



INSTITUTE FOR
MEDICAID INNOVATION

2020 Medicaid MCO Best Practices and Innovative Initiatives

Overview

About the Institute for Medicaid Innovation

The Institute for Medicaid Innovation (IMI), a 501(c)3 organization, is focused on providing innovative solutions that address important clinical, research, and policy issues in Medicaid through multi-stakeholder engagement, research, data analysis, education, quality improvement initiatives, and dissemination and implementation activities. To remain responsive to the evolving needs of the Medicaid population, the Institute seeks to understand what works well in the Medicaid program, identify areas for improvement, and disseminate innovative initiatives and solutions that address critical issues.

Mission

The mission of the Institute for Medicaid Innovation is to improve the lives of Medicaid enrollees through the development, implementation, and diffusion of innovative and evidence-based models of care that promote quality, value, equity, and the engagement of patients, families, and communities.

Vision

The vision of the Institute for Medicaid Innovation is to provide independent, unbiased, nonpartisan information and analysis that informs Medicaid policy and improves the health of the nation.

For the third year, the Institute for Medicaid Innovation (IMI) released its first-of-its-kind national, health plan survey on December 8, 2020. In conjunction with the 2020 Medicaid MCO survey report, IMI is proud to highlight Medicaid managed care organizations (MCOs) across the country that design, timely, targeted and effective programs to reach Medicaid members with a variety of needs. These innovative projects help MCOs bridge social service gaps and deliver effective health services to members, especially those with complex medical needs.

The 2020 Medicaid MCO Best Practices and Innovative Initiatives informational report highlights programs implemented by Medicaid MCOs that correspond with the following eight categories of the survey report:

- High-Risk Care Coordination
- Value-Based Purchasing
- Pharmacy
- Behavioral Health
- Women's Health
- Child and Adolescent Health
- Managed Long-Term Services and Supports
- Social Determinants of Health

Acknowledgments

The work of this compendium could not be accomplished without the dedication and commitment of our national experts who serve on the Best Practices Review Panel. Their systematic and objective review of the submissions is critical for the success of this project. In addition, there are people who work behind-the-scenes to produce this annual publication.

IMI's entire catalog of MCO Surveys and Best Practices Reports is available [here](#) as a free download. To access the full 2020 Medicaid MCO survey report, click [here](#).

Health Plan Overviews

AlohaCare is a community-led, non-profit health plan founded in 1994. AlohaCare serves those eligible for Hawaii's QUEST Integration (Medicaid) and Medicare program. Locations: Oahu, Kauai, Molokai, Lanai, Maui, Hawaii Island.

Community Health Plan of Washington (CHPW) was founded in 1992 by Washington's Community Health Centers (CHCs) as a local health plan. Location: Seattle, Washington.

Horizon Blue Cross Blue Shield of New Jersey is New Jersey's largest managed care organization serving children and adults in Medicaid and NJ FamilyCare. Location: New Jersey.

L.A. Care Health Plan was founded in 1997 and serves Medi-Cal members in Los Angeles County in partnership with Plan Partners. Location: California.

UnitedHealthcare Community & State serves millions of Americans with the mission to help people live healthier lives and make the health system work better for everyone. Locations: Arizona, California, Florida, Hawaii, Kansas, Kentucky, Louisiana, Maryland, Michigan, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia, Washington, Wisconsin.

University of Utah Health Plans is a health plan in the Mountain West integrated with University of Utah Health and founded in 1998 that serves fully insured and self-funded employer groups, individuals and families, Medicare, and Medicaid enrollees. Location: Utah.

UPMC for You is a health plan owned by the University of Pittsburgh Medical Center (UPMC) that is committed to providing its members better health, more financial security, and the peace of mind they deserve. Location: Pennsylvania.

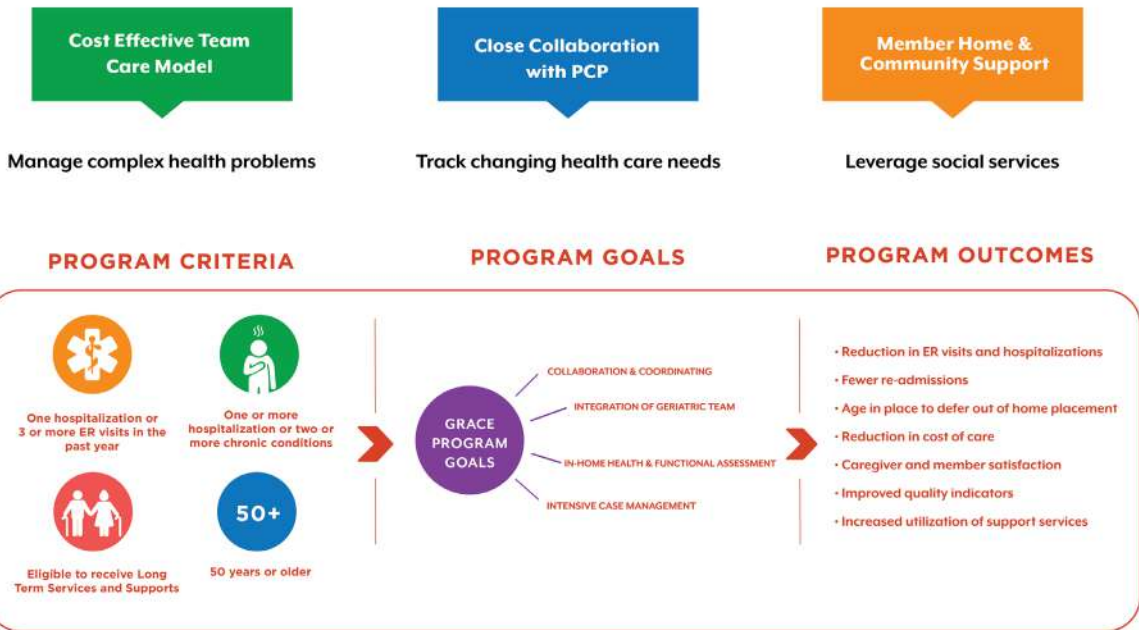
High-Risk Care Coordination

“Care coordination” is a broad term that encompasses a range of activities performed by clinicians, hospital systems, managed care organizations, and government entities. The most common forms of care coordination are case management services and discharge planning. High-risk care coordination looks specifically at individuals with multiple chronic conditions and often have high rates of service utilization that increase with the number of comorbidities. According to IMI’s 2020 annual Medicaid MCO survey report, in 2019, eighty percent of Medicaid MCO respondents indicated that less than six percent of their members received high-risk care coordination services. This section provides an overview of two innovative high-risk care coordination initiatives.

AlohaCare



Hawai'i GRACE Care Program



Program Name: Geriatric Resources for Assessment and Care of Elders (GRACE) Program.

Population: AlohaCare members, 50 years of age or older, who have experienced one or more hospitalizations and/or emergency room (ER) visits for one year, were diagnosed with two or more chronic conditions, and qualified for long-term services and supports.

Objectives: To address the high costs and complex health and social needs of older adults while reducing emergency department visits, hospitalizations, readmissions, and cost of care.

AlohaCare’s Geriatric Resources for Assessment and Care of Elders (GRACE) team provides evidence-based care to low-income seniors with multiple chronic medical conditions. The program is a Hawai'i adaptation of the Indiana University (IU) School of Medicine GRACE program. To implement the program, the AlohaCare team received training facilitated by the IU School of Medicine. The GRACE program aimed to address the high costs and complex health care needs of older adults and was implemented in May of 2019. The program utilizes a cost-effective team-based care model that involves coordination of care for members across providers, integration of geriatric care into primary care, intensive case management, and in-home health and functional assessments. The program also leverages social services to meet the social determinants of health needs identified by the member. AlohaCare collaborated with primary care providers from Kokua Kalihi Valley Family Health Services, an inner city Federally Qualified Health Center, the University of Hawaii Medical School Geriatric Workforce Enhancement Program, and the Hawaii Primary Care Association to implement this hybrid model. The hybrid model includes a GRACE Nurse Practitioner that acts as a physician extender and collaborates with the GRACE team members and primary care provider (PCP). GRACE team members include a geriatrician, social worker, pharmacist, and behavioral health consultant to assist in the development of the GRACE care plan. In 2020, 48 members participated in the GRACE program which successfully reduced hospitalizations and the overall cost of care. Initially, the program was limited to one ZIP code, however, in 2021, it will expand to include additional ZIP codes.

High-Risk Care Coordination

AlohaCare



BRIDGING POST-ACUTE CARE TO PERMANENT HOUSING FOR MEMBERS WITH HOUSING INSECURITY.

Tutu Bert's House



PROGRAM GOALS

- Reduce hospital stay by eliminating waitlist days
- Reduce readmissions
- Provide recovery support in a safe and clean environment



PROGRAM CRITERIA

- Adult members who are homeless or housing insecure
- Adult members who need some short term services post hospitalization to support their recovery
- Adult members who can perform activities of daily living with minimal assistance



PROGRAM OUTCOMES

- Many members have been placed in permanent housing
- Average waitlist days in the hospital decreased by 30 days
- Members are able to receive care in the community rather than a hospital setting



SERVICE COORDINATION

AlohaCare Service Coordinators and Tutu Bert's case manager work together to find permanent housing.

Program Name: Collaboration with Tutu Bert's House.

Population: Adult members who identified as homeless or housing insecure, received short-term services post a hospitalization, and were able to perform activities of daily living with minimal assistance.

Objectives: To meet the short-term stabilization and care needs of homeless and housing insecure members post-hospital discharge and reduce future hospital stays by eliminating waitlist days, reducing readmissions, and providing recovery support in a safe and clean environment.

Beginning in May 2019, AlohaCare collaborated with Tutu Bert's House to meet the short-term stabilization and care management needs of homeless and housing insecure members after a hospital discharge. Tutu Bert's House is an Institute of Human Services (IHS) program, Hawaii's oldest, largest, and most comprehensive agency dedicated to preventing and ending homelessness. Named in honor of Roberta DuTeil who ministered to homeless people along-side her spouse Claud DuTeil, the founder of IHS, Tutu is a Hawaiian endearment for grandmother. For medically frail Medicaid members unable to recuperate on the street or in a shelter, Tutu Bert's House is a sanctuary that provides meals, treatment, and case management.

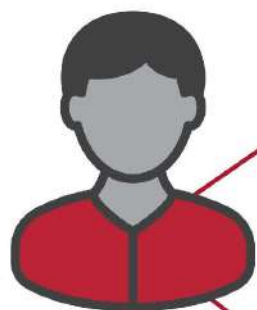
The program goals included reducing hospital stays by eliminating waitlist days, reducing readmissions, and providing recovery support in a safe and clean environment. AlohaCare's service coordinators ensured members received home health and personal care services while residing at Tutu Bert's House. Together, AlohaCare and Tutu Bert's House also sought permanent housing for members. In 2020, 29 unique members stayed in a Tutu Bert's house for an average length of stay of 45 days, decreasing hospital waitlist days and allowing the provision of care in the community rather than in a hospital setting.

High-Risk Care Coordination

University of Utah Health Plan

HIGH-RISK CARE COORDINATION

Collaboration with U Health Intensive Outpatient Clinic (IOC) and Healthy U Medicaid



U HEALTH IOC

- Medical care
- Behavioral health
- Pharmacists
- Community resources
- Trauma-informed care

U OF U HEALTH PLANS

- Care coordination
- Care planning
- Therapeutic adherence
- Social determinants of health

High-risk, high-cost Medicaid members were connected to resources at the U Health Intensive Outpatient Clinic and U of U Health Plans Care Management Team.



