fall of 2012 and is currently still in progress.

Abstract:

Human papillomavirus (HPV) is the most common sexually transmitted infection (STI). There are more than 40 HPV types that can infect males and females. About 79 million Americans are infected with HPV and 14 million people become newly infected each year. HPV can however be prevented with vaccines. The vaccine protects males and females against diseases caused by HPV when given in the recommended age of 11-12 years old. The goals of the project were created to address this problem by educating providers on the importance of vaccinating at every office visit, and stressing the importance that PCPs can help promote HPV vaccination by talking with parents about the HPV vaccine. The health plan also worked to address this problem as well by taking steps to improve access to vaccines in their offices and educate members about the importance of the HPV.

Key Objectives:

- Improve the health of the population
- Enhance the patient experience of care, including quality, access, and reliability

Actions Taken:

HAP Midwest Health Plan developed an action plan to meet the project goals that included the following interventions:

- Established a member incentive for the completion of the recommended HPV series.
- Mailed proactive incentive letters monthly to members due for the HPV vaccine.
- Joined Merck's vaccine outreach program to notify members quarterly via postcard that they were due to complete the HPV vaccine series.
- Partnered with Merck's vaccine account representatives to offer provider education sessions on HPV vaccine guidelines. The program was piloted with nine high volume practices and included four 15 – 20 minute educational sessions on immunizations and process improvement strategies.
- Mailed a letter to PCP offices regarding the recommended guidelines for HPV and the educational sessions available through the Merck partnership.
- Published articles in the Plan's member and provider newsletters to provide education regarding the importance of the HPV vaccine.
- Promoted use of Michigan Quality Improvement Consortium (MQIC) Routine Preventive Services for Children and Adolescents guideline among provider network.
- Executed opportunity reports to the provider portal to support improvements in preventive and chronic care for members. These reports integrate Michigan Care Improvement Registry (MCIR) data, laboratory data, claims, and encounter data. Opportunity reports are updated monthly and inform PCPs of the services due for their members. The reports are aligned with the Plan's pay for performance (P4P) bonus program so PCPs can use the reports to help increase their bonus payments.
- Implemented a provider incentive for HPV vaccine series completion through the P4P program.

Outcomes:

HAP Midwest Health Plan has seen improvements in its HPV HEDIS measure from 2012-2014. In 2012, HPV was a first year measure; therefore, no NCQA benchmark data is available. The plan's 2014 HPV rate exceeded the goal of the NCQA 75th percentile. The plan will continue to outreach to members and providers regarding the importance of HPV vaccination..

Location:

This program took place in Southeastern Michigan.

Contact:

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MDwise, Inc.

MDwise Battle of the Fit Program



Description:

Battle of the Fit is a unique fitness program that MDwise created, directly impacting students in public elementary schools in Indiana by promoting physical activity, health and wellness. Battle of the Fit has been held in Indianapolis and Terre Haute with two separate competitions involving three schools in each of these cities. Both competitions promoted fun and being physically active, and had over 2,800 students participate. The program encouraged teachers to incorporate fitness activities into their daily curriculum.

The schools spent over 1,500 hours staying active during the 12-week and 8-week competition. First place received \$6,000 and the title of "Fittest School," second place received \$3,000 and third place received \$2,000. The prize money was to be used towards the purchase of fitness-related equipment. Smaller prizes were awarded along the way to students, teachers and volunteers as motivation and reward for their hard work.

Abstract:

According to the most recent statistics, overall childhood obesity rates in Indiana are 29.9%. The medical problems associated with this overweight state are likewise increasing. These include diabetes, high blood pressure and heart disease. MDwise used Battle of the Fit to make physical fitness fun for kids, in hopes that they would be more active both at school and at home. We also hoped that teachers would continue to include physical activity in their daily lessons because healthy kids are known to do better in school. Another goal of the program was to forge strong relationships with Indiana public schools and increase MDwise awareness, especially with those that have a high rate of children on the free and reduced lunch program.

Key Objectives:

- Improve the health of the population
- Control or reduce the per capita cost of care or increase efficiency
- Reduce disparities in care of racial and ethnic minorities

Actions Taken:

Battle of the Fit is unique because MDwise created the program inception, including the logo development, development of all materials such as the parent and school information, contracts, rules and mechanics of the program. Before launching Battle of the Fit, MDwise administered focus groups with local schools to further tailor the program to fit the schools' needs. Two focus groups were conducted with a total of 13 people. The adult session included two parents of IPS students, two administrators, two general teachers and two PE teachers. The kids' session included five kids from IPS schools. The kid's session lasted approximately 45 minutes and the adult's session was approximately 90 minutes. The information garnered from this focus group helped shape the program.

