



INSTITUTE FOR
MEDICAID INNOVATION

MEDICAID MANAGED CARE BEST PRACTICES COMPENDIUM



2015-2016



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Message from the Director
Jennifer E. Moore, PhD, RN



Welcome to the inaugural edition of the Best Practices Compendium produced by the Institute for Medicaid Innovation. The Compendium highlights innovative projects that Medicaid Managed Care Organizations have implemented across the country to increase access to high quality care while decreasing disparities and addressing social determinants of health.

Through a rigorous review process led by a panel of scientific experts, clinicians, patient advocates, and federal government representatives, the Compendium is divided into five categories that encompass the wide range of services that Medicaid Managed Care Organizations offer. These categories include the following:

1. Children with Chronic Conditions & Complex Healthcare Needs
2. Long-Term Care (MLTSS/LTSS) & Transitions of Care for Elderly
3. Preconception, Prenatal, and Postpartum Care
4. Mental Health & Substance Use
5. Understanding and Addressing Unique Needs of the Expansion Population

The best practices selected for this edition address key clinical topics including substance abuse during pregnancy, coordination of care for kids with complex health needs, and sickle cell anemia. As you will discover, many of the innovative projects connect the clinician, community, and families together in addressing important health issues.

Most importantly, this compendium would not be possible without the contribution of Medicaid Managed Care Organizations and their commitment to improving care for the nation's most vulnerable population. By compiling best practices, we have a unique opportunity to share knowledge that will ultimately impact millions of people.

About the Institute for Medicaid Innovation and Compendium

We are excited to share with you the inaugural edition of the Institute for Medicaid Innovation's 2015-2016 Best Practices Compendium.

The Institute for Medicaid Innovation is dedicated to generating and disseminating evidence that demonstrates the impact of Medicaid managed care on access to quality care for vulnerable populations in the U.S. It is our belief that Medicaid is not just about providing healthcare and measuring quality outcomes but also encompasses understanding how core community services address social issues and inequalities. The Institute has taken on the ambitious agenda to identify what works well in Medicaid and to also identify areas that need improvement. Through the work of the Institute, it is our goal to inform and enhance the Medicaid program.

The Compendium showcases innovative initiatives by Medicaid Managed Care Organizations that focus on access to high quality care for important clinical topics while reducing disparities and addressing social determinants of health. The initiatives highlighted in this year's Compendium include projects on community outreach, enhanced communication and technology strategies, wellness and preventive measures for seniors and the disabled, and infants, children, and pregnant women.

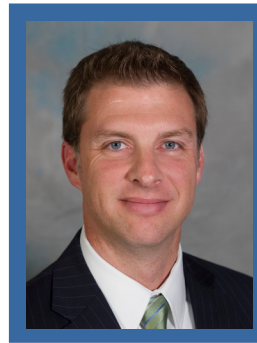
The Medicaid program serves over 70 million people with 66% enrolled in Medicaid Managed Care Organizations. As states move away from fee-for-service models and towards value-based payment systems, it is anticipated that enrollment in Managed Care Organizations will increase. Medicaid health plans partner with states to provide insurance coverage and benefits for low-income people, people with disabilities, foster children, and the poor elderly. Many of these individuals have multiple chronic conditions or physical health challenges that require additional services such as language interpretation, transportation, and other social services. Medicaid health plans are unique, compared to fee-for-service models, in their ability to develop programs and coordinate services by designing outreach and care management services that promote better health.

Medicaid Managed Care Organizations compete with other plans to participate in state Medicaid programs. Once selected to offer insurance coverage in the state, plans are expected to achieve quality and cost management metrics. Medicaid Managed Care Organizations are constantly seeking to identify new and innovative approaches, as highlighted in this year's Best Practices Compendium, to exceed these quality metrics.

Institute for Medicaid Innovation Best Practices Review Panel



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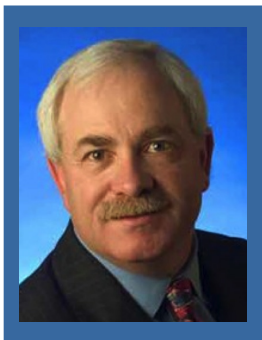
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MEDICAID INNOVATION

2015-2016

**MEDICAID MANAGED CARE
BEST PRACTICES COMPENDIUM**

Children with Chronic Conditions & Complex Healthcare Needs



High Value Care for Kids

UPMC for You

Description

This project, which began in May 2012, aimed to improve the value of care for children with medically complex conditions. This project had three components: provider flexibility and accountability, information sharing and transparency, and consumer engagement and activation.

There were 263 children in the target population, along with their families and caregivers, and providers at four pediatric practices. The children were all health plan members under age 21 living in Allegheny County, which is a mostly urban county that includes the Pittsburgh. The population had a variety of medically complex conditions, but was selected based on being in the top 10% of most expensive members two years in a row (2010 and in 2011). Within that larger population, 87 families were invited to participate in the consumer directed accounts portion of the health plan project.

This project demonstrated and documented a set of replicable methods and strategies to be used by other stakeholders as a road map for designing, implementing, and evaluating similar value-based payment models.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Promote patient-centered care through engagement and shared decision-making.
- Control or reduce the per capita cost of care or increase efficiency.

Research

Brown, R. S., Peike, D., Peterson, G., Schore, J., & Razafindrakoto, C. M. (2012). Six features of Medicare coordinated care demonstration programs that cut hospital admissions of high-risk patients. *Health Affairs*, 31(6), 1156-1166.

Claffey, T. F., Agostini, J. V., Collet, E. N., Reisman, L., & Krakauer, R. (2012). Payer-provider collaboration in accountable care reduced use and improved quality in Maine Medicare advantage plan. *Health Affairs*, 31(9), 2074-2083.

Kralewski, J. E., Dowd, B. E., & Xu, Y. W. (2012). Medical groups can reduce costs by investing in improved quality of care for patients with diabetes. *Health Affairs*, 31(8), 1830-1835.

Rosenberg, C. N., Peele, P., Keyser, D. R., McAnallen, S., & Holder, D. (2012). Results from a patient-centered medical home pilot at UPMC Health Plan hold lessons for broader adoption of the model. *Health Affairs*, 31(11), 2423-2431.

Turchi, R. M., Berhane, Z., Bethell, C., Pomponio, A., Antonelli, R., & Minkovitz, C. S. Care coordination for CSHCN: Associations with family-provider relations and family/child outcomes. *Pediatrics*, 124(Supplement 4), S428-S434.

Intervention

To facilitate identifying and understanding the target population, analysts developed the Population Dynamic Interactive View Tool (Population DIve), a portable, Microsoft Excel tool that lets stakeholders run rapid custom analyses on a defined population around costs and type of services used with embedded geographic tools to locate members by geography as well as by pediatric practice.

Analysts created patient profiles for each participating child. The profiles provided a snapshot of the care received by each patient in the target population over the past 12 months, including a breakdown of specific service use categories. The profiles were sent to the four participating practices on the 20th of each month between March 2013 and December 2014.

Various stakeholders from the community, families, health care providers, administrators and payers worked together to develop a value-based payment model with three main components: Provider flexibility and accountability; information sharing and transparency; and consumer engagement and activation.

Provider flexibility and accountability involved funding for care coordinators, expanded payments to physicians for other needed care coordination services, and shared savings. Information sharing and transparency covered patient profiles including service utilization and cost information, and quarterly quality reports. In the area of consumer engagement and activation, families identified consumer-directed accounts of \$500 each to cover nonclinical goods and services as being important to them.

The practice-based care coordination deepened the staff's understanding of the unique needs and challenges these families face, such as financial barriers and special accommodations for their child. This understanding, in turn, improved the level of assistance and care given to the child. Practices were able to make more informed decisions around care with the aid of the claims information for each child. Families appreciated the availability of consumer-directed funds for products and services to improve the health and quality of life of their child.

Outcomes

Patient outcomes. Patient outcomes were not measured for this program.

Clinician outcomes. Excellent HEDIS measures of quality were maintained throughout the project. The rate of child and adolescents' access to a primary care physician remained above 95% before and during the project. Annual dental visits increased from 56% pre-project to 65% during the second year of project implementation. Well-child visits for children aged 3-6 started at 77% pre-implementation and reached 84% in the first year of implementation. Adolescent well-care visits increased from 60% pre-implementation to 74% in the second year of implementation.

The program has generated several positive ripple effects, including new thinking around how practices are approaching children and youth with medically complex conditions, such as a push for medical home implementation, more care coordination by the practices, and planning around youth transition to adult care. Payers and providers also experienced improved communication in ways unrelated to this payment reform experiment. Now that UPMC for You has fully engaged pediatric practices in this effort, it is much easier to solicit their thoughts on other initiatives, including programs related to HEDIS scores and kids with ADHD, among others. If questions come up at the practices, physicians and staff can pick up the phone or send an email and get a quick, thoughtful

response, no matter the topic. Changes to the EPIC electronic health record system that were made for the project are still being used by the practices to more easily identify patients and groups of patients—an important step itself toward population health management.