COST PER MEMBER PER YEAR

OUTCOMES



ED VISITS PER YEAR



Program Name: Intensive Outpatient Clinic (IOC) Partnership with University of Utah Health.

Population: Patients identified through risk stratification with high utilization of resources (e.g., emergency department (ED) visits, prolonged hospitalizations).

Objectives: To reduce costs and improve health outcomes for members with high utilization of resources.

In 2017, University of Utah Health Plans (U of U Health Plans) partnered with the Intensive Outpatient Clinic (IOC) at University of Utah Health for a high-risk care coordination initiative to address high-risk, high-cost Healthy U Medicaid members. Participants were identified via risk stratification and connected to resources at both U of U Health Plans and the IOC. Patients with high utilization of resources (frequent ED visits, prolonged hospitalizations) were identified and served by a multi-disciplinary approach with medical and behavioral health providers working together to treat them with the goal of saving cost and improving outcomes. The program generally served adult patients, but the participating providers were trained in family medicine allowing for children to be served as well. Additionally, some chronically ill young adults have been supported in their transition from pediatric specialists over to the University. U of U Health Plans care managers helped members coordinate care, bridge care gaps, and increase adherence while the IOC provided medical and behavioral health care, pharmacists, and community health resources. Together, U of U Health Plans and the IOC also addressed key social determinants of health and developed a care plan unique to each member's health needs. To date, the program has resulted in lower member costs and reduced ED visits. The program currently has approximately 100 patients involved and has treated just under 200 since its inception.

Value-Based Purchasing

Value-based purchasing and payment models are used within Medicaid to create greater efficiency and improve health outcomes. Value-based purchasing models, in contrast to fee-for-service, link provider payments to provider performance. Approximately ninety-three percent of all Medicaid MCO respondents utilized an alternative payment model, or value-based purchasing arrangement, in 2019 according to findings from IMI's 2020 annual Medicaid MCO survey report. This section highlights two innovative best practices in value-based purchasing.

L.A. Care Health Plan

Value-Based Purchasing Program



Program Design & Development

- Program used to identify and communicate priorities**
- Designing a program that is challenging but achievable, getting buy-in
 - Selecting metrics that are comprehensive and relevant
 - Automatic enrollment, ease of participation is important

Performance Measurement & Reporting

- Providing meaningful and actionable data**
- Systematic scoring and reporting of provider performance
 - Peer-group benchmarking and defining targets
 - Data used to identify strengths, weaknesses, and improvement opportunities

Communications

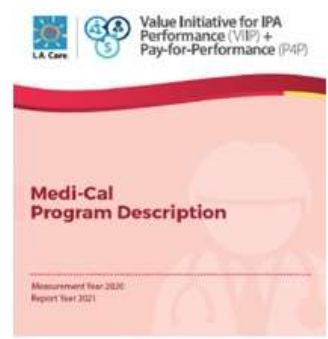
- Platform for engagement and accountability**
- Frequent and consistent engagement is key
 - Encourages process improvements, better care coordination and improved data capture

Goal Setting

- IPA Action Plans**
- Using S.M.A.R.T. method
 - Multiple progress updates
 - Feedback from health plan subject matter experts

Value-Based Revenue & Recognition

- VBP is one piece of a complete QI solution pie**
- Amplifier for other QI interventions
 - Rewarding and recognizing performance, for both attainment and improvement



Provider Group Name	Participation	Points & Final Score	Quality	Volume	Quality	Volume
Group 1	17.1	38	17.00	0.207	119,272	\$1,200
Group 2	19.47	38	19.47	0.207	189,995	\$1,200
Group 3	19.88	38	19.88	0.207	93,987	\$1,200
Group 4	19.99	38	19.99	0.207	99,174	\$1,200
Total	66.44	142	66.44	0.828	492,428	\$4,800

Your Final Total Payment: \$125,694.47

Program Name: Value Initiative for Independent Physician Association (IPA) Performance (VIIP) Program.

Population: L.A. Care's provider network.

Objectives: To enhance the quality performance of the L.A. Care provider network.

L.A. Care's Value Initiative for Independent Physician Association (IPA) Performance (VIIP) Program was developed by an interdisciplinary team as a strategic tactic aimed at enhancing the quality performance of providers within the network. Before the VIIP Program was launched, it was presented by L.A. Care's executive leadership to the leadership of all contracted provider groups to ensure transparency and garner buy-in in how measures were selected and how the program was designed. The program incorporated performance reporting, pay for performance (P4P), and quality improvement (QI) efforts to promote value and improve health outcomes. Industry standard metrics such as Healthcare Effectiveness Data and Information Set (HEDIS), Member Experience, Utilization Management and Encounters were used to measure, report and reward excellent performance. The program used a comprehensive and coordinated quality improvement strategy. Some learned best practices included implementing frequent mid-year reporting, performance improvement goal setting with feedback, and regular communication/engagement with the network including webinars, QI-IPA meetings, Continuing Medical Education (CME) sessions, and more. The program's success can be attributed to this multipronged approach.

Value-Based Purchasing

Community Health Plan of Washington

Rewarding Whole Person Care

CMS Certified Advanced Alternative Payment Model/Health Care Payment and Learning Action Network Category 3B

CHCs Managing Total Cost + Whole-Person Quality of Care

Including primary care, hospital, specialty, pharmacy, behavioral health



Payment + Quality of Care Measures

13 quality measures that include both HEDIS CAHPS, and locally developed BH measures.

More Community Investment

Housing, homelessness respite, harm reduction center, youth behavioral health, dental services, clinic expansion

Incentives

Includes an upside and downside gate and ladder based on measure improvement and performance. Encourages adoption of population health management systems, gap closures, and special projects (i.e. implementing a Social Determinant of Health screening tool and working on Health Equity initiatives).

Technology and Tools

Access and support to our innovative population health platform that merges claims and clinical data, support workflow development and registry efforts.

Practice Coaching

Practice support, workflow design and development, learning collaborative spaces with other providers to learn and grow together.

Program Name: Whole Person Care Advanced Alternative Payment Arrangement.

Population: Community health centers.

Objectives: To incentivize better care, better health, and sustainable spending.

Community Health Plan of Washington (CHPW) has experience in developing several alternative payment models to help incentivize better care, better health, and sustainable spending. CHPW's primary payment model, implemented in 2017, was centered on the strengths of the community health centers (CHCs) within its network in working in partnership with other providers, their members to manage their health, and the total cost of care. This was a Centers for Medicare and Medicaid Services (CMS)-certified Advanced Alternative Payment Model that included primary care, hospital, specialty, pharmacy, and behavioral health. The model included an upside and downside risk based on measure improvement and performance on 13 quality measures that included Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and locally developed behavioral health measures.

CHPW supported the CHCs in this effort by:

- Providing incentives to encourage providers' adoption of population health-management systems, gap closures, and other special projects such as implementing a Social Determinant of Health screening tool and working on Health Equity initiatives.
- Giving providers access to an innovative population-health platform that merges claims and clinical data and supports workflow development and registry efforts.
- Hosting practice coaching support and learning collaborative spaces with other providers to learn and grow together.

CHPW has seen the benefit of these arrangements lead to opportunities for further investment in the community by participating providers due to their ability for earnings. Examples of those investments have included building housing, homeless medical respite resources, supporting a harm reduction center, expansion of dental, youth treatment, and other behavioral health services. Since introduction of the arrangements, CHPW has seen improvement in HEDIS measures that have remained consistent in the program over time and where internal resources have provided additional support to providers, including assistance for the four medication management measures (asthma and antidepressants) and to a lesser extent, well-child visits and immunizations.

Pharmacy

Pharmacy coverage is an optional benefit under federal Medicaid law, though all states currently provide coverage for outpatient prescription drugs to all Medicaid enrollees. According to IMI's 2020 annual Medicaid MCO survey report, a majority of Medicaid MCO respondents (93%) reported being at risk for pharmacy benefits in at least one of their markets. Additionally, the percentage of MCOs at-risk for pharmacy benefits increased by twenty-four percentage points from 2017 to 2019. This section provides an overview of two innovative pharmacy initiatives.

UnitedHealthcare Community & State

Enhancing the Role of Pharmacists

Utilizing local pharmacists as care extenders to identify and address clinical and SDOH issues for members

Goals

This program aims to include pharmacists within the broader care team and encourages pharmacists to proactively participate and identify areas of opportunity.

Outcomes

Though the program is still in its infancy, pharmacists have already been able to:

- Identify a member in need of behavioral health services & connect them with their physician for diagnoses & treatment.
- Identify a member experiencing life stressors and engaged member in smoking cessation activities & treatment.



Partners:

- UnitedHealthcare Community Plan of Ohio
- Ohio Pharmacists Association
- Franklin Pharmacy
- Brewster Family Pharmacy



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Program Name: Pharmacy Care Extension Program.

Population: Community pharmacists.

Objectives: To include pharmacists within care teams and encourage pharmacists to proactively participate and identify areas of opportunity.

UnitedHealthcare's Pharmacy Care Extension program aimed to include pharmacists within the broader care team and encouraged pharmacists to proactively participate and identify areas of opportunity. The program created a partnership with community pharmacists to expand patient access to care, relieve pressure on health systems, and help drive better health outcomes for Medicaid members. By elevating pharmacists' role as active members of the member's care management team, the Pharmacy Care Extension program sought to achieve the Quadruple Aim - lower costs, better health outcomes, better experience of care, and better provider satisfaction. UnitedHealthcare Community Plan of Ohio collaborated with the Ohio Pharmacists Association (OPA), the Franklin Pharmacy, and the Brewster Family Pharmacy to implement this program. The program is still in its infancy, but pharmacists have already able to identified members in need of behavioral health services and connect them with their physician for diagnosis and treatment, and identify a member experiencing life stressors and engage them in smoking cessation activities and treatment.

Community Health Plans of Washington



Program Name: The Power of Community through Community Health Center (CHC) Pharmacies.

Population: At-risk members; Members with complex chronic conditions; Members with schizophrenia.

Objectives: To improve medication adherence for members.

Community Health Plan of Washington’s (CHPW) prescription drug benefits were designed around the holistic care its members received from its community health center (CHC) pharmacy partners. To improve medication adherence, CHPW provided its CHC pharmacists with targeted data to identify and reach out to at-risk individuals who could benefit from larger 90-day medication supplies and proactive refill reminders.

High-cost specialty medications used to treat complex conditions were usually restricted to specialty mail pharmacies. Over the past few years, CHPW has supported the enhancement of services available at its community health center pharmacies, and now 28% of specialty medication prescriptions are filled by community health centers. The resulting convenience for CHPW’s members allowed them to receive comprehensive pharmaceutical care at the clinics with which they were most familiar.

To ensure members with complex chronic conditions had appropriate medication therapies, pharmacists offered comprehensive medication reviews to qualifying members. These reviews were compromised and offered limited value when performed by pharmacists outside of the member’s care team. Consistent with support for community-based pharmacy services, CHPW piloted reimbursement models that allowed CHC pharmacists to provide comprehensive medication reviews in a setting that was truly integrated with the holistic care offered by the community clinics.

CHPW Pharmacy used data to identify and respond to the medication needs of its members. COVID-19 presented a disproportionate challenge to medication adherence for CHPW’s members treating schizophrenia with antipsychotic medications. To support this identified need, CHPW Pharmacy started meeting with behavioral health hospital pharmacists to offer high touch, coordinated medication management upon discharge from inpatient hospital stays.