A website was developed for use during the program to provide a tool to keep track of activities and points, provide information, a photo gallery and a graphic showing the placing of each school. The website can be seen at battleofthefit.MDwise.org. Before the program was launched, MDwise conducted training with each school contact on how to use the website and the general operations and rules of the program.

MDwise staff made several visits to the schools during both programs so students were motivated to stay active. The program began with kick-off events at the schools. MDwise's mascot, Ms. Bluebelle, was present and participated in a fitness activity with the kids. MDwise also held motivational visits once a month at each school. The motivational visits consisted of fitness activities in the classrooms. The MDwise staff led the visit and Ms. Bluebelle participated.

MDwise also provided bi-weekly Ms. Bluebelle's Health Tips for schools to include in their newsletters which are sent home to parents, as well as in their school-wide announcements. At the end of each competition, MDwise held an awards ceremony for each school. Schools were presented a check and a trophy to display.





“This program hits on so many cylinders – good health and helping to insure the well-being of our students and their families through MDwise service along with the physical education piece...We are blessed to be part of this!”

–Kate Voss, Battle of the Fit liaison and parent community coordinator, Paul I. Elementary School 114

“As for Battle of the Fit it has become a whole school initiative and my whole school is making it happen! The Bears want first place. We thank MDwise for such an awesome, motivational, health focused endeavor.”

–William Crawford, Battle of the Fit liaison and gym teacher, James A. Garfield Elementary School 31

“We discovered that we can easily incorporate fitness activities into our day. Staff and students look forward to our AM and PM Minute to Move. We’ll keep integrating activity after the competition ends-it’s become a habit.”

– Peggy Pfrank, School Principal, West Vigo Elementary

Over 2,800 students participated in both Battle of the Fit competitions. The schools completed a combined total of 1,510 hours of physical activity in the allotted timeframe for each program. In calendar year 2014, MDwise achieved dramatic increases in the HEDIS-based measures for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC). Our rates increased 18.97 percentage points for BMI percentile documentation, 12.66 percentage points for counseling for nutrition and 11.19 percentage points for counseling for physical activity.

A lasting effect of the program is that the curriculum at all of the schools changed permanently to include more activity. During the competition for example, Paul I. Elementary School 114 implemented the “Jammin’ Minute” to start their day and James A. Garfield Elementary School 31 took time throughout each day for “Brain Breaks.” All schools are planning to continue these activities beyond the Battle of the Fit competition.

In addition, we have built strong relationships with our contacts at each of the schools that participated in Battle of the Fit. Awareness about the services MDwise offers has increased as well. We are working with each school on additional outreach efforts such as the 100% Enrollment Campaign, health fairs and specific health education sessions.

Location:

The program was conducted in Indianapolis and Terre Haute, Indiana at three Indianapolis public elementary schools that have high rates of children on the free or reduced lunch program and were geographically spread out throughout the city.

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HAP Midwest Health Plan (HMO SNP)

Seeing Clearly Now: Addressing Glaucoma in Members at Risk

Description:

HAP Midwest Health Plan determined during its annual strategic planning that there was an unmet need to educate more members about the importance of glaucoma screenings. The project was implemented to encourage members to complete the screening and as a result, an improvement in HEDIS rates also occurred.

Abstract:

HAP Midwest Health Plan acknowledges and works diligently towards effectively educating their members about preventative health measures and preventing disease. The health plan also understands some of its members may be considered high risk. Members at risk are people over age 65, members with a family history of glaucoma; members diagnosed with diabetes, and/or are a part of certain minority groups. Early diagnosis and treatment is the key to preserving sight. Routine screenings are important because once damage to the optic nerve has occurred it cannot be reversed. HAP Midwest Health Plan recommends that their members over the age of 65 be screened for glaucoma every other year and worked to address this issue by informing and incentivizing members concerning the imperative nature of these screenings.

Key Objectives:

- Improve the health of the population
- Reduce disparities in care of racial and ethnic minorities

Actions Taken:

Many interventions were created in an effort to actively increase glaucoma screenings and educate the health plan’s population. Annual member newsletters with information specific to glaucoma were mailed, and educational letters regarding the importance of glaucoma screening were mailed twice a year. The plan also implemented an incentive for members that received a glaucoma screening according to HEDIS specifications and members received a quarterly incentive letter as a reminder that they were due for a glaucoma screening. The final action taken was the plan established a provider incentive for annual glaucoma screening through the Pay for Performance (P4P) program.

Outcomes:

Due to increased member education and member/provider incentives that HAP Midwest Health Plan implemented, the HEDIS measure for screening of glaucoma has increased significantly. HAP Midwest Health Plan HEDIS rates improved from 62.0% in 2012 to 71.9% in 2014. HAP Midwest Health Plan rates are above the NCQA 50% and just below the NCQA 75%. This is an incredible growth for the population at large in need of a glaucoma screening. This NCQA HEDIS rate serves as an excellent determinant of the positive ways HAP Midwest Health Plan is effectively reaching its community in need, and educating members through beneficial and informative methods.