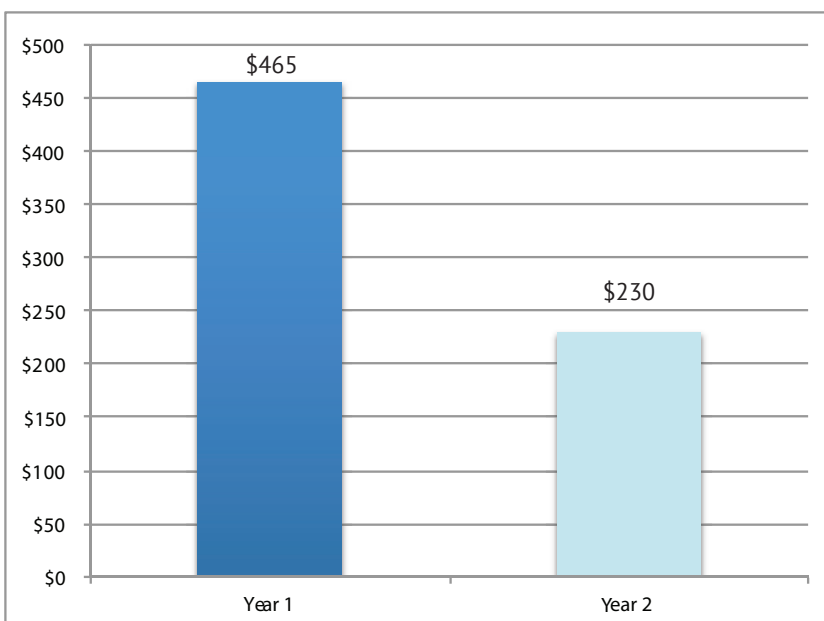
Community impact. This project helped to foster rich dialogue between a range of stakeholders from hospital and insurance administrators to physicians and care coordinators about some of the challenges and complexities in providing care for this population. In addition to regular monthly calls specific to the project, UPMC for You also hosted period learning collaboratives that were open to all staff members involved in the project and welcomed participants to discuss broader healthcare challenges. The topics of these learning collaboratives included shared decision-making and understanding cost of care.

Cost savings. In a statistical analysis, UPMC Health Plan’s Division of Health Economics compared the pre-program period (2011 and 2012) total cost of care for the target population to the post-program period (2013 and 2014) total cost of care and program costs for the target population and compared it to a matched comparison group. This evaluation took into consideration the program costs: funding for the consumer-directed accounts, care coordination and enhanced fee-for-service (FFS) payments to support chart review, coordination, and team meetings and other needed time not normally reimbursed through FFS. The analysis showed a statistically significant decrease in median costs ($p=0.04$) from before the program (March-December 2012) to the period during the program (March-Dec 2013 and March-December 2014).

Payment Reform Achieves Greater Savings than Comparison Group



Reduction in program’s Total Cost Relative to Change in Total for Comparison Group \$ PMPM)



Year 1 Savings of \$464.93 PMPM*
 2,561 Member Months =
Year 1 Savings of \$1,190,686

Year 2 Savings of \$229.90 PMPM*
 2,526 Member Months =
Year 2 Savings of \$578,454

Total Program Cost:
 \$423,000

Total Net Program Savings:
 \$1,346,140

ROI: 3.19

Key Components of Success

One key to the success was engaging a broad range of partners. The stakeholder advisory board included payers, providers, health care consumers, family caregivers, hospital and pediatric administrators, county and state health officials, nonprofit community health leaders, and behavioral health professionals. The partnership with four participating pediatric practices was critical to the success of the implementation. Those partnerships were formalized with contracts, but more importantly, the practices identified lead pediatricians who were project champions. Those lead physicians were critical to ensuring provider buy-in and adoption of the process and payment changes. Regular communication with those lead physicians, office managers, and their care coordinators was extremely important to clearly and accurately communicate expectations, challenges, and solutions.

Kudos To The Team

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B.E.S.T. Asthma Program – Breathe Easy. Start Today. ®

Keystone First

Description

The B.E.S.T. Asthma Program, started in 2013, is collaboration between Keystone First, a pharmacy services supplier (PSS), and network primary care providers (PCPs) to improve medication adherence and provide hands-on education to members with asthma with the aim of reducing asthma-related emergency department (ED) and inpatient (IP) admissions. A six-month pre/post analysis of all participating members in 2014 (N = 2,681) demonstrated statistically significant decreases in IP admissions and days, and potentially preventable ED visit (PPV) dollars and claims.

Keystone First and the PSS give providers the capacity to dispense asthma medication at the member's point of service (POS) and—through reimbursement and train-the-trainer instruction—supports provider education of members as they teach member the proper use asthma device and rescue and control inhalers. The program also provides member home delivery of refill medications before the member runs out.

Two observations have informed the development of the program: the primary care physician remains the primary patient contact for medication adherence (40.8%); and medication therapy management coupled with medication reconciliation account for more than 50% of the pharmacist's contribution to patient medication adherence. The training component of the program was informed by guidelines from the American Lung Association and the National Heart, Lung and Blood Institute.

Of the 2,681 participating members, 50% of those with asthma were age 6 or under, and 85% were age 12 or under, primarily African Americans living in Philadelphia County.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Control or reduce the per capita cost of care or increase efficiency.
- Address social determinants of health to increase access and engagement.

Research

Healthcare Intelligence Network. (2011). 2010 Benchmarks in improving medication adherence. Sea Girt, NJ, www.hin.com/library

National Asthma Education and Prevention Program. National Heart, Lung, and Blood Institute. (2007). Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma. Bethesda, MD. <https://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines/full-repor>

Rand, C. S., & Wise, R. A. (1994). Measuring adherence to asthma medication regimens. *Am J Respir Crit Care Med*, 149, S69.

Reznik, M., Silver, E. J., & Cao, Y. (2014). Evaluation of MDI-spacer utilization and technique in caregivers of urban minority children with persistent asthma. *J Asthma*, 51(2), 149-154.

Strategies for addressing asthma. (2015). Chicago, IL. <http://www.lung.org/lung-disease/asthma/for-health-professionals-and-volunteers/strategies-for-addressing-asthma.html>

Thoonen, B. P., Schermer, T. R., Van Den Boom, G., Molema, J., Folgering, H., Akkermans, R. P., GroL, R., Van Weel, C., Van Schayck, C. P. (2003). Self-management of asthma in general practice, asthma control and quality of life: A randomised controlled trial. *Thorax*, 58, 30.

Intervention

A pharmacy service supplier (PSS) contracted by Keystone First arranged to supply participating PCP offices with an automated unit consisting of a secured medication stock cabinet (fully stocked with asthma medication and supplies), computer system, prescription label-maker, and barcode scanner. To dispense medication or supplies, the member's prescribing information and medication directions are logged into the computer system, the cabinet automatically unlocks, and the UPC code on the item is scanned to verify dispensing of the product. A regulation-approved prescription label is printed and secured to the item. Finally, the PCP ePrescribes or faxes a prescription to the PSS for the items dispensed from the stock cabinet, triggering a claim to Keystone First while updating the inventory list for cabinet resupply. The pharmacy service supplier is reimbursed directly by Keystone First for any prescriptions written by the PCP. The PSS also contacts the patient four to five days before a refill is due ("pre-refill calls") and hand-delivers the refill medication to the member's home.