Medication adherence outcomes for 2020 showed strong improvement over 2019 for all three Medicare star measures of diabetes, hypertension, and cholesterol. Diabetes adherence in 2020 improved by 2.9 percent over 2019 compared to CHPW’s pharmacy benefit manager’s (PBM) national average of 1.2 percent. Hypertension adherence in 2020 improved by 2.8 percent over 2019 compared to the national average of 1.3 percent. Adherence to statins to treat cholesterol improved by 4.3 percent over 2019 compared to the national average improvement rate of 1.84 percent.

Table 1. Medication Adherence Results, 2020 versus 2019

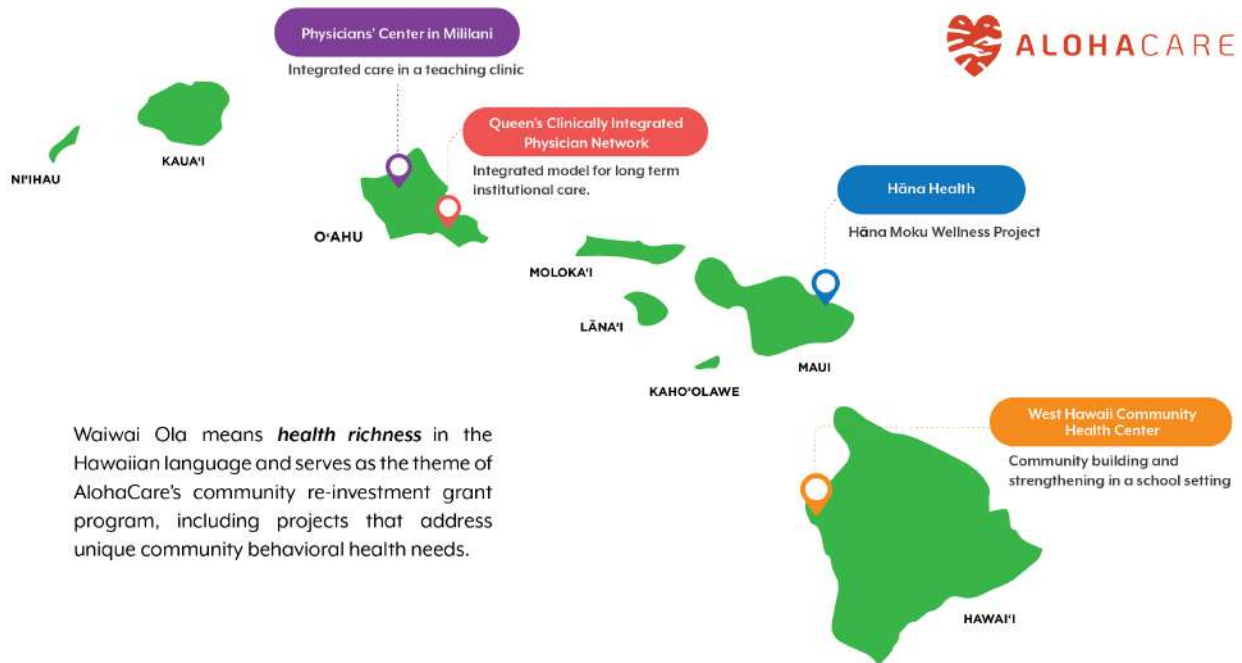
Adherence Measure	CHPW 2020 vs. 2019	PBM’S National Average 2020 vs. 2019
Diabetes	up 2.9%	up 1.2%
Hypertension	up 2.8%	up 1.3%
Statins	up 4.3%	up 1.84%

Behavioral Health

In 2019, seventy-three percent of health plan respondents indicated being at-risk for behavioral health services for their Medicaid members, according to IMI's 2020 annual Medicaid MCO survey report. Behavioral health services, including for both mental health and substance used disorder (SUD), are included in covered Medicaid benefits. Approximately 44.7 million adults in the United States live with a behavioral health condition. Although Medicaid covers only approximately fourteen percent of the general adult population, the program covers twenty-one percent of all adults with behavioral health conditions, twenty-six percent of all adults with serious mental illness (SMI), and seventeen percent of all adults with SUD. The following sections looks at two best practices and initiatives in behavioral health in Medicaid managed care.

AlohaCare

Community-Based Healthcare Transformation Projects: WAIWAI OLA



Program Name: Waiwai Ola Community Reinvestment Program.

Population: 1. Student population suffering from a high incidence of domestic and sexual abuse. 2. Youth in a remote island community. 3. Residents of a long-term care and skilled nursing institutional setting. 4. Individuals requiring behavioral health treatment.

Objectives: To increase access to behavioral health services for unique populations based on community assessments of need.

AlohaCare's \$5 million Waiwai Ola community reinvestment program included four projects focused on increasing access to behavioral health services for unique populations.

1. West Hawaii Community Health Center - "Building Community, Up-Stream and Down-Stream, through Partnerships"
The first project, led by West Hawaii Community Health Center, provided school-based clinic services to a student body suffering from a significant incidence of domestic and sexual abuse.

To address the identified needs of their community, the West Hawaii Community Health Center program implemented an innovative multi-dimensional approach targeting distinct components of the continuum of care. This approach consisted of the immediate engagement of the residents of the West Hawaii community and their part in educating the health center on the link between cultural values and overall health; a school-based behavioral health program that provided mental health supports and coordination for students and their families experiencing harmful or destructive behaviors; and a unique community paramedicine program that rendered acute and urgent care in a rural setting for a highly vulnerable and fragile geriatric population, homeless individuals and families, and residents with limited access to care.

For the school-based behavioral health program, West Hawaii utilized various psychiatric assessment instruments as appropriate to assist their team in identifying specific behavioral conditions, mental health symptoms, and potential diagnosis to inform necessary treatment or additional support amongst their youth population.

2. Hana Health - “Hana Moku Wellness”

The second project, the Hana Moku Wellness Project, linked residents of this remote and tight-knit Maui island community with onsite and telehealth services with providers outside of Hana to help de-stigmatize behavioral health treatment.

In December of 2018, in response to the behavioral health needs of their community, Hana Health implemented a program to create a “wellness moku (district)” through the development of a behavioral health provider network coordinated by the health center. The integration model coordinated mental health, substance use, and primary care within the clinic setting enhanced by established community partnerships with their local elementary school, local high school, and a local youth facility – Hana Youth Center, to address the growing behavioral health needs of Hana’s young people.

Hana Health’s behavioral health program developed a network of 12 Hawaii behavioral health providers based outside of Hana and contracted primarily to provide telehealth services. In addition, the program employed licensed marriage and family therapists and psychologists to provide services onsite as well as virtual. Implementation also involved working space (i.e., office area) and workstation set ups (i.e., computers) embedded within the school campuses while establishing service protocols through a collaborative working relationship with school-based administration and personnel. Hana’s wellness program provided services twice a week. To support its clinicians and overall program objectives to screen, provide brief intervention, and to make appropriate referrals to treatment (SBIRT), Hana Health utilized the SBIRT from their Lifespan Platform tool. Over 700 SBIRT screenings were conducted that helped to identify youth at-risk for a behavioral health problem, alcohol related issues, symptoms related to anxiety, depression, bi-polar disorder, post-traumatic stress disorder, substance, and tobacco use.

Part-time psychologists and social workers oriented to the school environment, met with administrators, counselors, and teachers to establish service protocols and began providing care at the school two half days per week.

Between December 2018 and July 30, 2020, Hana Health provided behavioral health services to 113 individuals who also accounted for 329 in-clinic visits and 188 virtual visits.

3. Queen’s Clinically Integrated Physicians Network- “Adaptation and Implementation of a Model for Integrated Behavioral Health in Long-Term Care and Skilled Nursing Facilities”

The third project, led by the Queen’s Clinically Integrated Physician Network, involved adoption of integrated behavioral health services for residents of a long-term care and skilled nursing institutional setting for timely prevention and treatment of depression and other conditions, particularly in the presence of multiple co-morbidities.

To address the behavioral health challenges well known and documented within the long-term care and skilled nursing facilities, as well as implement an evidenced-based collaborative care model to strengthen both capacity and range of supports for facility staff, the Queen’s Clinically Integrated Physicians Network (QCIPN) program implemented a robust support system for all participating care facilities in network. The QCIPN program leveraged a proven model of care to support the growing number of long-term skilled nursing facilities deficient in handling severe psychiatric conditions amongst its patient population by providing a collaborative team of primary care, behavioral, and psychiatric providers. QCIPN’s program produced increased competencies amongst its staff at various levels. Additionally, the program achieved increased access to high quality behavioral healthcare for their participating facilities, a service that was not previously available. Moreover, QCIPN was able to report a decrease in ED utilization and a relative reduction to total cost of care for its program participants. And most importantly, the program was able to report improved overall outcomes of its program participants captured over pre- and post-self-reports.

4. Physicians' Center in Mililani- "Integrated Behavioral Health in Non-FQHC's: A Pilot Program to Target Improved Access and Program Sustainability"

The fourth project, led by the Physicians' Center in Mililani, utilized care coordination and community health workers to quickly link patients to behavioral health services and strengthen active patient engagement in their health care. To perpetuate the efficacy of the integrated behavior health (IBH) care model, the program led by the Physicians Center in Mililani (PCIM) implemented its version of the IBH to improve patient access and outcomes while also aiming to demonstrate sustainability through a pay per encounter (vs. pay for time) alternative payment model. Having implemented full-time behavioral health services, a community health navigator for outreach, and a specified approach to potential financial sustainability, the program was able to meet all program objectives. Integration of the behavioral care model significantly increased access by reducing wait times while also impacting the no show rates of their patient population. Furthermore, there was a decrease in cost through health care utilization in total cost of care for patients assigned to the PCIM as primary care. Similarly, program participants who were also receiving assistance from the community health navigator tallied a reduction in total cost of care during the course of the program. Additional outcomes demonstrated improvement in depression and anxiety symptoms for participating patients.

As a teaching primary care clinic affiliated with the University of Hawaii School of Medicine, this partnership enhanced provisions for extensive clinical training for PCIM's medical and behavioral health providers; practice coaching to assist with maximizing true integration of behavioral health services; facilities redesign; and professional connections across the nation and various sites conducting similar clinical practices and interventions.



Office-Based Addiction Treatment (OBAT)

The Office-based Addiction Treatment (OBAT) is an initiative to increase the number of prescribers state-wide who can prescribe medication-assisted treatment medications (MAT) to individuals struggling with Substance Use Disorders.

- Medication-assisted Treatment (MAT) is the Gold standard for evidenced-based treatment of Substance Use Disorders.
- Taking MAT one step further, the OBAT program seeks to combine the services of prescriber-affiliated Psychosocial Navigators who's role it is to assist members in getting their psychosocial needs met in the community outside of the office-based encounter.
- These services might include – (but are not limited to) – examples such as: linking a member with a needed specialist, assistance with transportation, helping make linkages to key sober supports such as peer navigation, assisting with attainment of concrete needs, etc.
- Active Network interventions are underway to recruit prescribers to prescribe MAT and to convert MAT prescribers to OBAT.
- No outcome data available yet at this early juncture.



Program Name: The Office-Based Addiction Treatment (OBAT) Initiative.

Population: Providers who can prescribe Medication-Assisted Treatment (MAT).

Objectives: To increase the number of prescribers statewide who can prescribe MAT to individuals struggling with substance use disorders.

Medication-assisted Treatment (MAT) is the gold standard for evidence-based treatment of substance use disorders (SUD). The Office-Based Addiction Treatment (OBAT) initiative aimed to increase the number of prescribers statewide who can prescribe MAT to individuals struggling with SUD. The program sought to combine the services of prescriber-affiliated Psychosocial Navigators who assist members in getting their psychosocial needs met in the community outside of the office-based encounter. OBAT was initiated by the state as part of the Governor's initiative to address the opioid crisis. While there is an adequate amount of MAT providers who have the waiver that is required to prescribe MAT medications, there is a shortage of providers willing to prescribe the MAT medications. There is even more of a shortage of providers willing to become full-fledged OBAT providers by taking on the requisite psychosocial navigators required to fulfil the OBAT model.