Location:

This program took place in Michigan.

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UnitedHealthcare Community Plan of Arizona

Sports Fitness – Health and Wellness for Youth with Disabilities and Their Families

Description:

UnitedHealthcare Community Plan of Arizona (UHCCP-AZ) has been providing care for members with disabilities and special health care needs for more than 30 years. We know that people with disabilities are less likely to engage in regular physical activity than people without disabilities; they have similar needs, yet may not have the same access to participate. Over the past three decades, multiple studies have shown that physical activity and sport participation result in improved functional status and quality of life among people with disabilities. UHCCP-AZ and our community partners identified barriers youth with physical and mental disabilities and their families encounter when seeking a safe, accessible environment for trying out organized sports and fitness programs.

Abstract

UHCCP-AZ partnered with the Virginia G. Piper Sports & Fitness Center (SpoFit) located at the Disability Empowerment Center operated by the Arizona Bridge to Independent Living (ABIL) to open access and provide programs designed to promote the health, inclusion and independence for our members and their families. SpoFit has a state-of-the-art, 45,000-square foot, universally accessible facility with adaptive equipment and trained staff. However, several barriers existed. One participation obstacle was families did not feel comfortable at facilities or programs that lacked experience serving youth with disabilities, or didn't offer the family the opportunity to participate with their son or daughter. Many of our community partners were not aware of the SpoFit program and that it is available for children, youth and their families.

The second identified barrier was the availability of sports-specific wheelchairs. Many potential league participants do not own or have access to the type of chairs needed to participate in these sports. UHCCP-AZ donated 10 sports-specific wheelchairs for youth participants and their families to gain exposure and possibly discover and enjoy the benefits of physical activity and team participation in the various sports programs offered at SpoFit. UHCCP-AZ partnered with a wheelchair vendor, Numotion, to adapt the donated chairs and provide the ongoing maintenance needed to keep these chairs ready and available. The final barrier was how individuals could take away the experience gained at SpoFit and apply it to a community program or fitness center. The SpoFit staff works with members as they prepare to transition to their community or school programs to ensure continued involvement in fitness activities. UHCCP-AZ and SpoFit have also partnered with Special Olympics Arizona to assist and support the participation of individuals with disabilities through the Healthy Athletes, Young Athletes and Unified Sports programs throughout the entire state of Arizona.

Key Objectives:

- Improve the health of the population
 - Create additional programs at SpoFit for ongoing physical activities and learning opportunities for youth with disabilities and their families. Children and youth with disabilities participate in clinics designed to prepare them for participation in fun runs, including the UHC-sponsored IronKids Run.
 - Establish monthly events specifically designed to address the needs of families with youth with disabilities who serve/have served in the military, are members of special needs programs, or families who have English as a second language.
- Reduce disparities in care of racial and ethnic minorities
 - Inaugurate an annual Youth-Parent Health and Fitness conference to offer youth and their parents the chance to work out or play together, learn healthy eating strategies specific to their unique needs, and tips for parents to stay healthy in their caregiver role.
 - At the national level, influencing future health and fitness promotions for persons with disabilities and special health care needs of all ages.

Actions Taken:

- Leveraged partner relationships to expand fitness programs for the diverse population of Arizona's persons with disabilities. Currently, the program serves 40 families, with plans to double that number before the end of 2014.
- Recruited SpoFit athletes, Paralympics rugby champions, professional wheelchair basketball players, and Paralympics tennis, swimming, and weight lifting athletes to provide technical assistance and support for youth and family participation.
- Expanded relationships with community partners to include the promotion of health and wellness for persons with disabilities and their families through member materials, promotions and contracts. SpoFit has more than 20 active community partners; forums for these partners are held quarterly in Tucson and Phoenix.
- Created integrated plan with partner organizations to promote fitness activities and events.

Outcomes:

- Established partnerships with shared investment in increasing access and addressing needs and barriers to physical activities, accessibility and affordability for youth with disabilities and their families.
- Increased awareness, understanding and response to the fitness needs of persons with disabilities with community partners, providers, members and families.
- Identified community-based fitness programs for members to transition to once they become confident in their fitness skills and routines.
- Partnered with IronKids to provide the first-of-its-kind special needs segment of the IronMan/IronKids race to be held in Tempe in the fall of 2014, allowing individuals the opportunity to race whether utilizing this new equipment or on their own.
- Provided opportunity for individuals with disabilities to receive a free visit to SpoFit to explore the available options the center has to offer. If individuals choose to continue at SpoFit, UHCCP-AZ sponsors a family punch card good for 12 visits. To date, SpoFit has sponsored 103 punch cards, equaling a total of 1,236 visits. Visits were made by youth both with and without their families.
- Created opportunity for event to be held at SpoFit, through the newly formed relationship established by UHCCP-AZ; Special Olympics Arizona will work with participants throughout the state. Special Olympics Arizona's Unified Sports program will continue to track transitioning youth as they move from SpoFit to their local school districts' Unified Sports program. Another opportunity for families to join the SpoFit program will be provided through a youth/parent health, wellness and fitness conference to be held this fall.