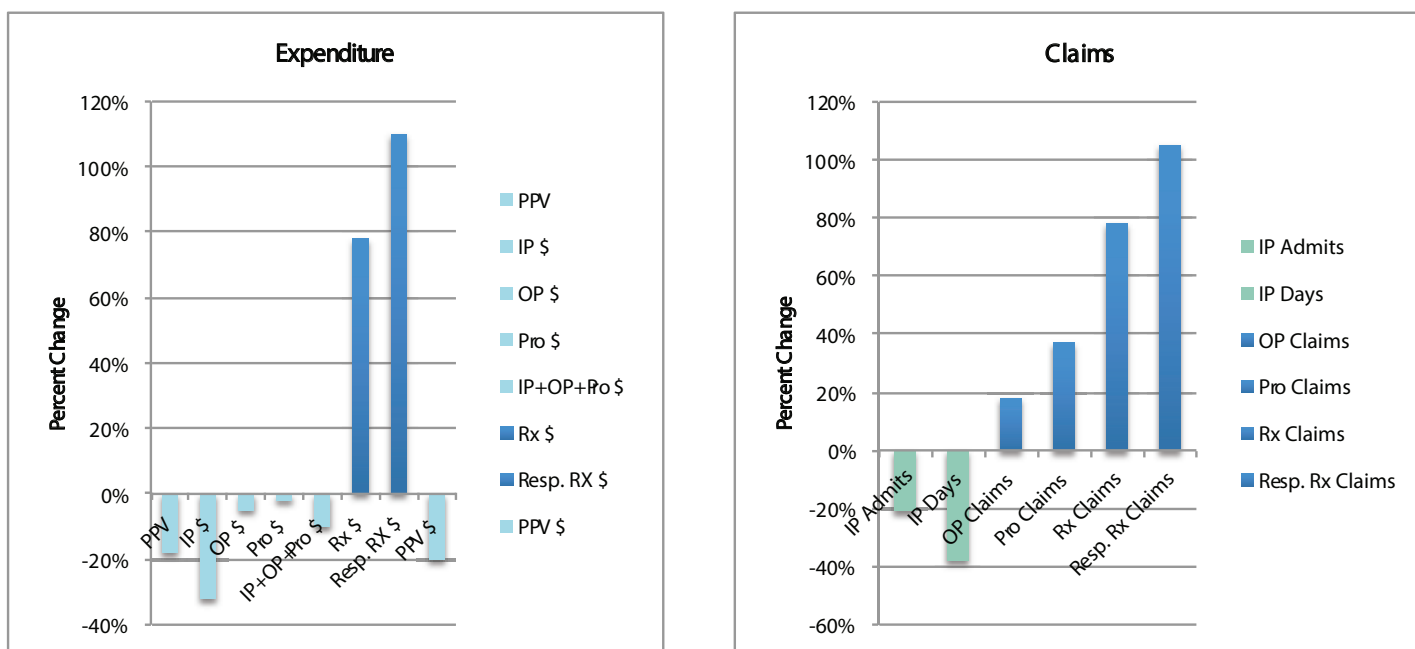
When contacted by the PSS, the member is asked to read out the number on the inhaler to calculate the time necessary for resupply and determine the member's level of medication adherence. This information is relayed to the PCP and Keystone First for member follow-up (including care management as necessary)

Thus, the member receives the asthma medication and supplies while in the physician's office, along with any education and training on using them. Upon request, a respiratory therapist from the pharmacy service supplier goes to the PCP's office to "train the trainer" using the proven teach-back method, where the member or guardian demonstrates use of the supplies to ensure proper technique and understanding. Specifically, the PCP trains the member on using his or her own asthma spacers and rescue and control inhalers. The member is properly fitted with a mask, which comes in three sizes, that is then secured to the spacers. The member is taught how to secure the appropriate inhaler to the inhaler port on the spacers, followed by administration of an inhaler dose.

Outcomes

Patient outcomes. To date, more than 5,500 Keystone First members have been affected by the B.E.S.T. Asthma Program. In 2014, 2,681 Keystone First members received asthma prescriptions or supplies. About 400-500 pre-refill calls are made weekly by the pharmaceutical service supplier. A six-month pre/post analysis (allowing for a 30-day grace period after engagement) of all participating members in 2014 (N = 2,681) demonstrated the following: (1) statistically significant decreases in IP admissions (-21.3%; P < 0.034) and IP days (-36.8%; P < 0.038); (2) statistically significant increases in outpatient visits and professional claims (+17.2% and +36.8%; P < 0.0001 for both); (3) statistically significant increases in overall prescription and respiratory prescription claims (+79.9% and +103.8%; P < 0.0001 for both); and (4) statistically significant decreases in PPV claims (-15.7%; P < 0.0001). All claims are reported as per member per year (PMPY).

B.E.S.T. Asthma Program-related Claims and Expenditures IP, Inpatient; OP, Outpatient; Pro, Professional; Rx, Prescriptions; PPV, Potentially Preventable (ED) Visits



Clinician outcomes. In 2014, 13 cabinet units were distributed to 22 participating practices in Keystone First's southeastern Pennsylvania service area; the remaining participating practices have elected to use their own secured cabinet spaces. Participating PCPs engaged their patients or parent/guardian in insurance-billable instruction on the proper technique and understanding in using asthma medication and supplies. Additionally, all asthma medication and supplies dispensed are either ePrescribed or faxed directly to the PSS without any additional administrative effort on the part of PCP office staff.

In identifying B.E.S.T. Asthma Program participants to engage the largest membership, Keystone First has partnered with the top regional pediatric providers (The Children's Hospital of Philadelphia, St. Christopher's Hospital for Children and Nemours/Alfred I. duPont Hospital for Children, Crozer ED, and other large independent practices) as well as two smaller pediatric specialist practices (headed by a pulmonologist and an allergist). One of the participating sites employs more than 90 providers and houses two units requiring weekly refills.

The success of the B.E.S.T. Asthma Program led to its recognition as the winning initiative for the 2014 National Association of Managed Care Professionals' (NAMCP) Innovation Award.

Community impact. The initiative has drastically reduced members' lost school days and parents'/ guardians' lost work days from acute asthma-related exacerbations and resulting hospitalizations. Additionally, Keystone First and the PSS can better monitor asthma medication adherence based on calculated refill dates, while refills are delivered directly to the member's home without the member having to make a separate trip to a pharmacy.

Cost savings. In 2014, Keystone First observed statistically significant increases in overall prescription and respiratory prescription expenditures (+98.9% and +137.0%; $P < 0.0001$ for both), but statistically significant decreases in nonprescription expenditures (inpatient + outpatient + professional claim dollars; -14.6%; $P < 0.0001$) and PPV expenditures (-20.6%; $P < 0.001$). All expenditures are reported as per member per month (PMPM).

Key Components of Success

The program's success is based on supporting asthma medication adherence in five ways: Access to asthma medication and supplies was provided at the physician's office, thereby addressing challenges to medication adherence at the member's POS. Because the patient receives medication and supplies in the PCP office, the patient can start therapy immediately. Putting a refill in the patient's hands near the refill due date without requiring member action established continuity in asthma medication management. Billing was simplified: Keystone First was billed directly for the medication and supplies, as well as for any provider-conducted demonstration and/or evaluation of patient ability to properly use the approved asthma supplies. The program received high rates of PCP buy-in, leading to higher levels of member engagement. Assisting PCPS identified a program champion within the practice and worked with them to incorporate the program into PCPs' workflow.

Kudos To The Team

Team Lead

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Collaborative System's Monitoring and Planning Utilizing the Child and Adolescent Needs and Strengths (CANS) Assessment in Pennsylvania's Community Behavioral Health System

PerformCare/CABHC/BHSSBC/CDR

Description

PerformCare partnered with Community Data Roundtable (CDR), Capital Area Behavioral Health Collaborative (CABHC), and Behavioral Health Services of Somerset and Bedford Counties (BHSSBC) to identify systems of care and objective criteria for the Child and Adolescent Needs and Strengths (CANS) Assessment for use as a decision-support tool in managing the care of children and adolescents with serious mental illness under consideration for behavioral health rehabilitation services (BHRS).

Analysis of child cohorts with and without autism sorted by levels of severity displays vastly different expected treatment trajectories; children with lower severity scores at the beginning of care are expected to have worse outcomes as treatment progresses, while children who begin with higher severity scores are expected to improve in the BHRS. When a psychologist evaluator knows severity levels, he or she can make better-informed decisions regarding the type of services to which they should refer their clients based on predefined severity levels.

The population for this program includes children (mean age, 7; range, 3-21) with serious mental illness and/or autism. The population is primarily male (70%) and Caucasian (63%), but some localities contained concentrations of racial and/or ethnic minorities (African American, 15%; Asian 2%; other, 20%, primarily Latinos).

PerformCare and CDR used a cloud data analytic platform called DataPool™ to administer, store, analyze, and move CANS information in a secure and clinically helpful manner. Various statistical modeling techniques were then applied to the CANS data to identify needs in the system and to craft decision-support algorithms for the evaluators using CANS data to make referral decisions. These included the following: cluster analysis (K-means and cosign variance) to identify CANS items that “drive” risk and need; communimetrics algorithms to identify clinical profiles that could match for various programs in the system of care; and likelihood scenario analyses to understand the relationship between services prescribed and their impact on clinical outcome.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Control or reduce the per capita cost of care or increase efficiency.
- Demonstrate accountability of Medicaid health plans, including addressing fraud and abuse.

Research

Lyons, J. S. (2009). *Communimetrics: A communication theory of measurement for human service enterprises*. Dordrecht, Netherlands: Springer, 93-134.