Services included in the initiative included but were not limited to linking a member with a needed specialist, assistance with transportation, helping make linkages to key sober supports such as peer navigation, and assisting with attainment of concrete needs. Active network interventions were undertaken to recruit prescribers to prescribe MAT and to convert MAT prescribers to OBAT. Outcomes data from the program are not yet available.

Women's Health

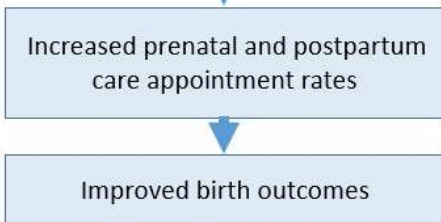
Women's health services are covered benefits in Medicaid. Services include family planning and maternity care. IMI recognizes that there are individuals who become pregnant and give birth who might not identify as women. Individuals who identify as women may also depend on a diverse set of health care needs. Approximately ninety-three percent of health plans provided targeted women's health programs for Medicaid members in 2019, according to IMI's 2020 annual Medicaid MCO survey report. Consistent with Medicaid's role in providing coverage for people who are pregnant, one hundred percent of health plans indicated that prenatal and postpartum care was a priority women's health topic, with one-hundred percent also indicating that they had targeted programs and engagement strategies to address this priority. This section identifies three best practices in women's health in Medicaid managed care.

L.A. Care Health Plan

L.A. Care Health Plan Medicaid Perinatal Care Programs



Healthy Pregnancy	Healthy Mom
Interventions: <ul style="list-style-type: none"> • Prenatal appointment scheduling assistance • Educational mailing packets • Coordination of interpreting and transportation services • Availability of blood pressure monitor & cuff and weight scale for remote monitoring 	Interventions: <ul style="list-style-type: none"> • Postpartum appointment scheduling assistance • Coordination of interpreting and transportation services • Incentive awarded for completed postpartum visits



Program Name: The Healthy Pregnancy Program & the Healthy Mom Program.

Population: Pregnant members.

Objectives: To increase prenatal and postpartum visit rates and improve birth outcomes among members.

L.A. Care serves 370,000 women of reproductive age, including pregnant women, and women with a recent birth. Two, high-touch, perinatal coordination interventions were implemented to increase prenatal and postpartum visit rates and birth outcomes among members. Newly enrolled members who were pregnant were included in the Healthy Pregnancy program. The Healthy Pregnancy Program, which was first implemented in 2009, included proactive outreach to assist with appointment scheduling, mailing educational material packets, coordinating transportation, providing interpreters as needed, and ensuring availability of blood pressure monitors, cuffs, and weight scales for remote monitoring. Members who received interventions as part of the Healthy Pregnancy Program were also identified and outreached to participate in the Healthy Mom program. The Healthy Mom Program was implemented in 2012 and included proactive outreach to assist with appointment scheduling, coordinating transportation, providers interpreters as needed, as well as offering incentives for completion of the postpartum visit. A recent data analysis demonstrated a borderline statistically significant 5.1 percent difference ($p=.05$) in the completion of the postpartum visit between members who received an outreach call from L.A. Care verses those who did not. The results indicated that the intervention has the potential to not only improve patient outcomes, but positively influence Healthcare Effectiveness Data and Information Set (HEDIS) rates as well.

Women's Health

Horizon Blue Cross Blue Shield of New Jersey



Getting Early Maternity Services (GEMS) Case Management

GEMS Case Management

➤ GEMS Case Management aims to

- ❖ Improve prenatal and postpartum compliance
- ❖ Connect members to community resources through regional Central Intake
- ❖ Overcome social determinants of health (SDOH) through improved health care navigation and empowerment



➤ Best Practices

- ❖ Identify high risk maternity members through perinatal risk assessments (PRA) which is submitted to HNJH by the OB.
- ❖ Stratify members based upon risk to target member engagement/education

Over the last three years, Case management team has engaged on an average 7500 members per year in the GEMS program. This represents over 50% of total deliveries.

Program Name: Getting Early Maternity Services (GEMS) Case Management Program.

Population: High-risk members requiring maternity care.

Objectives: To improve prenatal and postpartum compliance, to connect members to community resources, and to address social determinants of health (SDOH).

The Getting Early Maternity Services (GEMS) case management (CM) program, led by Horizon NJ Health, aimed to empower members to improve prenatal and postpartum compliance, connect members to community resources through regional Central Intake, and overcome social determinants of health (SDOH) through improved health care navigation and empowerment. Horizon NJ Health strived to help members become familiar with formal and informal support networks to address SDOH. High-risk members were identified through perinatal risk assessments (PRA) which were submitted by obstetrical providers. Horizon NJ Health imported a daily feed from Family Health Initiatives of all members' PRAs, and identified those members at high, moderate, or low risk for maternal complications. This helped guide education and engagement outreach initiatives to those members with the highest level of needs.

Activities undertaken by the case management team to increase compliance included:

- Education on the importance and value of prenatal check-ups, and postpartum visits;
- Assistance with scheduling appointments with members and the office;
- Assistance with coordinating transportation, when needed;
- Connection to community resources;
- Education on and empowerment to have a birth plan, help set up appointments for their babies with pediatrician;
- Education and help with navigation of the newborn enrollment process with new moms; and
- Performance of the Edinburgh Depression Screening and connection to resources for treatment.

Over the last three years, the case management team has engaged an average of 7,500 members per year in the program, which represents over 50 percent of total deliveries. Based on 2018 and 2019 Healthcare Effectiveness Data and Information Set (HEDIS) data, there has been a 5 percent increased compliance rate for Prenatal/Postpartum measures for those members actively engaged in GEMS CM as compared to pregnant members not actively engaged in GEMS CM.

Women's Health

Horizon Blue Cross Blue Shield of New Jersey



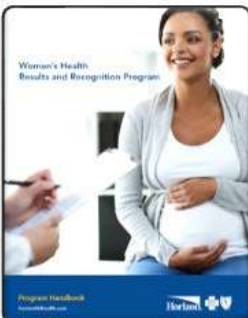
Results & Recognition Women's Health Program

Improving the health of women and infants through OB/GYN engagement and education



HEDIS measure education and tools

Educational webinars

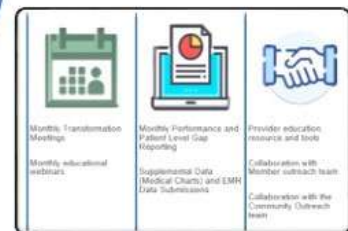


Best Practices

Collaboration



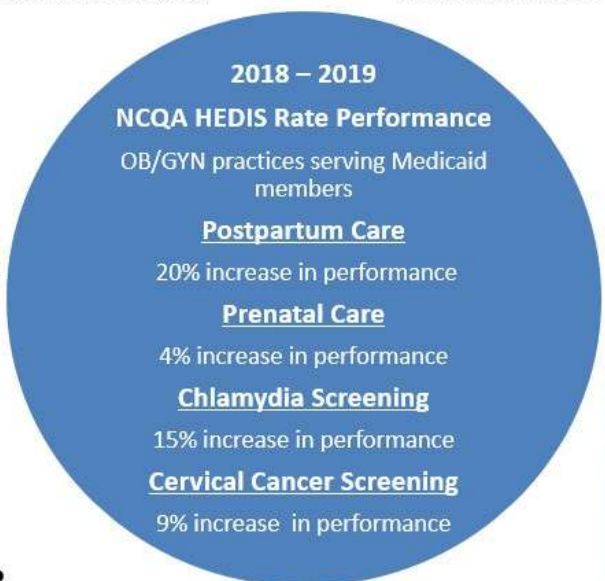
Practice Transformation Meetings



EHR

Optimization

Performance and Patient Level Gap Reporting



Program Name: Results & Recognition Program.

Population: Obstetrical practices.

Objectives: To improve infant and maternal health outcomes in New Jersey through member engagement and education.

Horizon NJ Health's Results & Recognition program aimed to improve infant and maternal health outcomes in New Jersey through member engagement and education. The program was launched in 2019. Each participating practice received a dedicated clinical liaison as a single point on quality who provided a comprehensive overview of the program, education, support and resources to promote and achieve incentives through improved quality performance and practice transformation. The program involved Healthcare Effectiveness Data and Information Set (HEDIS) measure education and tools, educational webinars, electronic health record (EHR) optimization, performance and patient-level gap reporting, and collaborative practice transformation meetings. Obstetrical practices received incentives when HEDIS measures reached the 50th and 75th percentiles as deemed by the National Committee for Quality Assurance (NCQA). Patient Risk Assessment (PRA) data was used to identify OB/GYN providers who had the highest PRA submissions. HEDIS data was used to identify all the Medicaid members with Prenatal and Postpartum Care, Chlamydia, and Cervical Cancer Screening care gaps for the identified OB/GYN practices. NCQA HEDIS rate performance for OB/GYN practices serving Medicaid members increased 20 percent for postpartum care, four percent in prenatal care, fifteen percent in chlamydia screening, and 9 percent in cervical cancer screening from 2018 to 2019.

Pregnancy Recovery Center/Women's Recovery Center

Women's health: our established partnership

The Pregnancy and Women's Recovery Center (PWRC) at UPMC Magee Women's Hospital provides both buprenorphine treatment and coordinated counseling for opioid use disorder and prenatal care/delivery at the same location. The PRC is an Opioid Center of Excellence with a PMPM arrangement for specialized care coordination including Certified Recovery.

Goal: Long-term support to women suffering from the chronic disease of opioid use disorder

Partnership: UPMC for You employs an onsite mobile social worker at the PWRC to assist the high acuity member population there and improve outcomes

The social worker conducts a comprehensive needs assessment to identify opportunities for care management services and ongoing social work intervention throughout their pregnancy and after delivery.

Preliminary Results: Early results reveal reduced antpartum inpatient spending for members treated with buprenorphine, as well as reduced neonatal costs for members receiving care at the PWRC.

UPMC HEALTH PLAN

Program Name: Pregnancy Recovery Center/Women's Recovery Center.

Population: Women who are suffering from the chronic disease of opioid use disorder.

Objectives: To provide long-term support to women suffering from the chronic disease of opioid use disorder.

In July 2014, UPMC for You began supporting the Pregnancy and Women's Recovery Center (PWRC), located at UPMC Magee-Womens Hospital. The PWRC provided both buprenorphine treatment and coordinated counseling for opioid dependence and prenatal care and delivery at the same location. The goal of the PWRC was to encourage long-term support to women suffering from the chronic disease of opioid use disorder. Over the past decade, UPMC for You has worked collaboratively with Magee to develop and support a comprehensive program that includes case management, peers, and close coordination with behavioral counseling.

UPMC for You employed one full time equivalent (FTE) social worker as a mobile social services care manager who was located onsite to support members receiving services at the PWRC. The social worker dedicated work time to this program's complex population and their high level of acuity to profoundly impact their lives, as well as pregnancy outcomes. The social worker conducted comprehensive needs assessments to identify opportunities for care management services and ongoing social work intervention throughout their pregnancy and after delivery.

Early results revealed a reduction in antepartum inpatient spending for members treated with buprenorphine, as well as a reduction in neonatal costs for members receiving care at the PWRC. The analysis of members treated with buprenorphine indicates much higher retention rates in treatment than those with OUD who don't receive it.