Location:

This opportunity is open to all individuals with special needs across Arizona.

Contact:

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Gus LaZear
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The Adventures of Boingg & Sprockette: Spotch the Madpole Does A Whole Lot of Bullying!

Description:

The Adventures of Boingg & Sprockette is a comprehensive educational book series, for children ages 5-9, that teaches the reader about various health and behavioral issues. "Spotch the Madpole Does A Whole Lot of Bullying" is a book in the series that takes the reader on a journey that explores various types of bullying (e.g., physical abuse, verbal abuse, and social bullying like spreading of rumors).

This book includes activities to initiate positive interactions with others, self-awareness tools, and a memorable anti-bullying pledge and is accompanied by a parent/guardian guide with information to help their child understand the impact of bullying. Creative phrases and messaging such as "Spotch is a mad tadpole, Team Mean, Team Nice and No Bullyfrog Zone," provide the reader with simple "verbal takeaways" to impact their future behavior.

Abstract:

Bullying is a serious threat to children and teenagers. According to Kidpower at www.kidpower.org, bullied children are more likely to skip school, engage in criminal behavior in adulthood and develop suicidal thoughts. At least half of educators are untrained in how to handle bullying situations, and most students are not confident that they can get help from their teachers for bullying incidents. Moreover, when bullies target appearances and behaviors with verbal assaults, many bullies felt the victim was at fault for these behaviors or appearances.

The Adventures of Boingg & Sprockette - "Spotch the Madpole Does A Whole Lot of Bullying" was created and designed to educate the readers on types of bullying, as well as increase their awareness on the causal relationship that their words and actions have with others. Dr. Joseph Wright, a leading authority in anti-bullying education and public policy, provided a medical and clinical perspective for the book. Dr. Wright and Michelle Bain, an award-winning children's author, combined their efforts to provide an impactful experience for the reader.

Key Objectives:

- Improve the health of the population
- Improve quality of care in a specific clinical area, i.e. prenatal care, diabetes, asthma, etc.

Actions Taken:

This educational book program is part of Centene's larger Adopt- A-School Program, which targets grade schools in our states of membership, with the goal of educating the student community as a whole on important topics in health. As part of this anti-bullying campaign, the children's author of the book came into schools for an assembly where she read the book, "Spotch the Madpole Does A Whole Lot of Bullying," to the students. Darby, our mascot, appears during the assembly and helps tell the story. Children took an anti-bullying pledge and took part in signing a traveling anti-bullying wall.

At the completion of the assembly, each child received a copy of the anti-bullying book, a parent/guardian guide and a bracelet that reminds him or her of the lessons learned during the assembly.

Outcomes:

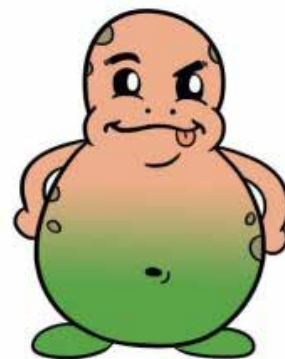
The 1,184 participants in the program completed a five-question pre-test exercise assessing prior knowledge and awareness of key bullying issues. Students in the program ranged from Kindergarten through fifth grade across eight states. At the conclusion of the program, students repeated the assessment, creating a measure of pre- to post-test enhancements in accuracy and awareness of bullying concepts. 16% of the 1,184 participants tested improved their scores from pre- to post-test.

Location:

"Spotch the Madpole" has been distributed in over 15 states, to over 20 schools and 15,000 children, teachers and parents.

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Part III:

The Awards

MHPA Best Practice Awards:

1. Technology Award
2. Children's Health Award
3. Cultural Competency Award
4. Outreach Award
5. Innovation Award
6. Making A Difference Award





Each year, MHPA recognizes Medicaid health plans that have demonstrated innovative and effective approaches to providing services to Medicaid beneficiaries and communities.

For 2014, MHPA is pleased to honor six health plans for outstanding programs in the areas of health disparities, prenatal care, behavioral health, oral health, and women's health. Each of the award winners has demonstrated innovative approaches to improving quality health care for a challenging population, and has achieved measurable results. These plans are outstanding examples of how Medicaid health plans are accountable for high-quality, patient-centered services.