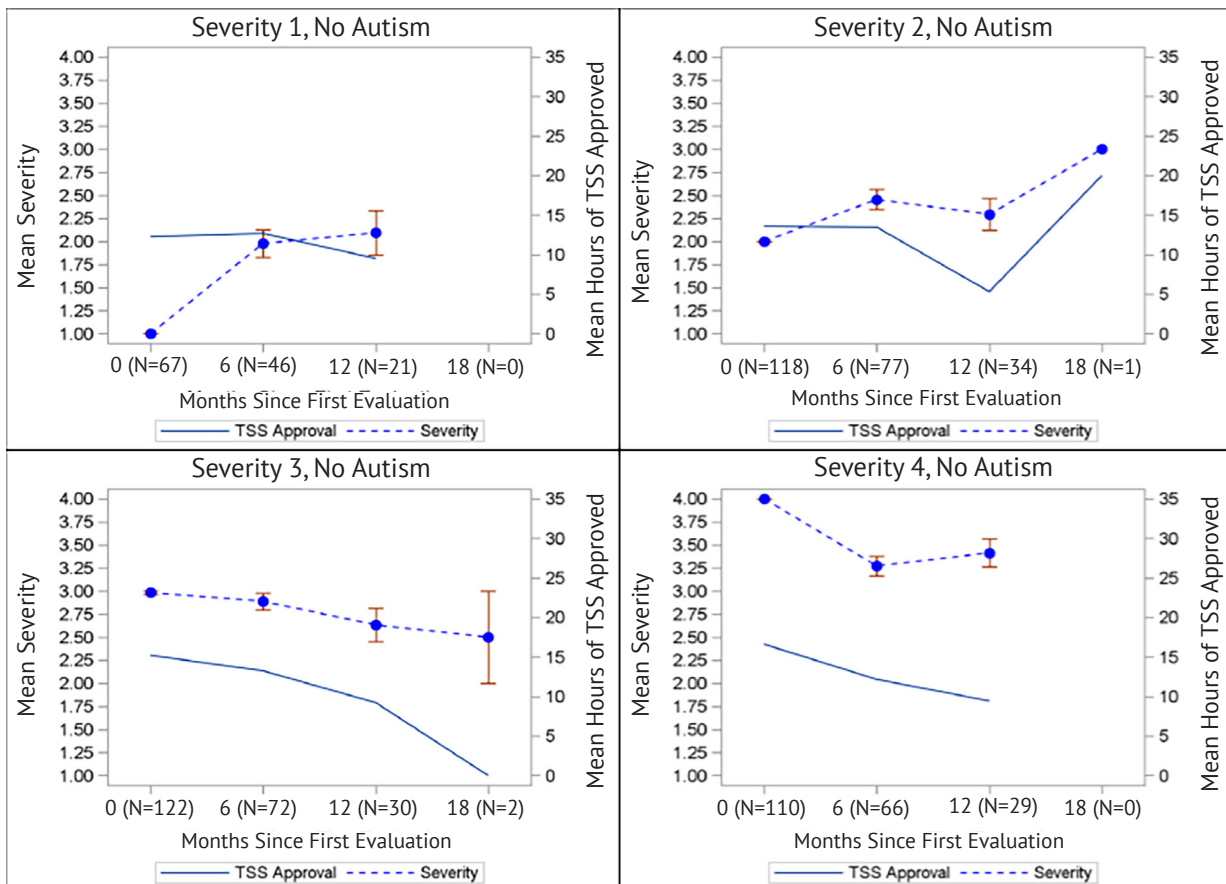
Intervention

To set up the CANS outcomes system, PerformCare and its partners—CDR, CABHC, and BHSSBC—worked for two years to establish a strong, validated measurement program in the BHRS. Through collaboration with CDR, PerformCare formed stakeholder groups in participating contracts to steer the overall program. The stakeholder groups identified partnering providers for implementing the CANS measurement system, as well as appropriate versions of CANS to measure the most important clinical features for any given local system of care. The stakeholders also agreed that CANS should be scored by psychologist evaluators, who function as key referral entry points to BHRS care. The decision-support tool provided the evaluator with one or two treatment recommendations for consideration that best matched the CANS profile before service authorization. PerformCare put its resources into monitoring and managing the implementation, so that the group’s vision could be actualized as intended.

Outcomes

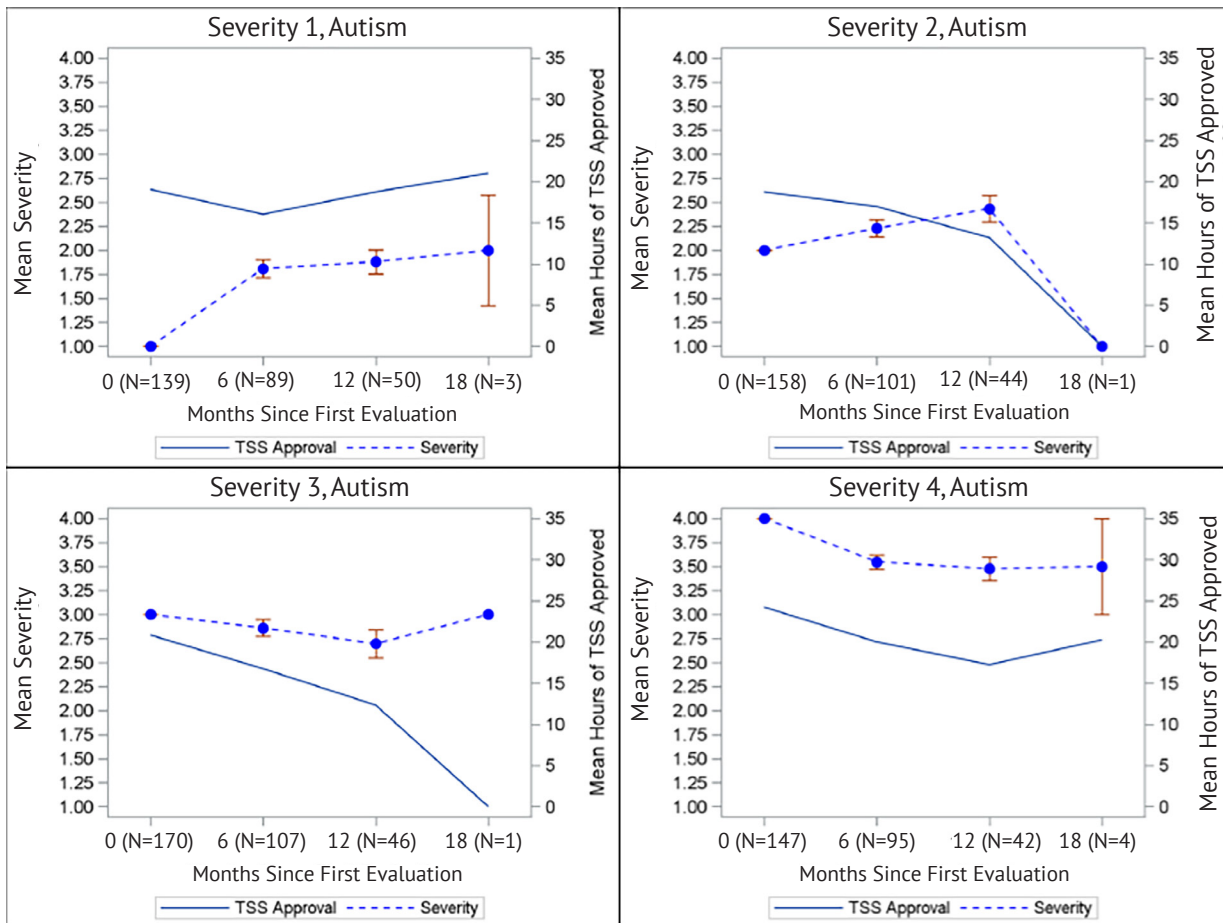
Patient outcomes. The generation of outcomes information relating to BHRS of any kind is, in itself, a major accomplishment. In the 2013 pilot study (markedly expanded since), a statistically significant reduction of 11% ($P < 0.05$) was observed in the intensity of BHRS-recommended services. Outcomes panels for children both with and without autism, having vastly different expected treatment trajectories, are displayed below. The cohorts were analyzed after the populations were sorted into one of four groups (severity 1 to 4), where lower severity represents reduced risk and general clinical presentation, and higher severity represents very high clinical risk and need.

Overview: No Autism



After cohort stratification, the treatment trajectories for children in different severity categories appear very different; children with lower severity scores at the beginning of care (especially children classified as severity 1) are expected to have worse outcomes as treatment progresses, while children who begin with higher severity scores (severity 4) are expected to improve in the BHRS.

Overview: Autism



Clinician outcomes. Clinician outcomes were not measured as part of this program. However, information derived from the CANS assessments may help psychologist informed decisions regarding the type of service to which they should refer clients who fall into any of the predefined severity levels.

Community impact. The outcome data above identify individuals who are languishing in the BHRS system but could benefit from other evidence-based programs available in the system of care. With other analytic techniques, PerformCare identified multiple members like this. Two such programs are Parent-Child Interaction Therapy (PICT) and Multisystemic Therapy (MST), evidence-based programs that are validated to affect the type of children increasingly observed who do not improve with BHRS—those often falling into the severity 1 category (N=1) and who, on average, progress to more severe states.

Cost savings. Not applicable.

Key Components of Success

A successful outcomes intervention requires appropriate technology; collaboration between and among payers, government, clinicians, and patients; an auditing and training arm to maintain the program; and ongoing data review and action.