Mobile Maternity Care Management Program

Women's health

The UPMC Health Plan Maternity Program is a maternity care management program offered to women enrolled in applicable UPMC Health Plan insurance products. An experienced maternity nurse serves as a health coach throughout the continuum of a woman's pregnancy, including the postpartum period.

The program is supported by:

- 10 mobile nurse care managers and 2 mobile social workers who are aligned with high volume/high need practices to provide support to practice sites for complex member needs
- 15 telephonic nurse care managers



UPMC HEALTH PLAN

Program Name: Maternity Program.

Population: Members who are pregnant or are in the postpartum period.

Objectives: To connect pregnant and postpartum members with complex needs to appropriate community resources and postpartum depression treatment.

The UPMC Health Plan Maternity Program was implemented in 2016 as a maternity care management program offered to women enrolled in all applicable UPMC Health Plan insurance products. For members enrolled in the program, an experienced maternity nurse served as a health coach throughout the continuum of a woman's pregnancy, including the postpartum period. The program was supported by 10 Mobile Nurse Care Managers and 2 Mobile Social Workers who were aligned with high volume/high need practices to provide support to practice sites for complex member needs and 15 Telephonic Nurse Care Managers.

The program involved three key components. First, information from an Obstetrical Needs Assessment Form (ONAF) was used to generate referrals to the maternity team (mobile or telephonic) as appropriate. Second, a maternity health coach completed comprehensive assessments that included social determinants of health (SDOH). Third, based on the assessment, the health coach connected the member with appropriate community resources to support mom and baby (breastfeeding support, identification and referral for postpartum depression treatment, and plans for well-baby care).

As of December 2019, the program completed 2,358 referrals and reached 1,637 individuals. The reach rate was 69.4 percent, and the participation rate was 57 percent.

Table 1. UPMC for You's Maternity Program Interventions in 2019

Interventions	Q1 2019	Q2 2019	Q3 2019	Q4 2019	2019 Total
Care Coordination	52	38	70	40	200
Transportation Assistance	8	14	24	27	73
Education of member on chronic conditions	110	116	155	101	482
Medication Reconciliation	3	0	0	0	3
Referrals- Community Resources	55	49	88	0	192
Referrals- Behavioral Health	78	78	97	95	348
Referrals- Drug and Alcohol	40	43	54	14	151

Child and Adolescent Health

Child and adolescent health services are covered for children enrolled in Medicaid from birth to twenty-one years of age. Services include essential medical, vision, hearing and dental screenings, and services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. All Medicaid MCOs offered targeted child health programs in 2019. Furthermore, IMI's 2020 annual Medicaid MCO survey report found that over ninety-three percent of health plans, regardless of size, contracted with a state Medicaid agency to provide coverage for children with special healthcare needs (CSHCN). This section provides an overview of three innovative child and adolescent health initiatives.

Horizon Blue Cross Blue Shield of New Jersey

Horizon Dental Operations Fluoride Varnish Program



TABLE 1
INSTRUCTIONS TO CAREGIVER AFTER FLUORIDE VARNISH APPLICATION

- Child's teeth may be discolored for 24-48 h (only with yellow products). This will resolve with thorough brushing.
- No brushing of teeth until the next morning.
- Children can eat and drink immediately after application.
- Avoid sticky, hot, very hard, and crunchy foods the same day as they may crack or remove the varnish.

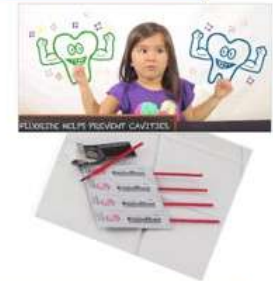
From Clark MB, et al.¹⁸

Fluoride varnish is a highly concentrated form of topical fluoride that is applied to teeth in a professionally supervised setting. Research shows fluoride varnish is highly effective in caries reduction with a decrease in caries incidence between 18% to 24% in 1 study and as high as 59% in another. Fluoride varnish application is safe and effective. In some states, not only physicians and advanced practitioners but also nurses and medical assistants can apply the varnish. The recommended dosage for fluoride varnish is 5% sodium fluoride (NaF).

HNJH Summary of Fluoride Varnish Program					
Year	Number of PCP's Participating in Fluoride Varnish Program	Total Number Applications of Fluoride Varnish	Unique Members Assigned to Participating PCP's	Dental Encounters after Application of Fluoride Varnish	Amount
2019	187	5,549	7,355	0-30 days	437
				31-60 days	345
				61-90 days	1,519
				Total Encounters in a Dental Home	2,301

41% of members less than 6 years of age, who received fluoride varnish, had their first dental encounter in a dental home within 90 days of the application of fluoride varnish.

- PCP's are trained on the application of fluoride varnish
- PCP's follow this link for training: www.smilesforlifeoralehealth.org
- HNJH pays for fluoride varnish by using CPT code 99188.
- Incentive is paid quarterly to PCP's if the member is established in a dental home within 90 days.



Program Name: Dental Operations Program.

Population: Primary care practices.

Objectives: To decrease caries incidence in children and increase the number of members in dental homes by the age of one.

The Horizon NJ Health Dental Operations program aimed to decrease caries incidence in children. Most drinking water in NJ is not fluoridated causing an increase in rampant early childhood caries. The program focused on administering dental varnish to members six years of age and under. The program trained and paid for primary care physicians (PCPs) to administer the varnish and incentivized them with a quarterly payment when a child had a dental encounter within 90 days of a fluoride varnish treatment. Primary care physicians were trained on the application of fluoride varnish via an online link and tool. The main objective of the program was to assign children to a dental home by the age of one. Horizon NJ Health encouraged medical and dental home integration so more children would receive the recommended dental care and education supporting good oral health. One hundred and eighty-seven PCPs participated in the program. The partnership has led to PCPs providing caries risk assessments, anticipatory guidance, fluoride varnish applications, and a referral of members to a dental home, at a very early age. The program assigned 7,355 members to participating PCPs and resulted in 5,549 applications of fluoride varnish. Forty-one percent of members less than six years of age who received a fluoride varnish had their first dental encounter in a dental home within 90 days of the application.

Child and Adolescent Health

Horizon Blue Cross Blue Shield of New Jersey



Adolescent Risk Behaviors and Depression Performance Improvement Project

Tobacco use, alcohol and drug use, risky sexual behaviors and depression are high-risk conditions that are associated with adolescent premature mortality due to unintentional injury or suicide

Methodology

- Partner with provider groups that complete a high rate of adolescent well-care visits (AWC)
- Identify adolescents with Medicaid ages 12-21 that have had an adolescent well-care visit
- Audit providers to determine screening rates for risk behaviors and depression screenings

Interventions

- Monthly member mailing for overdue or due well-visits
- Quarterly meetings with participating provider groups
- Quarterly audits of random medical records
- Project handbook for providers

Best Practices – Quality Improvement aims to:

- Work with providers to improve compliance and medical record documentation for routine risk behavior and depression screenings
- Work with provider groups to improve office workflow for standardized depression screenings
- Work with provider groups to improve follow-up response and documentation for a positive screening result



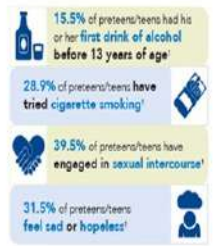
Preteen/Teen Annual Wellness Visits

It is important for your child to have an annual wellness visit with his or her Primary Care Provider (PCP) or pediatrician.
* Your child is due for a well visit.

Schedule an annual wellness visit!
Horizon NJ Health wants to make sure your child gets the care he or she needs.
Contact your child's doctor today!

Call <ProviderName> at <ProviderNumber>.

Health Risk Behaviors
Your child's doctor should screen for and talk to your child about health-risk behaviors during your child's annual wellness visit.



Program Name: The Adolescent Risk Behaviors and Depression Performance Improvement Project (PIP).

Population: Three provider groups with a high rate of adolescent well-care visits (AWC).

Objectives: To address high-risk conditions in adolescents including tobacco use, alcohol and drug use, risky sexual behaviors, and depression to prevent premature mortality due to unintentional injury or suicide.

The Adolescent Risk Behaviors and Depression Performance Improvement Project (PIP) was a collaborative effort across managed care organizations in New Jersey, at the request of the state of New Jersey. The PIP addressed high-risk conditions including tobacco use, alcohol and drug use, risky sexual behaviors, and depression in adolescents to prevent premature mortality due to unintentional injury or suicide. Horizon NJ Health recruited three provider groups that completed a high rate of adolescent well-care visits (AWC) to participate in this project and worked closely with them to implement interventions and track their results. Interventions included monthly member mailing for overdue or due well-visits, quarterly meetings with participating provider groups, quarterly audits of random medical records, and a project handbook for providers. Horizon NJ Health identified adolescents ages 12-21 that had an adolescent well-care visit. Screening rates were determined by a random medical record audit that was performed at the end of every year. All three provider groups made changes in their workflows to ensure that risk behaviors and depression were being addressed during adolescent well care visits. Tobacco, alcohol, and drug screenings were already being completed and documented at a high rate. Sexual behaviors and depression screenings had the most room for improvement and the provider groups have since met and exceeded the set goals. Horizon NJ Health worked with providers to improve compliance and medical documentation for routine risk behavior and depression screenings, to improve office workflow for standardized depression screenings, and to improve follow-up response and documentation for a positive result. 2021 is the sustainability year of the project and the provider groups will work to maintain the progress that they have made.

Child and Adolescent Health

Horizon Blue Cross Blue Shield of New Jersey



Program Name: Results & Recognition Program.

Population: Primary care practices.

Objectives: To improve child and adolescent health outcomes through utilizing best practices for wellness visits, preventive screenings, and immunizations; to implement a team-based collaborative learning approach informed by data and technology to build strategies to address care gaps.

Horizon NJ Health’s Results & Recognition program aimed to improve child and adolescent health in New Jersey through enhanced collaboration. The program was launched in 2016. Each participating primary care practice received a dedicated clinical liaison as a single point of contact. The clinical liaison provided a comprehensive overview of the program, education, support, and resources to promote and achieve incentives through improved quality performance and practice transformation. The program involved utilizing best practices for wellness visits, preventive screenings, and immunizations, a team-based collaborative learning approach, and the use of data and technology to build strategies to address care gaps. Involved practices received incentives when Healthcare Effectiveness Data and Information Set (HEDIS) measures reached the 50th and 75th percentiles as deemed by the National Committee for Quality Assurance (NCQA). NCQA HEDIS rate performance for weight assessment and counseling for nutrition and physical activity for children and adolescents was monitored for pediatric primary care practices. A 40 percent increase in performance was seen for body mass index (BMI) percentile, a 42 percent increase was seen in counseling for nutrition, and a 51 percent increase was seen in counseling for physical activity from 2017 to 2019.

NICU Case Management and Coordination of Care

Child and adolescent health

In collaboration with UPMC Magee-Womens Hospital and UPMC Children’s Hospital of Pittsburgh, the **NICU Community Team** offers a comprehensive approach that begins before birth and continues into childhood.

It involves health professionals, families, and communities as partners to meet needs of infants and families. The team facilitates coordinated care management between the various groups that help the families be successful at home.

Program Goals

- Improve length of stay, readmissions, timeliness of services, and family satisfaction.
- Improve the lives of patients and families by ensuring care coordination, confidence in care, and that resources and needed services are provided to the right member, in the right way, at the right time.
- Identify families at risk for adverse health outcomes through assessment — engaging in interventions and goals in conjunction with family strengths to deliver support and resources
- Help families succeed as caregivers and parents/children through meaningful engagement and connection to relevant resources

UPMC HEALTH PLAN

Program Name: NICU Case Management and Coordination of Care.