All submissions from this year and those published in the 2013-2014 Best Practices Compendium were considered for awards. Special thanks to the Best Practices Advisory Panel (listed on page 116), experts in Medicaid and quality improvement, for their review of case studies and recommendations on award winners.

Listed below and on the following pages are the award recipients in the following Best Practice categories: Technology; Children's Health; Cultural Competency; Outreach; Innovation; and Making a Difference.

Technology Award

The program that demonstrates innovative use of technology in improving the health of Medicaid members

Keystone First

Moms2B Program: Improving Birth Outcomes through Use of Cell Phones, Texting and Intensive Case Management

Children's Health Award

The practice that best embodies Medicaid health plans' commitment to quality in children's health

Centene® Corporation

Start Smart for Baby Texting Program

Cultural Competency Award

The program that epitomizes Medicaid health plans' dedication to reducing health care disparities and providing culturally-specific services

Midwest Health Plan

Spread the Word, Not the Disease - Improving Chlamydia Screening in Women

Outreach Award

The prime example of how Medicaid health plans engage members in health improvement activities

UnitedHealthcare Community Plan of Mississippi

Farm-to-Fork Program, a Partnership between UHC and Alcorn State University Extension Program

Innovation Award

The model program for using groundbreaking programs, policies, or approaches that improve Medicaid services

Health Partners Plans

Oral Health Initiative

Making a Difference Award

The practice that has made the biggest positive change in the lives of Medicaid health plan enrollees

Cigna-HealthSpring®

Cigna-HealthSpring Behavioral Health Intensive Outpatient Program

Honorable Mentions

AmeriHealth Caritas Family of Companies

Multifaceted Interventions Improve Medication Adherence in Patients with Chronic Conditions (page 76)

Health Partners Plans

Healthier YOU! Baby Partners Program (page 49)

Meridian Health Plan

Care Coordination – It Takes a Team (page 14)

WellPoint, Government Business Division

Case Management Stabilization (page 16)

The program that demonstrates innovative use of technology in improving the health of Medicaid members

AWARD WINNER

Moms2B Program: Improving Birth Outcomes through Use of Cell Phones, Texting, and Intensive Case Management

Keystone First

Abstract:

In an effort to reverse the trend of premature birth and the associated negative outcomes in the Philadelphia area, Keystone First, in partnership with Verizon Wireless, launched the Moms2B program to directly engage our high-risk pregnant members. In this voluntary pilot program, participants were supplied with cell phones and free minutes with the goals of improving frequency of prenatal care and health outcomes, as well as keeping members connected to the Keystone First Bright Start Maternity program. The program encourages participants to receive early prenatal care; provides them with current information about screenings; and encourages participation in educational and community-based programs.

Early and regular prenatal care can help keep both mothers and their unborn babies healthy. Babies born to mothers who do not receive prenatal care are three times more likely to have a low birth weight and five times more likely to die than those born to mothers who do receive prenatal care (HHS/HRSA). Philadelphia ranks as the fifth worst of more than 200 most populous counties nationwide in infant mortality (Sapatkin, 2013). African-American women—the largest racial membership of Keystone First—have the highest rate of inadequate prenatal care (CDC, National Vital Statistics Report, 2012) and are two-to-three times more likely as Caucasian women to give birth early (HHS/OMH, 2005).

Actions Taken:

Keystone First, in partnership with Verizon Wireless, supplied cell phones and free minutes to our high-risk pregnant members. Keystone First's Bright Start Care Management team used the cell phone to remain in contact with and provide coaching and care coordination for the member during the pregnancy and postpartum period. Text messages were sent to members, with specific nutritional and clinical information based on gestational age. Participants received encouragement to obtain regular prenatal care and information about screenings, educational and community-based programs. Several incentives were provided to participants as a means of encouraging their adherence to prenatal and postpartum doctor visits. Keystone First's Community Outreach Solutions team provided support to the program through additional participant contact in the community to keep them connected to Keystone First care managers.

In May 2012, Keystone First launched the Moms2B program at two Community Baby Showers, where each participant received Bright Start assessments, nutrition counseling, and information about the importance of prenatal care and resources available. Participants were introduced to the Moms2B program, receiving free phones and text messaging services for immediate connection with their Bright Start care coordinators. All moms meeting treatment guidelines also received dental screenings.

Outcomes:

In 2012, 106 pregnant expectant moms attended two Community Baby Showers in Philadelphia and Chester, PA. Thirty-one participants were also introduced to the Mom2B program and received phones and text messaging services. Twenty-six of the 31 high-risk pregnant moms (84 percent) successfully delivered babies less than 31 days from their expected delivery date (many of whom had multiple diseases and multiple prior preterm deliveries), while only five high-risk pregnant moms (16 percent) delivered earlier. Participants reported high rates of satisfaction and positive feedback concerning the program.