Kudos To The Team

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Community Health Worker Embedded in Primary Care Practice for High-Risk Asthma Pediatric Members

Keystone First

Description

A community health worker (CHW) from the Keystone First Community Care Management Team was embedded into the Center for the Urban Child at St. Christopher's Hospital for Children to support management for high-risk asthma pediatric members. The embedded CHW serves as an extension of the practice and health plan care management by providing face-to-face care coordination, home assessments, and asthma-related education for pediatric members and their families while addressing the social determinants affecting member health.

Keystone First members ages 2-21 years identified as high-risk for poor asthma control and their families were considered candidates for participation in the embedded CHW program. To date, this program has supported 32 members. The Center for the Urban Child at St. Christopher's Hospital for Children is located in the eastern part of northern Philadelphia, home to a large Hispanic population, an area with the third-highest childhood poverty rate in the country (45%), the highest rate of violent crime in the city, the second-highest rate of food insecurity in the nation, and other characteristics associated with vulnerability to poor health outcomes.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Promote patient-centered care through engagement and shared decision-making.
- Control or reduce the per capita cost of care or increase efficiency.
- Reduce disparities in care of racial and ethnic minorities.
- Address social determinants of health to increase access and engagement.

Research

Beck, A. F., Bradley, C. L., Huang, B., Simmons, J. M., Heaton, P. C., & Kahn, R. S. (2015). The pharmacy-level asthma medication ratio and population health. *Pediatrics*, 135(6), 1009-1017.

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Pennsylvania Department of Health. (2014). Pennsylvania Asthma Fact Sheet 2014. Data Source: PA Health Care Cost Containment Council (PHC4).

Kangovi, S., Grande, D., & Trinh-Shevrin, C. (2015). From rhetoric to reality—Community health workers in post-reform U.S. health care. *N Engl J Med*, 372(24), 2277-2279.

Intervention

In early 2015, a Keystone First-funded community health worker (CHW) from the Keystone First Community Care Management Team was embedded into the Center for the Urban Child at St. Christopher's Hospital for Children to support practice-based population health management for high-risk members with asthma.

Member referral and intervention in the embedded CHW program is affected by collaboration between Keystone First care managers and St. Christopher's. First, Keystone First provides practice-based population profiles of pediatric members with asthma who are candidates for this program. The St. Christopher's team provides the physical space for the health plan-sponsored CHW and shares in the day-to-day supervision of the CHW. Ongoing, regular meetings between the two teams improve the process and communication cycles, tool development, work flow design/redesign, and reporting.

The CHW serves as a community-based extension for both Keystone First care management and for the outpatient asthma clinic at St. Christopher's. She engages referred members and provides ongoing, face-to-face member care coordination, home visits and education concerning proper medication use and environmental triggers that contribute to asthma symptomology. The CHW supports members' families in scheduling members' medical appointments, ensuring families are connected to a pharmacy so members are always able to get medications when needed, connecting families to other needed social services, and providing emotional support to families, who are often overwhelmed.

The CHW also helps connect members to the Healthy Homes program, a federally funded, state-run initiative that performs free home hazard assessments and subsequent interventions in at-risk homes. Finally, the CHW reports back to the telephonic care managers and providers at St. Christopher's Hospital regarding her findings from the home environmental scan, which, in turn, supports improved communication between care team and the members' families.

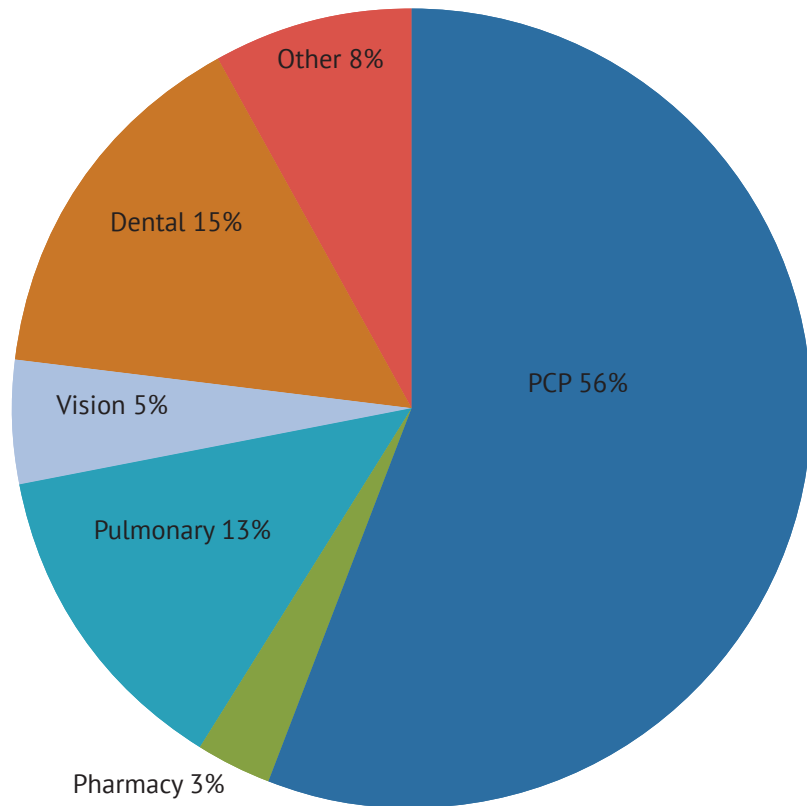
Outcomes

Patient outcomes. The CHW can support multiple intervention pathways for any given member. Based on member needs at the time of initial home visit, 76% have had at least one medical referral pathway. Similarly, 88% have had at least one social service pathway, an average of 2.1 social service pathways per member, the majority of which are family-centered pathways.

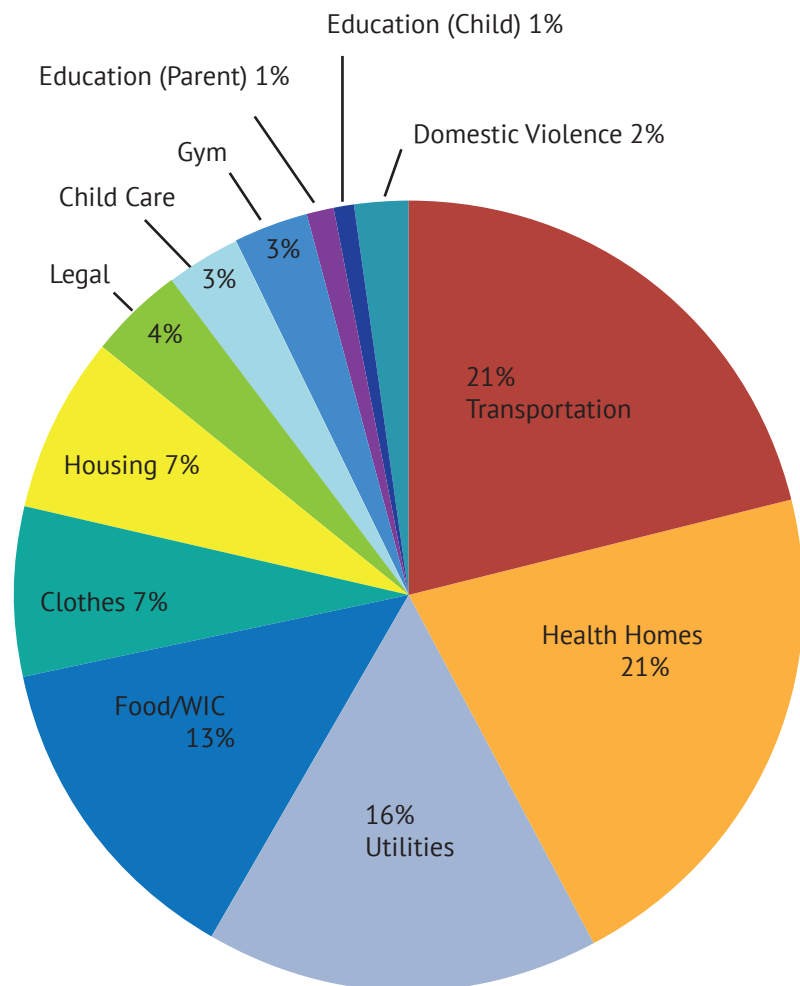
"It took new windows"

The embedded CHW met 12-year-old "Billy" and his family during a clinic visit and scheduled a follow-up home assessment. At Billy's home, she observed broken and taped-over windows which led to a heavy reliance on space heaters, as well as evidence of pest infestation, both of which were potential triggers for uncontrolled asthma. The embedded CHW collaborated with the Keystone First care manager, St. Christopher's team, the Sisters of Mercy and Healthy Homes in the Philadelphia Department Public Health to order and install brand-new windows. After having this critical home improvement, the family became more open to asthma education and greater medication adherence. As a consequence, "Billy" has not been to the hospital since January 2015.

Medical Connection Pathways



Social Service Pathways



Clinician outcomes. Clinician outcomes were not measured as part of this program. However, the embedded CHW program fosters the creation of opportunities for new types of relationships and communication improvement cycles between Keystone First and St. Christopher's that has improved coordination of care management for pediatric members with asthma. St. Christopher's providers report the collaboration serves as an incredible support for their practice and that the timely feedback provided by the CHW after home visits has improved providers' ability to pose questions to patients during appointments.