Population: Pediatric members requiring intensive care.

Objectives: To meet the social and medical needs of infants and families.

UPMC *for You's* Neonatal Intensive Care Unit (NICU) Community Team offered a comprehensive care coordination approach that begins before birth and continues into childhood. Planning for this initiative began in 2020 and staffing of the integrated care management team and the new care management model initiated in the first quarter of 2021. The approach involved health professionals, families, and communities as partners to meet the social and medical needs of infants and families. The team facilitated coordinated care management between the various groups that helped the families be successful at home: Hospital, Health Plan, primary care physician (PCP), shift case services, substance use disorder (SUD)/opioid use disorder (OUD) recovery, and home-based supports. The effects of health disparities were particularly pronounced for infants requiring intensive care and their families because of the already significant risk for neurodevelopmental disabilities and needs for specialized services. For this reason, the team also identified and helped to address social determinants of health (SDOH) barriers that members and families have. The approach was enacted in close collaboration with partners at UPMC Magee-Womens Hospital and UPMC Children’s Hospital of Pittsburgh. Outcomes are not yet available to share from this program.

Foster Care Coordination Program

Child and adolescent health

- UPMC *for You's* Foster Care Coordination Program began in December 2016
- Pediatric Social Worker Case Management team conducts monthly outreach to Children & Youth Services (CYS) county liaisons and has developed personalized, one-on-one relationships with liaisons in 32 counties covering UPMC *for You's* current Pennsylvania service area.
- Over 1,000 unique members are served through this program annually

Program Goals

- Addressing gaps in care (well visits, dental visits, immunizations, lead screening)
- Management of antipsychotic medications and any associated metabolic lab work
- Integration of physical and behavioral health needs
- Increased coordination of care for members requiring Private Duty Nursing services

Program Name: Foster Care Coordination Program.

Population: Pediatric members in foster care in 32 counties.

Objectives: Addressing gaps in care (well visits, dental visits, immunizations, lead screening). Management of antipsychotic medications and any associated metabolic lab work. Integration of physical and behavioral health needs. Increased coordination of care for members requiring Private Duty Nursing services.

UPMC *for You's* Foster Care Coordination program began in December 2016 to address pediatric care gaps, support management of antipsychotic medications and assisted metabolic lab work, integrate physical and behavioral health needs, and increase coordination of care for members requiring Private Duty Nursing (PDN) services. Members of the Pediatric Social Work Case Management team outreached monthly to county liaisons at Children & Youth Services (CYS) in 32 counties covering UPMC *for You's* current service area in Pennsylvania. The case management team reviewed a comprehensive data report that provided a detailed snapshot of member physical and behavioral health information which allowed the staff to review gaps in care for well visits, dental visits, immunizations and lead screenings as well as the following:

- Initial examination requirements for members entering substitute care;
- Upcoming metabolic lab work for an antipsychotic medication; and
- Updates for any member who requires PDN services.

The program has recently made updates to the electronic health record, which allows access to data and documentation to provide real-time gaps in care information, allowing for timely interventions to promote gap closure. The program has resulted in a notable improvement in gaps in care closure for members in substitute care. Annually, the program services over 1,000 members.

Community-based Public Health Dental Hygienist (PHDHP) program

Child and adolescent Health

- UPMC *for You* utilizes **Public Health Dental Hygiene Practitioners (PHDHP)** as oral health educators that focus on oral health education and whole household management. The team is comprised of 8 Regional PHDHPs, supported by 3 Telephonic PHDHPs. PHDHPs have a key role in oral health intervention that is member-, provider-, health plan-, and community-facing.
- PHDHPs focus on increasing member utilization of well dental care through targeted engagement.

Provide Oral Health Education to Members

- Community events
- Education in daycares and pre-school settings

Coordinate Community Dental Events

- Pop-up dental clinics at community locations
- Virtual events (via telehealth) during COVID-19 pandemic

Participate in Oral Health Groups and Initiatives

- Oral health coalitions
- Community health initiatives
- Local interagency coordinating counsels

Program Name: Community-based Public Health Dental Hygienist (PHDHP) Program.

UPMC HEALTH PLAN

Population: Pediatric members and their families.

Objectives: To help members and their families achieve positive oral health practices, encourage and assist families to stay up to date with dental exams, hygiene routines, and treatment for active issues.

UPMC *for You* started the Community-based Public Health Dental Hygienist (PHDHP) program in November 2016. The Regional PHDHP Team at UPMC *for You* worked with members in their designated territories to provide face-to-face educational encounters. These encounters occurred during situations including community education activities (such as health fairs), and community dental clinic events. The team was dedicated to helping members and their families achieve positive oral health practices, encouraging and assisting families to stay up to date with dental exams, hygiene routines, and treatment for active issues.

The Regional PHDHP team also supported the following initiatives:

- Participation and support for coalitions, healthy community initiatives, local interagency coordinating counsels, etc.;
- Participation as oral health educators at community health events (back to school, health fairs, etc.);
- Providing oral health education in daycares/preschool settings during oral health month (February) to encourage children to form good habits through a day of hands-on play; and
- Coordination of pop-up dental clinics at community partner locations such as community support centers so that members can be drawn to that location and learn about the service offerings while getting care. During the coronavirus pandemic, the team has facilitated virtual dental days via telehealth where possible.

Between October 2019 and September 2020, a total of 36,666 members had an encounter with a PHDHP. UPMC *for You* had an increase of 7.69 percentage-points in the Annual Dental Visit rate from calendar year (CY) CY 2018 to CY 2019.

Elevated Lead Screening Follow-up Case Management

Child and adolescent Health

- UPMC *for You* care management opens an elevated lead case for any member with a lead test of 5 µg/dL or greater. Care managers monitor these cases to ensure that a venous test is done within 3 months of initial testing, if initial test was capillary. Follow up continues until lead levels are within normal range.
- Care management staff outreach to both the family and provider to assist with the following:
 - Coordination of care
 - Environmental Lead Investigation (ELI) referrals
 - Any further testing
 - Lead education
 - Early Intervention (EI) referral
 - Any other needs

Environmental Lead Investigation (ELI) Request Form		
To request authorization for an ELI, complete and return this form to the UPMC Health Plan Pediatric Case Management Department at peditriclead@upmc.edu . Once approved, UPMC will email you a notification that the service has been authorized.		
To be completed by ELI vendor		
ELI VENDOR INFORMATION		
Name of ELI vendor:	Date ELI form submitted:	
Email address:	Telephone number:	
REQUESTING PROVIDER INFORMATION		
Provider name:		
Date provider requested ELI:	Telephone number:	Fax number:
Address:		
MEMBER INFORMATION		
Member first name:	Member last name:	County:
Insurance ID number:	Member DOB (mm/SS/yyyy):	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
Blood level result:	Date of most recent venous blood lead level test:	
Parent/Guardian name:	Parent telephone number:	
Child's primary address:		
Child's secondary address (if applicable):		

UPMC HEALTH PLAN

Program Name: Elevated Lead Screening Follow-up Case Management.

Population: Pediatric members with a lead test (venous or capillary) of 5 Qg/dL or greater.

Objectives: To ensure that venous tests are completed within three months of a member completing a lead test with a result of 5 Qg/dL or greater; To assist families and providers with coordination of care, referrals, further testing, and lead education.

UPMC *for You* Care Management implemented a program in 2005 to open cases for any members with a lead test (venous or capillary) of 5 Qg/dL or greater. Care Managers monitored these cases to ensure that a confirmed venous test was done within 3 months of initial testing, if the initial test was capillary. The outreach process was initiated with any confirmatory venous draw of 5 Qg/dL or greater.

Care Management staff outreached to both families and providers to assist with coordination of care, Environmental Lead Investigation (ELI) referrals, any further testing, lead education, Early Intervention (EI) referral, and any other needs. Care Management continued to follow up until lead levels were within normal range.

UPMC *for You* was the top performing Pennsylvania Medical Assistance MCO in calendar year (CY) 2018 and CY 2019 and was consistently in the 90th percentile Healthcare Effectiveness Data and Information Set (HEDIS) bracket. In CY 2020, UPMC *for You* received 917 referrals, reached 600 members (65.4%), and assessed 68.7 percent. Over 91 percent of members that were reached participated in the program.

Patient-Centered Medical Homes

In high-volume, high-quality pediatrician practices



- UPMC *for You* partners with pediatric practices by providing support in the form of clinical and quality reporting, care coordination fees, and practice-based care management staff to achieve the goals of the Triple Aim.
- **Metrics and Reporting:** Key utilization metrics include ED and inpatient utilization, seven-day follow-up care after an admission, and quality rates. Partners receive ongoing clinical and quality reporting as well as patient gap in care rosters.
- **Payment:** Some PCMH partners receive an enhanced care coordination fee that is intended to reimburse partners for services that they provide that are not compensated under a traditional fee-for-service model.
- **Practice-Based Care Managers:** In certain practices, UPMC Health Plan has embedded practice-based care managers (PBCM) to minimize health care access barriers that prevent patient populations from achieving optimal outcomes.

UPMC HEALTH PLAN

Program Name: Patient-Centered Medical Homes (PCMHs).

Population: Pediatric practices.

Objectives: To achieve the goals of the Triple Aim: improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care.

UPMC *for You* partnered with high-volume, high-quality pediatric practices by providing support in the form of clinical and quality reporting, care coordination fees, and Practice Based Care Management staff to achieve the goals of the Triple Aim.

Metrics and Reporting: Key utilization metrics include emergency department (ED) and inpatient utilization, seven-day follow-up care after an admission, and quality rates. Partners received ongoing clinical and quality reporting as well as patient gap in care rosters.

Payment: Some PCMH partners received an enhanced care coordination fee to participate in the program. This monthly payment is intended to reimburse partners for services that they provide (or plan to provide) that are not compensated under a traditional fee-for-service model such as community-based staff to support a population health model.

Practice-Based Care Managers: In certain practices, UPMC Health Plan has embedded practice-based care managers (PBCM). Their focus is to minimize health care access barriers that prevent patient populations from achieving optimal outcomes.

Healthy First Steps Program

Child and adolescent Health



- The **Healthy First Steps Program** is a focused care management program designed to connect members to consistent care management during and after pregnancy, continuing through the first years of a child's life.
- **Purpose:** Support and increase member engagement in well-care visits, early childhood immunizations, and member awareness of developmental milestones.

Care Management Activities

- General care management
- Accessing care
- Making appointments
- Education on child development
- Addressing Social Determinants of Health (SDOH)

UPMC HEALTH PLAN

Program Name: Healthy First Steps Program.

Population: Families in the prenatal period through the child's first year of life.

Objectives: To connect members with consistent care management during and after pregnancy through a child's first year of life; To increase member engagement in well-care visits, early childhood immunizations, and member awareness of developmental milestones.