A comparison analysis was performed that matched 17 participants actively engaged in the Moms2B Program (intervention group) to 17 severely high-risk pregnant members with similar risk factors (control group). The matching variables included: age group (<18, 18–34, 35+), race, ethnicity, number of high-risk diagnosis codes, and member's zip code. Both groups had high-risk diagnoses—including prior history of preterm delivery, insulin dependent diabetes, hypertension, multiple gestation, and incompetent cervix—which are known predictors of low birth weight and premature delivery.

This best practice was submitted by Keystone First in August 2013. You can find the full case study in its entirety with graphs and tables on pages 83 to 85 of the 2013-2014 Best Practice Compendium published last October or online at www.mhpa.org

NOTE: For those submissions that were submitted in 2014 and appear in this booklet, a short abstract of the best practice is featured. For those winning submissions that received awards that were submitted in 2013 and published in last year's compendium, an abbreviated summary of the case study is provided.

Children's Health Award

The practice that best embodies Medicaid health plans' commitment to quality in children's health

AWARD WINNER

Start Smart for Baby Texting Program
Centene® Corporation

Abstract:

The Start Smart For Your Baby® (SSFB) Texting Program is a component of our comprehensive Start Smart For Your Baby Care Management program that was created in 2008. The Texting Program was rolled out in January 2012 and aims to improve maternal and infant health by providing timely health information, resources and reminders to members during their pregnancy and continuing six months after birth. Specifically, the program's goals are to encourage breastfeeding and increase prenatal, postpartum and infant well-child visits for our Medicaid members.

In 2010, we determined breastfeeding initiation rates among many of our health plans were lower than the national average of approximately 75%. Increasing these rates was important because of the benefits breastfeeding has. Studies have shown breastfeeding helps protect babies from infections such as earaches, coughs, colds, and diarrhea. It also helps protect against diseases later in life. Adults who were breastfed as babies have less tendency to become overweight as well as a lower chance of getting diabetes, asthma, childhood leukemia and some other cancers. Moms who breastfeed also have less chance of getting ovarian cancer, breast cancer, and diabetes. We also saw prenatal and postpartum visit rates were lower in the Medicaid population. In response, the Start Smart For Your Baby Texting Program was developed to communicate the benefits of breastfeeding, share other prenatal and postpartum health tips and send reminders about doctor visits and certain health plan benefits to our members who are pregnant or have just delivered. With the digital divide closing across all ages and socio-economic groups, we find that online and texting services are increasingly effective in reaching and engaging our target population.

This best practice was submitted by Centene® Corporation in August 2014. You can find the full case study in its entirety on page 55 of this book.



Cultural Competency Award

The program that epitomizes Medicaid health plans' dedication to reducing health care disparities and providing culturally-specific services

AWARD WINNER

Spread the Word, Not the Disease — Improving Chlamydia Screening in Women
Midwest Health Plan, Inc.

Abstract:

Midwest Health Plan created and implemented interventions concerning its large Middle-Eastern population with culturally sensitive materials and focus groups to better assist this demographic. The program has been chosen by the NCQA "National Committee for Quality Assurance" as a Best Practice and has seen highly favorable results within the population at hand.

Midwest Health Plan (MHP) serves a culturally and linguistically diverse membership with the majority of its members residing in the cities of Dearborn and Detroit, Michigan. In 2010, MHP's HEDIS® rates for Chlamydia Screening in Women were below national Medicaid benchmarks. Plan results reflected disparities that were consistent with national data with regard to preventive health for minorities.

Actions Taken:

Actions taken for the adolescent population include but are not limited to: A Teen Talk newsletter that is sent out to our teen members. The articles in the newsletter are geared towards the adolescent population. Midwest now employs Arabic- and Spanish-speaking customer services representatives to better serve our diverse population. Bi-lingual staff is called upon to assist with member outreach activities when needed. Targeted reminder letters and incentives mailed out to teen members as well at health fairs that are conducted throughout the community in both English and Arabic materials.

Midwest has also worked with providers in the Dearborn area which predominately Arabic demographically to ensure the practices have female Arabic Medical Assistants (MA) and office staff. Finally providers are given incentives for performing Chlamydia screens on their members; in 2010 we increased the Pay for Performance "P4P" from \$25 a screening to \$35 a screening in an effort to improve screenings for the health of Midwest members.

Outcomes:

Since 2011 Midwest has maintained chlamydia screening rates in the 75th percentile by the National Committee for Quality Assurance (NCQA) standards. Midwest was asked to speak at NCQA's 2012 HEDIS Updates and Best Practices on Chlamydia due to our innovative and proven interventions that are a Best Practice for Chlamydia Screening. Chlamydia screenings with provider "P4P" incentives have increased dramatically from \$65,000 in 2009, \$72,300 in 2010, \$73,740 in 2011, and \$105,875 in 2012. The outcome has been wonderful for the member as well as the ability for the health plan to effectively connect with its community and members.