"The collaboration between Keystone First and St. Christopher's Center for the Urban Child represents everything that health care COULD and SHOULD be. Through sharing data, resources and best practices, we are hoping to close the care gaps for our most vulnerable children with asthma. The energy and willingness to innovate on the payer side has reinvigorated my faith in the U.S. health care delivery system. We are hoping to standardize, publish and replicate this model for others to learn from us." Katie E. McPeak, M.D. Medical Director, Center for the Urban Child at St. Christopher's Hospital for Children.

Community impact. The CHW program has fostered strong connections between and among provider, payer, member, and community-based organizations to improve coordination of asthma care in the community. Successful asthma management leads to fewer missed school days for children and fewer missed work days for parents/caregivers, leading to increased community-based productivity. Cost savings. Not applicable.

Key Components of Success

Placing a Keystone First-funded, embedded community health worker who acts as a field-based extension of a PCP practice and as the physician's "eyes and ears" to directly report relevant member issues and barriers is the heart of the program. Likewise, home visits have brought an enhanced capacity to identify and support member and family goals.

Committed leadership and supportive environment of both Keystone and St. Christopher's teams has contributed to the program's success, as has coordination of care management services within and between Keystone First and St. Christopher's teams, and collaboration with community services. The program involves regular, ongoing meetings between Keystone First and St. Christopher's staff to discuss process and communication improvement cycles.

Data and enhanced information-sharing systems related to identifying members targeted for intervention has been vital, as well as determining how to measure and track outcomes in a collaborative manner.

Kudos to the Team

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Improved Readmission Rates for Low Birthweight NICU Graduates in Their First Year of Life

United Healthcare Community Plan Pennsylvania and ProgenyHealth

Description

Hospital readmission occurs frequently for infants who are discharged from a neonatal intensive care unit (NICU). NICU nurse case managers engage and educate families of NICU graduates while the infant is in the hospital and educate the families about issues that could lead to a readmission. Case managers apply evidence-based best practices in developing customized care plans, and they plan outreach according to the individual needs of each infant and family.

The managers also collaborate with specialists and social workers to ensure the best outcome for each infant. Ongoing family education, appointment and vaccination reminders, continuous follow-up, and the availability of care management nurses to families by phone 24/7, all work to keep these young Pennsylvania members healthy and out of the hospital.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Promote patient-centered care through engagement and shared decision-making.
- Control or reduce the per capita cost of care or increase efficiency.

Research

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Lorch, S. A., Passarella, M., & Zeigler, A. (2014). Challenges to measuring variation in readmission rates of neonatal intensive care patients. *Academic Pediatrics*, 14(5 Supplement).

Patient Protection and Affordable Care Act. 111th Congress of the United States of America at the Second Session. (2010). Washington, DC. <http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>

Wade, K. C., Lorch, S. A., Bakewell-Sachs, S., et al. (2008). Pediatric care for preterm infants after NICU discharge: High number of office visits and prescription medications. *J Perinatol*, 28, 696-701.

Intervention

The health plan conducted a retrospective data analysis from its Baby Trax® database on all NICU patients who were Pennsylvania members that required a readmission in 2013-2014. These readmissions included both medical diagnoses (78.8%) and surgical procedures (21.2%).

The program is designed to provide health care members with enhanced case management support and care coordination by a dedicated nurse case manager after their baby is admitted to the NICU. The family is contacted by a case manager when the infant enters the NICU, and he or she is available to the family 24/7 the first year of life. Case managers assist with discharge planning in conjunction with the hospitals and supervise the transition of care to the home. They are also available 24/7 to ensure families are connected to their providers and receiving necessary health care services after NICU discharge. Case managers work to educate and empower families so they feel comfortable and confident. They provide parents with valuable information about milestones, health, nutritional needs, and developmental goals. In addition, if a mother is interested in breastfeeding support, a lactation consultant is available to her as needed.

Outcomes

Patient outcomes. The outcomes data reviewed from the Baby Trax® database were from the fifth program year covering the 12 months from June 2013 to May 2014. During this time, there were 105 readmissions of NICU graduates in all birthweight categories. For the low birthweight (LBW) infants in this group, those less than 2.5 kilograms, there were 50 readmissions out of 269 LBW infants. The readmission rate of the LBW infant population was 18.6% and compares with the benchmark of 27.4%. The readmission rate for LBW infants managed by the health plan was 32% lower than the benchmark data.

Clinician outcomes. Upon review of those in the case management program, participating families had infants with lower readmission rates than those who did not participate. In the cohort of infants who required readmission, the enrollment rate in case management was only 29%. In contrast, of the population not requiring readmission, 48% of the families were enrolled in case management. From this review, it is clear that enrollment in the case management program reduced the likelihood of a readmission.

Community impact. Families who enroll in the program rate their satisfaction among the highest levels of satisfaction. The plan already carries a satisfaction rate of 88% among all members.

Cost savings. The paid-claims database demonstrates that Medicaid payers in 2014 were paying approximately \$25,000 per readmission for NICU graduates. During the period of 2013-2014, the program reduced LBW readmission for NICU graduates by 32% from benchmark data, which are approximately 24 readmissions. Estimated savings for the state is approximately \$600,000.

Key Components of Success

The initial challenge faced by case managers is to make certain families understand the value of having a dedicated case manager to support them and then to encourage them to enroll in the program. Motivational coaching of case managers better equipped them to engage parents in a conversation. It is also very important to let families know that the service is provided at no cost to them and is an additional benefit being provided to them by their health plan. Educating and reassuring parents is a key factor.

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My Route to Health Sickle Cell Program

Centene Corporation

Description

The program identifies members with a sickle cell disease (SCD) diagnosis and subsequently determines how well the member manages his or her disease and compliance with hydroxyurea. This is determined by using member claims data on hospital emergency department (ED) use, inpatient visits, outpatient visits, gaps in preventative care, and narcotics use. The program aims to improve the health of these members by removing care barriers, providing member education on the disease, distributing new member support kits, and offering provider education on hydroxyurea.

A particular emphasis has been placed on the pediatric sickle cell population by providing pediatric-specific information on pain, communicating with local specialists to increase pediatric access to care, creating transition of care plans for teens, and increasing hydroxyurea prescriptions. The program has shown a decrease in ED visits and inpatient admissions, while increasing hydroxyurea use, the number of preventative care visits, and the number of members with SCD receiving care management.

The initiative began in 2011, but an increased focus was placed on the program in 2014.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Control or reduce the per capita cost of care or increase efficiency.

Research

Candrilli, S. D., O'Brien, S. H., Ware, R. E., Nahata, M. C., Seiber, E. E., & Balkrishnan, R. (2011). Hydroxyurea adherence and associated outcomes among Medicaid enrollees with sickle cell disease. *Am J Hematol*, 86(3),273-277. doi: 10.1002/ajh.21968

Platt, O. S. (2008). Hydroxyurea for the treatment of sickle cell anemia. *N Engl J Med*, 358, 1362-1369.

Wang, W. C., Oyeku, S. O., Luo Z., Boulet, S. L., Miller, S. T., Fish, B., Thompson, B. W., & Grosse, S. D. (2013). Hydroxyurea is associated with lower costs of care of young children with sickle cell anemia. *Pediatrics* [epub September 2, 2013].

Wang, W. C., Ware, R. E., Miller, S. T., Iyer, R. V., Casella, J. F., Minniti, C. P., ... Thompson, B. W. (2011). A multicenter randomized controlled trial of hydroxyurea (hydroxycarbamide) in very young children with sickle cell anemia. *Lancet*, 377(9778), 1663-1672. doi:10.1016/S0140-6736(11)60355-3

Intervention

In 2014, the health plan's care management team was re-educated on the importance of hydroxyurea use, on completing the clinical assessment and provider outreach. Health plan staff also has the opportunity to present sickle cell cases to a top pediatric hematologist to obtain feedback and assistance on how to manage members with sickle cell. An emphasis was placed on removing barriers, with member and provider education and outreach.

Reports were created to assist staff in prioritizing member outreach based on risk level and hydroxyurea candidacy. Goals and metrics were set to assess and compare the performance of the intervention and the health plans. One goal was to complete at least 50% of the sickle cell clinical assessments per care management candidate month. Health plan-specific goals were also set for hydroxyurea fills per member per month (PMPM) per 1,000.