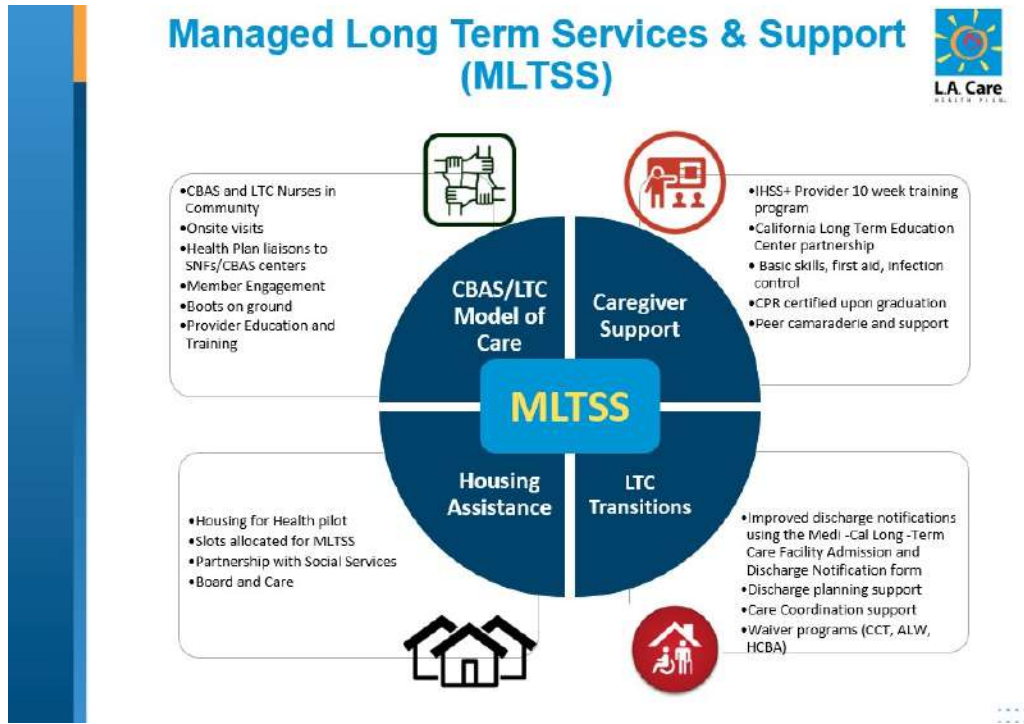
The Healthy First Steps Program, implemented in January 2019, was designed to connect members to consistent care management during and after pregnancy, continuing through the first years of a child's life. This family-focused care management process sought to support and increase member engagement in well-care visits, early childhood immunizations, and member awareness of developmental milestones. Care management activities included assistance with accessing care and making appointments, education on child development, addressing SDOH issues, and general care management.

In calendar year (CY) 2020, the Healthy Steps Program made 1,158 referrals with a reach rate of 63.8 percent and a participation rate of 98.7 percent.

Managed Long-Term Services and Supports

Managed Long-Term Services and Supports (MLTSS) include a range of medical and non-medical benefits administered through Medicaid managed care programs. Services include nursing home coverage, home health care, intermediate care facility services, and services provided through Home and Community-Based Services (HCBS) waivers. In 2019, over half of survey respondents indicated that they were at risk for needing long-term services and supports (LTSS), according to IMI's 2020 annual Medicaid MCO survey report. The most common approaches for innovation in MLTSS that were led by health plans in 2019 were member-centric, including self-advocacy (88%) and innovative approaches for caregiver supports and services (63%). This section highlights three innovative best practices in MLTSS in Medicaid managed care.

L.A. Care Health Plan



Program Name: MLTSS Care Model.

Population: Members receiving long-term services and supports.

Objectives: To support members in avoiding institutionalization while fostering independent living in the community. Managed Long-Term Services & Supports (MLTSS) assists beneficiaries in avoiding institutionalization while fostering independent living in the community by coordinating Home and Community-Based Services (HCBS) and MLTSS benefits such as In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), and Community-Based Adult Services (CBAS). L.A. Care's MLTSS team implemented a program to work directly with skilled nursing facilities (SNF) onsite to support Long-Term Care (LTC) members who have the desire and support to return to a community setting.

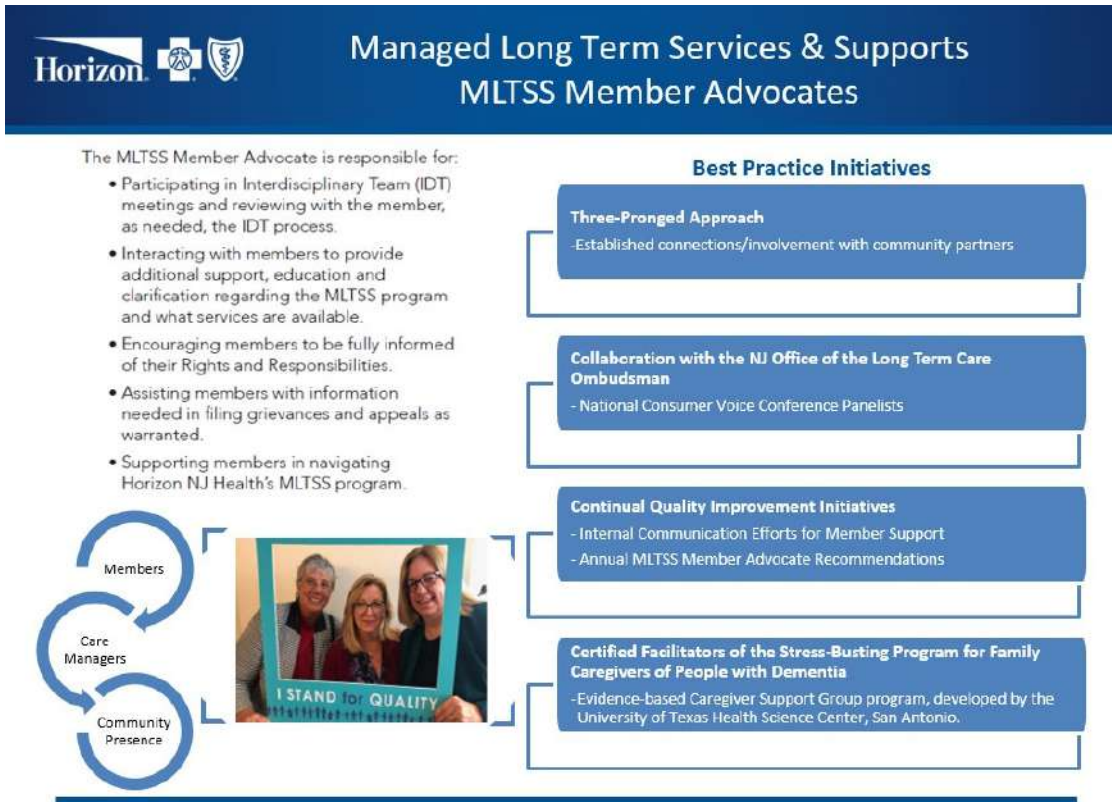
L.A. Care's model of care focused on care coordination, provider support, and in-person member engagement through scheduling daily onsite visits by the MLTSS Nurse Specialists from the plan. The goal of Community-Based Adult Services was to avoid institutionalization and provide caregiver support, while the goal of Long-Term Care was to transition beneficiaries to the community. By fostering relationships with skilled nursing facilities (SNFs), communication regarding discharges improved and allowed for better support. As part of this model, SNFs looped L.A. Care into discharge planning and provided notifications post-discharge, allowing L.A. Care to follow up with the member to determine if a care management referral was needed for continued monitoring. Medical groups within the skilled nursing facilities that L.A. Care contracted with were tasked with improving discharge planning and care coordination to prevent the re-institutionalization. L.A. Care hosts weekly rounds with the SNFist medical groups.

L.A. Care Care Management and Social Services teams addressed social determinants of health needs through a partnership with the Department of Health Services (DHS) Housing for Health Division that provided subsidized housing for eligible beneficiaries through a short-term pilot program with board and care homes. The Housing for Health Pilot referred 57 members in long-term care with limited to no resources. Thirty of those members were accepted to the program for transitions out of long-term care.

Additionally, the MLTSS team provided resources and trainings to enrollees and their families/caregivers to ensure continued success in the community setting. L.A. Care, in partnership with California Long Term Education Center (CLTEC), offered caregiver training through a 10-week In-Home Supportive Services (IHSS+) training program where IHSS provided basic skills training in first aid, infection, control, body mechanics, and CPR, etc. with the goal of enhancing the care provided to IHSS consumers. The program has trained 3,498 caregivers to date.

Managed Long-Term Services and Supports

Horizon Blue Cross Blue Shield of New Jersey



Program Name: Member Advocate Program and Stress Busting for Family Caregivers Program.

Population: Aging adults and individuals with disabilities; Caregivers.

Objectives: To support the health and wellbeing of older adults and individuals with disabilities.

Horizon NJ Health utilized managed long-term services and supports (MLTSS) member advocates to support the health and wellbeing of older adults and individuals with disabilities. Member advocates have been in place at Horizon NJ Health since July 1, 2014. The Horizon NJ Health member advocacy team in partnership with internal and external connections served as the basis of the member advocacy model. Horizon NJ Health provided three full-time member advocates for the MLTSS program, each with extensive experience in home- and community-based services and advocacy of elders and individuals with disabilities. Member advocates were based within the MLTSS Department and maintained strong connections across the organization to support members in all aspects of the program, including Quality Management, Utilization Management, Marketing, Communications, and Provider Contracting and Services. On an annual basis, they made recommendations to Horizon NJ Health of any changes needed to improve the system for MLTSS Members. The member advocacy model involved three core components:

- Assisting MLTSS members (Rights & Responsibilities; Member Grievance and Appeal processes; MLTSS Services & program parameters);
- Providing support to MLTSS Care Managers (Complex Cases/Family Dynamics; IDT Meetings, Provider issues; sharing external resources); and
- Maintaining a community presence (ADRC roundtables, Community Agency networking meetings – Advocates have established wide-ranging partnerships with community resources and advocacy agencies throughout the State).

Horizon NJ Health MLTSS Member Advocates were responsible for:

- Internally representing the interests of the member;
- Assisting members with navigating Horizon NJ Health's system. This includes being a resource for members, providing information, making referrals to appropriate staff, and facilitating resolution of any issues; and
- Providing education to members, families and providers on issues related to the program.

MLTSS member advocates provided members with additional community resources as well as additional education regarding the MLTSS program and their member rights and responsibilities. MLTSS member advocates were an additional avenue for addressing and resolving member concerns. Member advocate activities were monitored internally and were reported to MLTSS Subcommittee, including information with regard to the number of members served and the types of services provided. Based on their activities, the MLTSS member advocates also made annual recommendations to Horizon NJ Health about program operations and suggested improvements. Year over year the member advocates have maintained high levels of member satisfaction as obtained through member surveys.

National Advisory Board

Addressing the needs of the aging & disabled populations

Goals

- Cultivate a consumer-centered culture
- Advance awareness and knowledge of individuals served
- Identify emerging trends or policy issues
- Create a pathway to enable policy advancements
- Develop innovations for populations with special health care needs

Outcomes

Since its inception in 2012, the National Advisory Board has developed recommendations & programming around topics such as:

- Addressing Elder Abuse
- Quality in LTSS & I/DD programs
- Supporting Family Caregivers & Direct Service Workers
- Creating a Culture of Access

The Board is comprised of leading experts and aging and disability advocates as well as members and family members of individuals with special health care needs.

National Advisory Board Representation



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Program Name: National Advisory Board.

Population: Aging, disabled population.

Objectives: To address the needs of aging and disabled populations.

UnitedHealthcare’s National Advisory Board addressed the needs of aging and disabled populations. It served as an independent advisory council to provide input in actively engaging members, providers, advocacy groups, and other key stakeholders in the design and delivery system that supports individuals with special health care needs. The National Advisory Board has made recommendations, developed and championed innovations, and advised on member engagement strategies that support clinical approaches. The advisory board was launched in 2012 and is comprised of leading experts, aging and disability advocates, as well as members and family members of individuals with special health care needs. Since its inception, the National Advisory Board has developed recommendations and programming around topics such as addressing elder abuse, quality in long-term services and supports (LTSS) and Individuals with Developmental Disabilities (I/DD) programs, supporting family caregivers and direct service workers, and creating a culture of access.