This best practice was submitted by Midwest Health Plan, Inc. in August 2013. You can find the full case study in its entirety on pages 100-101 of the 2013-2014 Best Practice Compendium published last October online at www.mhpa.org.



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Outreach Award

The prime example of how Medicaid health plans engage members in health improvement activities

AWARD WINNER

Farm-to-Fork Program, a Partnership between UnitedHealthcare and Alcorn State University Extension Program

UnitedHealthcare Community Plan of Mississippi

Abstract:

In Q2, 2012, our community outreach deployed UnitedHealthcare Community Plan of Mississippi "Farm-to-Fork Project," a partnership with Alcorn State University Extension Program. The program consists of UnitedHealthcare distributing free, locally grown, organic vegetables from designated facilities throughout the state to MSCAN members. The distribution points started in the MS Delta and extended to the Jackson Metro area. In the "Farm-to-Fork Project," members were notified through various advertisements distribution times and locations. Upon arrival to distribution points, members were required to show their member identification cards in order to receive the food at no cost.

Farm-to-Fork exemplifies the mission of UnitedHealthcare, which is to help people live healthier lives. By partnering with the Extension Program at Alcorn State, we provided nutritionally sound options to our members and greater the community. Additionally, we positioned ourselves as contributors to preventative healthcare. Mississippi has a critical need for nutrition education and healthy food habits. Providing healthy food options affords us the opportunity to be at the forefront in the fight against diseases such as, heart disease, diabetes and obesity, three of the most prevalent chronic illnesses in the state. By sponsoring this project, the community outreach team empowers members and plays a role in health and wellness of the communities served by UnitedHealthcare.

Actions Taken:

Mississippi has a critical need for nutrition education and healthy food habits. Providing healthy food options affords us the opportunity to be at the forefront in the fight against diseases such as, heart disease, diabetes and obesity, three of the most prevalent chronic illnesses in the state. More than half of the diabetes cases caused by obesity are preventable with proper nutrition. Close to 4 out of 10 people in Mississippi are obese. Nearly \$170 billion in obesity-related health care costs are in the US every year. Farm to Fork allows UnitedHealthcare to begin addressing this health issue within a vulnerable population.

Outcomes:

UnitedHealthcare has administered a survey to participants beginning in July 2012 to-date. With four main distribution points, 3% percent of membership has been reached over the course of the project, starting in May to-date (4% of members were reached in 2012).

Please note that we are currently at 3% membership reached and are on track to surpass our distribution totals of 4% for all last year. This is significant because we increased our total membership numbers with the expansion from approximately 130,000 in 2012 to 162,000 members in 2013. We have increased the produce from Alcorn by 50% (from approximately 2 tons in all of 2012 to 4 tons to-date). So far in 2013, we have donated \$2495 to our distribution center partners.

This best practice was submitted by UnitedHealthcare Community Plan of Mississippi in August 2013. You can find the full case study, including graphs and tables in its entirety on pages 49 to 51 of the 2013-2014 Best Practice Compendium published last October and online at www.mhpa.org.



Innovation Award

The model program for using groundbreaking programs, policies, or approaches that improve Medicaid services

AWARD WINNER

Oral Health Initiative

Health Partners Plans (HPP)

Abstract:

In the US, approximately 53 million children and adults have untreated tooth decay in their permanent teeth. Much of this problem is preventable. Tooth decay remains one of the most common chronic diseases of childhood. Therefore, we targeted children ages 2-20. By taking a proactive approach we are hoping to help combat tooth decay early.

The Oral Health Initiative is designed to increase dental screenings and access to preventive services for our pediatric at-risk population. Oral health impacts physical health. Additionally, there are significant cost benefits of preventive services versus restorative services. Our program attempts to close the "dental care gaps" of our members who have not seen a dentist since 2013. The initiative is also designed to encourage collaboration between medical and dental providers. Conference calls and site visits are conducted with the FQHC's Chief Medical Officer and dental providers to discuss and coordinate participation and implementation of the program

This best practice was submitted by Health Partners Plans in August 2014. You can find the full case study in its entirety on page 53 of this book.



Making a Difference Award

The practice that has made the biggest positive change in the lives of Medicaid health plan enrollees

AWARD WINNER

Cigna-HealthSpring Behavioral Health Intensive Outpatient Program
Cigna-HealthSpring®

Abstract:

Data analysis revealed that members with primary behavioral health and substance use disorders resulted in higher cost services, and unusual use patterns. Apart from transplants and a few extraordinary drug costs, 21 of the top 25 most expensive members were noted to have primary behavioral health and substance use diagnoses. As we investigated further, we found that these diagnoses were the primary cost and utilization drivers for our most expensive top five percent of members.