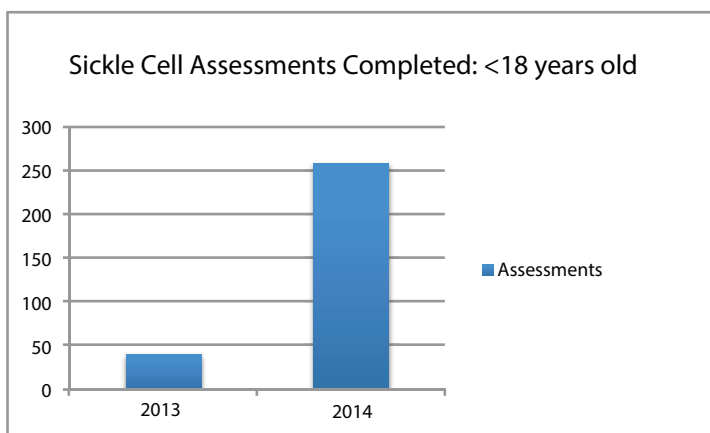
To encourage members to contact the health plan and complete the clinical assessment, Centene developed a sickle cell support kit. This kit provides two copies of a quick reference guide on sickle cell disease, digital thermometer, collapsible water bottle, hot/cold pack, pain bracelets, and a “Living Well with Sickle Cell” booklet. The quick reference guide is meant to be given to teachers or caregivers who are not familiar with the disease. The guide provides information on when to get medical assistance and what to do during pain crises, offers a pain-level scale for children, and gives tips on how to stay well. The pain bracelets are meant for children as well. There are three bracelets: one for mild pain, moderate pain, and severe pain. These bracelets allow children to discretely inform their teacher or caregiver of their pain level.

Provider outreach and education is important to increase the use of hydroxyurea and improve care and treatment access. An increased effort was placed on provider outreach for members who have not had a hydroxyurea fill in the past 12 months. The letter asks the provider to consider prescribing hydroxyurea, serves as a notice of noncompliance if the hydroxyurea was prescribed, and reminds providers about Centene’s care management program. A reference guide for prescribing hydroxyurea was recently developed for nonhematologists who manage sickle cell patients. The guide is meant to increase the number of hydroxyurea prescriptions by providing useful information about the drug’s indications, precautions, dosing, titration, monitoring, and side effects. A pilot program, which will provide nonhematologists the opportunity to consult with hematologists, is in development for Missouri and Kansas.

Outcomes

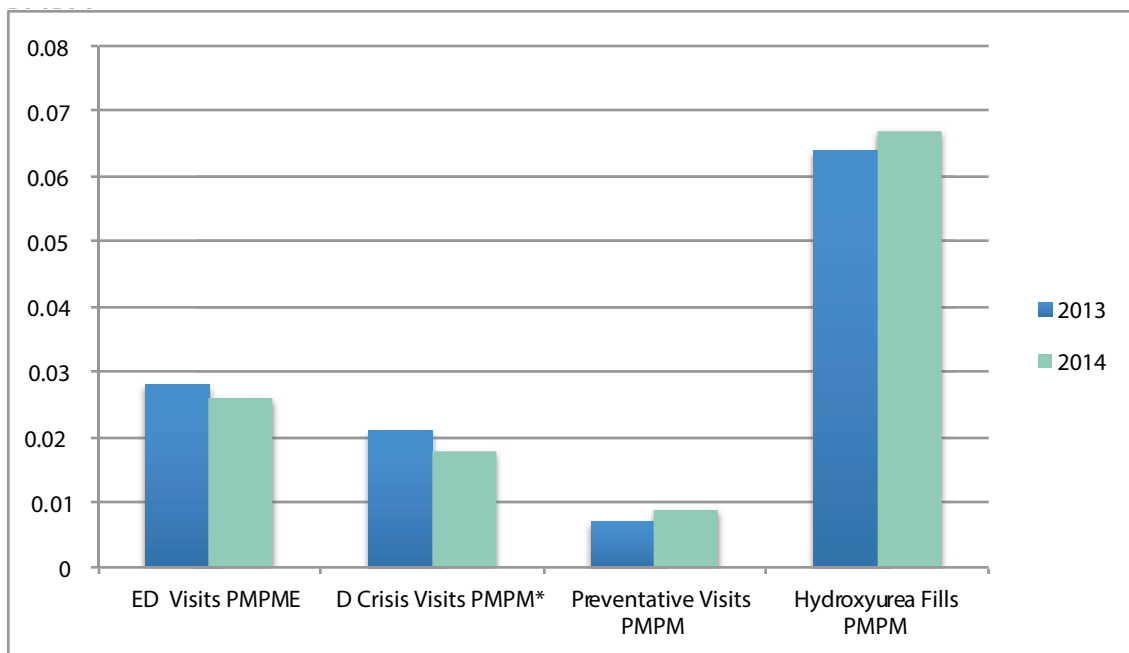
Patient outcomes. Since revamping the program and implementing the new processes and initiatives, there has been increased identification of pediatric members with sickle cell and enrollment into care management.

Sickle Cell Assessments Completes



Hydroxyurea prescriptions by providers increased in this population from 0.064 in 2013 to 0.067 PMPM in 2014 ($p=0.242$) and preventative care visits increased from 0.007 to 0.009 PMPM ($p=0.013$). ER visits decreased from 0.028 to 0.026 PMPM ($p=0.121$) while ED crisis visits declined from 0.021 to 0.018 PMPM ($p=0.049$).

ED Vists and ED Crisis Vists



*statistically significance at p< 0.01 level

Clinician outcomes. The program has also seen an increase in the rates of hydroxyurea prescriptions and preventative care visits while there has been a decline in the rates of ED visits and ED crisis visits.

Community impact. Members who visit the emergency department less frequently lighten the burden on the ED.

Cost savings. The decrease in ED crisis visits produced by this initiative resulted in an overall cost savings of 11.9% (almost \$40,000) from 2013 to 2014 in the pediatric population. This was calculated based on an average ED crisis visit cost of \$528.52 per visit with 540 crisis visits in 2014.

ED Crisis Visit

Savings	Visits	Dollars*
Predicted 2014 ED Crisis Visit amounts based on 2013 PMPM rate	613	\$323,981.16
Actual 2014 ED Crisis Visit Amounts	540	\$285,399.39
Estimated 2014 ED Crisis Visit savings	73	\$38,581.77
% Reduction in 2014 ED Crisis Visits	11.9%	

Key Components of Success

The first element that contributed to the success of the intervention was the staff training and re education about the disease, importance of hydroxyurea, and utilization of the outreach reports. Staff members worked hard to reach out to the highest-risk members, who may not have a reliable phone or home address, and worked with their providers to ensure hydroxyurea was prescribed and filled. This resulted in more sickle cell clinical assessments being completed and an increase in hydroxyurea prescriptions.

Staff re-education contributed to the second element, which is provider outreach and utilizing community support services. Continued communication with providers connects members with quality care and community services. Another element is the health plan's partnership with a pediatric hematologist/oncologist who evaluates all program aspects and provides feedback, advice, and assistance to health plan staff during sickle cell rounds.

When considering a similar initiative, other plans should know that it is important to create a streamlined care management process that is effective for staff and provides quality care for members. Using outreach reports helps identify, stratify, and prioritize member outreach based on the disease state or intervention. Access to community support services, specialists, and provider communication are imperative. Providing member incentives and transportation to doctor visits or treatments are also important to successful interventions.

Kudos to the Team

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Pediatric and Medically Complex Children Care Coordination

Simply HealthCare and Better Health Care Plans

Description

Significant advances in pediatric care made throughout the last half century have prolonged the survival of children with complex health conditions. These children often now live with significant physical and neurologic disorders, which can include lifelong disabilities, declining health, and increasing medical fragility and complexity. The rising numbers of such children and youth are placing new and more complex demands on the health care system. Children with complex conditions often require a multifaceted approach to care coordination, with significant family support and education, primary care provider (PCP) engagement and assistance, and a multi-coordinated specialized care plan emphasizing medical, behavioral, pharmacy, technology, caregiver assistance, and service needs.

The program began in 2014. The members have been targeted for intervention based on predictive modeling and analytics. Monthly utilization and pharmacy reports and HRA responses have also been used, as well as internal referrals from medical management teams, member services, providers, and member caregivers. The average age is 6.7. Approximately 34% are Hispanic.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Promote patient-centered care through engagement and shared decision-making.
- Control or reduce the per capita cost of care or increase efficiency.
- Reduce disparities in care of racial and ethnic minorities.
- Demonstrate accountability of Medicaid health plans, including addressing fraud and abuse.
- Address social determinants of health to increase access and engagement.

Research

Burke, A. (2010). Impact of children with medically complex conditions. *Pediatrics*, 126(4), 789-790.

Intervention

The Medically Complex Children Care Coordination plan seeks to reduce controllable expenses associated with high utilization and to improve quality of care through appropriate and timely provision of care and coordinated services using the following interventions: Thorough in-home/ telephonic comprehensive assessment, disease assessment, and home evaluation; medication reconciliation and discrepancy identification; comprehensive care plan, including medical, behavioral, and service needs of the member; development of personal health record, including member and providers in creation of the record; development of self-management/monitoring plan; education sessions (disease, signs, and symptoms); coordination of outpatient appointments, including transportation; coordination of DME and home health needs; coordination of visiting physician when needed; identification and coordination of community resource needs and caregiver support needs; and designs for children in private duty nursing and skilled nursing facility transitions.