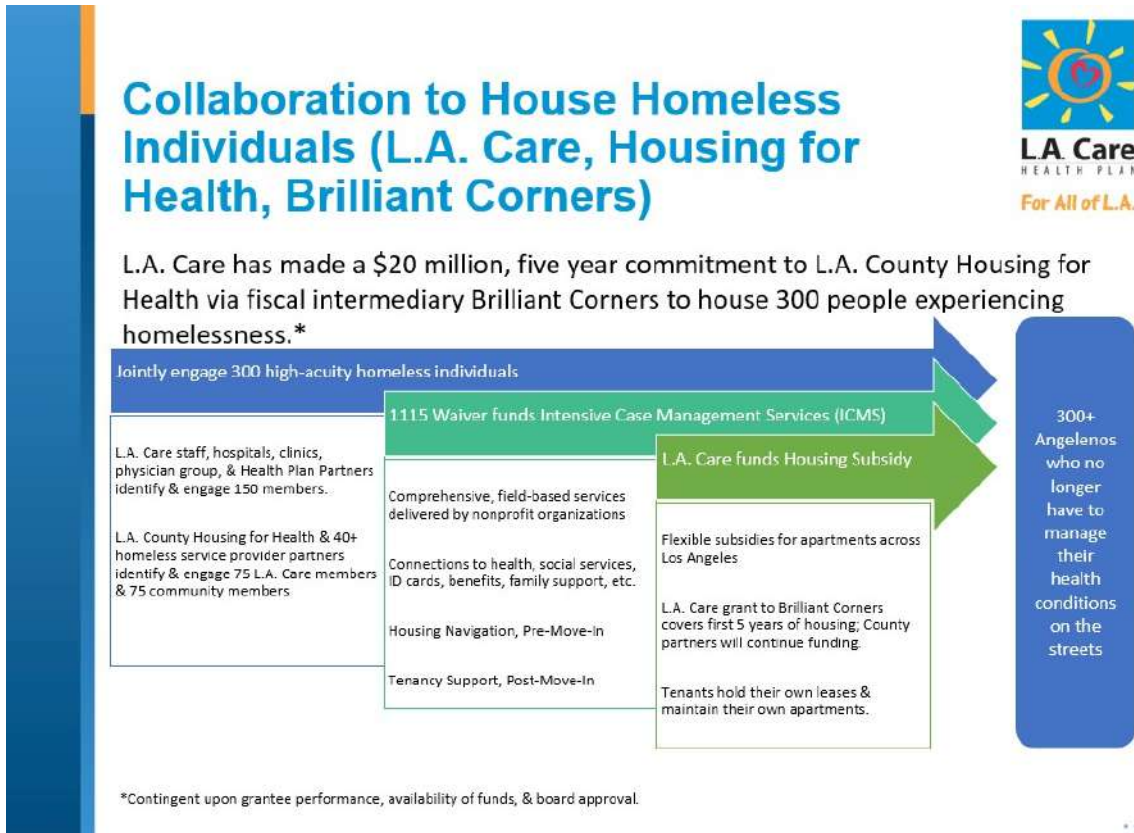
Elder Abuse: The efforts of the Board resulted in the development of enhanced clinical trainings and tools used by UnitedHealthcare Community and State clinical leaders, care coordinators, and case managers to ensure awareness, screening, and swift notifications if seniors were thought to be in jeopardy of elder abuse. The Community & State team then helped to distribute these resources to Medicare and Commercial benefits businesses to create broad awareness about the needs of elderly individuals, whether they be members themselves or someone a member is caring for.

Quality: The Board developed quality frameworks focused on both clinical and non-clinical supports, leveraging measures for not just process and outcomes, but also quality of life. As a result, UnitedHealthcare Community and State implemented quality reporting metrics for each of its LTSS plans to report on the metrics within the LTSS framework. UnitedHealthcare Community and State is now working to implement the ID/DD framework across its health plans serving individuals with ID/DD.

Direct Support Workers and Family Caregivers: The Board’s caregiving work led to a dedicated focus for UnitedHealthcare Community and State to evaluate and improve how it supports the individuals it serves by supporting their caregivers. Two pilots have been developed and launched that focus on improving member outcomes by integrating the roles of personal care attendants with the broader care team and providing competency-based training to direct support workers to build a more competent workforce and ultimately increase the quality of care and quality of life for members.

Social Determinants of Health

Social determinants of health (SDOH), also referred to as social influencers of health are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functional, and quality-of-life outcomes, and risks. For example, housing, food, and public safety. This section provides a description of three interventions that health plans have implemented in their service area. From the IMI 2020 annual Medicaid MCO survey report, in 2019, all respondents indicated that they offer targeted SDOH programs. The most common populations that were targeted for SDOH programs were individuals who were homeless/housing insecure (87%), people who were pregnant (73%), and adults with serious mental illness (67%).



Program Name: Housing for Health.

Population: Members experiencing homelessness.

Objectives: To provide pathways to permanent housing for high-need members experiencing homelessness.

As of January 2021, L.A. Care has awarded \$20 million to Housing for Health via fiscal intermediary Brilliant Corners as part of the \$20 million, five-year commitment. L.A. Care’s grant provided five-year rental subsidies to house 300 individuals experiencing homelessness using the Housing for Health program model. The program provided pathways to permanent housing for high-need L.A. Care members experiencing homelessness. L.A. Care staff, hospitals, clinics, physician groups, and Health Plan Partners planned to engage 150 members. L.A. County Housing for Health and over 40 other homeless service provider partners committed to identify and engage 75 L.A. Care members and 75 other community members. Section 1115 waiver funds were used toward Intensive Case Management Services (ICMS). Comprehensive field-based services were delivered by nonprofit organizations and connections were made with health and social services to assist members with obtaining ID cards, reviewing benefits, and family support. Housing navigation services were provided pre-move-in and tenancy support was provided post-move-in. L.A. Care funded flexible subsidies for apartments across L.A. L.A. Care to Brilliant Corners covered the first five years of housing with future funding covered by county partners. Tenants in the program held their own leases and maintained their own apartments. The program increased resources available to address homelessness in L.A. County by leveraging federal matching opportunities through the Whole Person Care pilot and County funding (e.g., Measure H). As of January 2021, the total number of households ever housed was 325. The grant had a 90 percent one-year retention rate for those housed through the program. An internal evaluation looking at pre- and post-utilization is in progress.

Social Determinants of Health

Horizon Blue Cross Blue Shield of New Jersey



Horizon Neighbors in Health: Education Works

This program helps members earn a High School Equivalency (HSE) diploma by providing them the necessary support to prepare and pay for their HSE test.



Horizon Neighbors in Health:
Education Works



The Member Life Coach Responsibilities

- Identify barriers to successful completion of the program
- Design a customized/individualized program
- Connect members to social resources
- Provide telephonic coaching
- Prepare members for college/job post program

Program Accomplishments

- Students have graduated from the program
- Partnered with at least one HSE prep center in each NJ County
- Connected members to a HSE prep centers
- Purchased supplemental materials such as study-guides and electronic devices
- Paid for HSE prep courses & HSE test
- Assisted with transportation to test centers via Lyft
- Coordinated with members' case managers, as needed

Program Name: Horizon Neighbors in Health: Education Works Initiative.

Population: Members who did not complete high school.

Objectives: To support Medicaid members who did not complete high school to earn the equivalent of a high school diploma.

Access to educational and job opportunities have the potential to positively influence the health outcomes of Medicaid recipients. Based on data from the American Community Survey, the high school dropout rate for 16- to 24-year-old residents in New Jersey was 3.7 percent in 2016. According to Census Bureau's 2016 Current Population Survey data, the unemployment rate for high-school dropouts was 4 percent higher than the unemployment rate for adults with a high school degree among 25- to 34-year-old adults. Moreover, high school dropouts age 25 and older reported poor health when compared to adults who completed high school, irrespective of their income levels. According to the National Bureau of Economic Research, "an additional four years of education lowers five-year mortality by 1.8 percentage points; it also reduces the risk of heart disease by 2.16 percentage points, and the risk of diabetes by 1.3 percentage points."

Horizon NJ Health has the highest market share for Medicaid in New Jersey. Given the close association between education and health, Horizon NJ Health sought to support Medicaid members who did not complete regular high school to earn the equivalent of a high school diploma.

The Horizon Neighbors in Health: Education Works initiative was developed to help members earn a High School Equivalency (HSE) diploma by providing them the necessary support to prepare and pay for their HSE test. While enrolled in the program, members had access to support through a Member Life Coach. The coach established a relationship with the members, motivated them and aided in reducing barriers while providing them with the necessary resources they needed to take the HSE test such as electronic devices, stationeries, books, etc.

The program has partnered with at least one HSE prep center in each county in New Jersey, has connected members to HSE prep centers, paid for HSE prep courses and tests, purchased supplemental materials such as study-guides and electronic devices, assisted with transportation to test centers via Lyft, and coordinated with case managers as needed. As of January 2021, a total of 112 members have been reached by the program and 4 members have graduated to date.

Social Determinants of Health

Community Health Plan of Washington

SDoH Innovation at Community Health Plan of Washington (CHPW)

Survey of Community Health Centers in our network about their collection and use of Social Determinants of Health data.

Only half of the CHCs were using a standard assessment tool in their EHR

Need identified to support efforts to systematically collect and document data in the electronic medical record (EHR) for integration with clinical data.

13 of 20 Community Health Centers were funded to electronically integrate SDOH assessment data into their EHRs

CHC projects also included:

- ☉ Training on workflow integration
- ☉ Strategies for completing patient assessments
- ☉ Coding education
- ☉ Expanding assessments to all patient populations

Due to COVID, many of the projects have been postponed or delayed.

Assessment results:



Of CHCs are currently collecting some SDOH data



Of CHCs are currently monitoring SDOH data to coordinate community services



Of CHCs would find additional data on SDOH helpful



Of CHCs are not routinely documenting SDOH on claims



Of CHCs are using a custom EHR assessment, 40% are using none traditional screening tools

Program Name: The Power of Community through Social Determinants of Health (SDOH) Data Collection and Integration with Community Health Center (CHC) Partners.

Population: Twenty community health centers.

Objectives: To augment or initiate SDOH data collection and documentation activities within community health centers.

Community Health Plan of Washington led efforts to augment or initiate data collection and documentation activities across Community Health Centers (CHCs) and to share those experiences and lessons learned with the network. In May of 2019, all 20 CHCs in the Community Health Network of Washington (CHNW) were surveyed on their collection and use of SDOH data. Survey results indicated a need to support efforts to systematically collect and document data in CHC Electronic Health Records (EHR) for standardized reporting across the network. Many CHCs had invested extensive time and resources into building SDOH capacity, while others were just initiating this process. Community Health Plan of Washington (CHPW) and the Community Health Network of Washington (CHNW) extended an invitation to all CHNW Community Health Centers to submit a proposal that would positively impact electronic SDOH data collection. Successful proposals demonstrated the ability to electronically capture SDOH data in a structured format that can be aggregated for enterprise reporting. Each award was noncompetitive up to \$20,000 and open to all CHNW CHCs. This work will ultimately be used to develop and inform the network strategy around data collection and usage to support SDOH activities. Results from the assessment were as follows:

- 50% of CHCs were collecting some SDOH data;
- 40% of CHCs were monitoring SDOH data to coordinate community services;
- 80% of CHCs would find additional data on SDOH helpful;
- 69% of CHCs were not routinely documenting SDOH on claims; and
- 55% of CHCs were using a custom EHR assessment, and 40% were using non-traditional screening tools.



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