Additional review of the members with behavioral health and substance abuse diagnoses uncovered patterns of repeated Emergency Room (ER) use and hospital readmission rates that far exceeded all other member risk groups. Hospital admissions for some of these members occurred twice a month. The Health Plan discussed our concerns with the Texas Medicaid Health and Human Services Commission staff regarding super-utilizers and confirmed that these members had been tracked for years by the State, noting the same ER and hospital admission patterns.

This best practice was submitted by Cigna-HealthSpring® in August 2014. You can find the full case study in its entirety on page 17 of this book.



Part IV

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Express Scripts has been supporting the Medicaid market for two decades. Today, it provides high-value pharmacy management and specialty pharmacy benefit management (PBM) services for dozens of clients and millions of their members. For the managed Medicaid market, it provides strategic PBM management services to make the use of prescription drugs safer and more affordable, including network-pharmacy claims processing, specialty benefit management, benefit design consultation, drug-utilization review, formulary management, and medical and drug data analysis services. Their Medicaid clients benefit from its compliance excellence, considerable track record working with federal and state regulators, understanding of state-by-state regulations, consultative partnership and innovation solutions for managing care and costs. Express Scripts' superior service model for serving regulated markets includes a dedicated division aligned with Medicaid, Medicare, Medicare-Medicaid Plans (MMPs) and the Public Exchanges. For more information, visit www.express-scripts.com/governmentsolutions, Lab.Express-Scripts.com or follow @ExpressScripts on Twitter.

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First Quality is a diversified family of companies that manufactures a variety of products including absorbent hygiene products for the home care, long-term care and retail markets. Our Home Care Group focuses on disposable absorbent incontinence products for adults and children and manufactures these products exclusively in the US. With more than 20

years of experience implementing best practices across the post-acute care spectrum that deliver high quality products and reduce costs in a capitated environment, First Quality now offers a continence management program, Continenace Coach™, for Medicaid Health Plans. Continenace Coach is specifically designed to help Health Plans analyze and reduce supply costs and help Health Plan Members receive the education and products they need to better manage their incontinence condition. Please visit Prevail.com/CC for more information.

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Gorman Health Group, LLC (GHG) is a leading consulting and software solutions firm specializing in government health programs, including Medicare managed care, Medicaid and Health Insurance Exchange opportunities. For nearly 20 years, their unparalleled teams of subject-matter experts, former health plan executives and seasoned health care regulators have provided strategic, operational, financial,



and clinical services to the industry, across a full spectrum of business needs. Further, its software solutions have continued to place efficient and compliant operations within our client's reach. Find out more at www.gormanhealthgroup.com.

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Health: ELT is a mobile- and cloud-based solution for managing managed care in Medicaid. Designed to coordinate care, continuously connect members and plans, and create conversations between member and provider, Health: ELT is poised to give information a central home in an industry segment plagued by silos and boundaries, and give all stakeholders simple yet sophisticated mobile apps and web dashboard tools that can drastically change the way we all do business. The Health: ELT approach utilizes mobile apps for members, and for providers and supervisors in the field who would be better served by new technologies and streamlined, app-based communications and systems. Users are able to coordinate between plan and provider, between provider and patient, in simpler, faster communication paths. Health: ELT is creating transformative tools for the Medicaid managed care sector to make real and lasting change.



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HMS powers health care with integrity through coordination of benefits, program integrity, and eligibility solutions for payers. HMS' clients include health and human services programs in more than 40 states; commercial payers, including group health plans, Medicare Advantage Plans, more than 150 Medicaid managed care plans, and employers; the Centers for Medicare and Medicaid Services; and Veterans Administration facilities. As a result of the company's services, every year clients recover more than \$3 billion and save billions more through the prevention of erroneous payments.

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www.incomm.com



InComm Healthcare, a leading prepaid product and transaction services company, and Finity Communications, a leading systems-based technology solutions company, are partnering to create a new interactive member incentives platform that will reward health plan members for making healthy choices, and ultimately improve on health plans' ROI. The new rewards platform

offering will combine features from InComm's restricted-spend, personalized engagement rewards card product with Finity's integrated behavior-based health, wellness, and condition management solution, EveryBODY Get Healthy. Health plans will have access to Finity's closed-loop platform that delivers personalized engagement and reward communications in multiple mediums, including personalized LifeTrack portals, text messaging, email communications, mobile apps, auto-calls, and on-demand printed communications, as well as InComm's restricted-spend card for members. Plan administrators can customize the platform to create a tailored experience for plan members. Administrators also have access to robust program tracking and reporting on-demand, creating a powerful package that helps to improve health and reduce spending for health insurers and members.



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