Outcomes

Patient outcomes. The program has made documented improvements in health outcomes, including reduction or elimination of malnutrition diagnosis, coordination of DME and home health needs (incorporating member and caregiver cultural values and beliefs), coordination of dental care and waiver program inclusion, and coordinated pharmaceuticals, eliminating dangerous drug interactions.

Clinician outcomes. Clinician outcomes were not measured as part of this program. However, an important component of the program is ensuring coordination of care.

Community impact. The program helps bridge what can often be fragmented systems of care so the different parts can work in tandem to meet the needs of Florida's most vulnerable Medicaid beneficiaries. The program helps children manage serious medical and behavioral health conditions so that they can participate in schooling and other activities important to childhood development.

Cost savings. Of complex child members targeted for intense case management through predictive modeling, expenses per month were reduced by an average of \$199,034. Actual savings has reached \$625,592.

Key Components of Success

Programs designed for children require the participation of teachers, administrators, and school nurses in addition to the traditional care teams associated with management of chronic conditions. The plan had to focus all the various stakeholders on the best action plan to meet the needs of the member and their families.

System flexibility is important. An organization must be willing to staff the program at a smaller caseload per case manager than usual to manage the individual member. Family buy-in is essential to the program's success and is enhanced by caregiver assistance programs, education, and services. The following elements promote the achievements of this program: Incorporation of cultural values and practices into care plans and home evaluations; a member-centric approach, including bilingual case managers and coordinators; and extensive training of complex case managers, with a focus on skilled nursing transitions, private duty nursing options, and state assistance/community-based programs. Also important was a coordinated approach, focused on pediatric medical, behavioral, and social needs of the member and caregiver. Consistent communication with provider(s), state partner, community resources, case manager, pharmacy, member services, and member/caregiver was vital

Kudos to the Team

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Pediatric Dental and Well-Visit Outreach Program

UPMC Health Plan

Description

In October 2013, UPMC Health Plan contracted with an outside vendor, Clark Resources, in an effort to improve preventive dental screening and well visit rates for its pediatric population. Clark Resources is a fully functional call center/customer support center that provides inbound and outbound telephone services. Vendor staff offered assistance in locating participating providers and scheduling dental and well-visit appointments. As a result of the outreach, targeted children attended more than 3,642 dental and 2,718 well-visit appointments in 2014.

The initiative targeted approximately 93,000 MA and 19,000 CHIP members throughout Pennsylvania between the ages of 3-21 who had gaps in care.

The program described is responsive to the following Medicaid priority area:

Priority

- Improve access and health outcomes for vulnerable populations.

Research

Greenberg, B., Kumar, J. V., & Stevenson, H. (2008). Dental case management: Increasing access to oral health care for families and children with low incomes. *Journal of the American Dental Association*, 139(8), 1114-1121.

McPherson, K. (n.d.). State strategies to improve dental compliance in Missouri's Medicaid population. Missouri Foundation for Health.

Intervention

The health plan identified the pediatric population due or overdue for a dental and/or well visit based on claims data. The population was grouped by household to improve the efficiency in which outreach could be made, as well as to minimize multiple calls to a household. Outreach was initially prioritized to households with multiple gaps (both dental and well-visit gaps). The health plan refreshed the data monthly, based on current membership and claims information.

As the program continued throughout the year, the health plan evaluated the outreach strategy and determined that the most efficient use of resources would be to shift the focus to individuals and households who had not yet been contacted. Those who had at least one contact attempt were still contacted, but as a lower priority.

The health plan contacted households to remind them that their child/children were due for preventive services. Assistance was offered in scheduling an appointment or in locating a new provider, as needed. If the vendor staff assisted the family in scheduling the appointment, a reminder call was made to the family beginning 72 hours before to the appointment. If the family was not initially reached, two subsequent attempts were made, at 48 and 24 hours before the appointment.

Key Components of Success

Employing an outside vendor for this program improved the efficiency of the outreach. Vendor staff were trained specifically for this campaign, and although they focused on this particular project, they also provided additional member support services. Vendor staff had the capability to update the member's PCP listed on file and have a new member identification card mailed to the member. This reduced the need for a member to be transferred to another internal representative. Inbound calls from members who had received a message from the vendor staff were directed to the internal member services department. The internal member services department assisted these members with appointment scheduling, and this process was seamless to the member.

This program was a targeted outreach campaign to a high volume of members, with the main goal of scheduling both well-child and dental visits. Outsourcing this clerical function was efficient from cost and process perspectives. On-site visits/training was key to a smooth implementation. Because of the overlap of potential responsibilities by the vendor and internal member services staff, it was important to develop clear workflows. Maintaining ongoing and frequent communication with the vendor post-implementation was also vital to program success.

Kudos to the Team

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Psychotropic Medication Management Coaching Program (PMC)

Amerigroup Georgia

Description

The use of psychotropic medications with children is a controversial area in children’s mental health. The side effects, potential for misuse or overuse, and potential for drug interaction result in a clear need to provide timely and accurate information to the prescribing physician(s) to ensure the safety of the pediatric patient.

Furthermore, studies have indicated that children in a restrictive placement setting are the most likely to receive psychotropic medications. In a study of Texas children with Medicaid coverage, foster care youth received at least three times more psychotropic drugs than comparable children in poor families. The study also indicated that decisions to give children three or more psychotropic drugs may be largely based on behavioral and emotional symptoms rather than conclusive diagnosis of a specific mental condition. And more than 75% of the psychotropic medication use for children is off-label, a practice of prescribing drugs for a purpose other than the approved use on its label.

The health plan’s behavioral health (BH) team—a component of the Georgia Families 360° program—deployed a program to monitor prescriptions of psychotropic drugs for youth in foster care who receive one or more of these medications. The use of psychotropic medications is an integral part of treatment for people receiving care for behavioral health conditions, and the health plan’s goal is to ensure that youth in foster care are treated safely and effectively—not overprescribed medications or receiving inappropriate medications.

Description of the Population

Program	Member Count
Adoptive assistance	12,063
Foster Care	11,420
Juvenile Justice	214
CHAFFEE	200
Temporary Member	1

23,898* Adoptive Assistance (AA), Foster Care (FC) and the Department of Juvenile Justice (DJJ) program members

* Approx. 7,237 on members are currently using at least 1 psychotropic medication.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Promote patient-centered care through engagement and shared decision-making.

Research

Governing.com. (n.d.). How America's overmedicating low income and foster kids. www.governing.com/topics/health-human-services/gov-america-overmedicating-poverty.html

Illinois Department of Child and Family Services. Guidelines for the Utilization of Psychotropic Medications for Children in Foster Care.

Improving the lives of foster children through evidenced-based interventions. (2009). NIH Public Access Manuscript, 4(2).

Nauert, R. (2008). Psychotropic medications overused among foster children. Psych Central. Retrieved on September 2, 2015, from <http://psychcentral.com/news/2008/08/04/psychotropic-medications-overused-among-foster-children/2688.html>

Ohio Minds Matter: Improving the Appropriate Use of Psychotropic Medication for Children in Foster Care. (2013, September). Presented at the Center for Health Care Strategies.

Texas Psychotropic Medication Utilization Parameters for Foster Children: \\agpcorp\files\VA 1\shared\ESI Files\inbound\MISC

Intervention

The unique Management Coaching Program (PMC) model works with prescription claims to qualify members and identify potential drug therapy problems. SinfoniaRx, operated through the University of Arizona, reviewed the receipt of prescription claims for all eligible members. Pharmacy claims data are stratified to identify prescribing and usage trends, and the physician prescribers who are not following recommended evidence-based psychotropic treatment guidelines are identified.

Prescribers who are deviating from best clinical practices are flagged, and the health plan follows up with these prescribers through routine alerts, educational materials and letters, and peer-to-peer calls as needed. They are encouraged to adjust their prescribing habits, although the program does not infringe on the prescribers' decisions. Allowing them to self-regulate their prescribing patterns avoids the need for many external controls, such as prior authorizations or limit of access to psychotropic drugs.

The program has hundreds of proprietary clinical algorithms, and specific alerts were developed for the health plan's member population to target opportunities to improve medication therapy in the following areas: Adherence (mental health), coordination of care, behavioral health agents from multiple prescribers, members taking more than two behavioral health agents, safety measures such as therapeutic duplication, drug-to-drug interactions, atypical antipsychotics (e.g., diabetes screening and behavioral health max dosing), identifying the need for behavioral therapy in addition to medication, and behavioral health agent use in children younger than 4 years old.

Outcomes

Patient Outcomes/Clinician Outcomes

Alert Name	Total Alerts Sent Since May 2014	May/Jun/Jul/Aug/Sept/Oct/Nov/Dec/Jan Total - Eligible to refire	Re-Fired
TD - Antidepressant	184	129	44
TD - Amphetamine ER	122	110	8
TD - Atypical Antipsychotic	139	65	40
Max Dose - Adderall XR > 15mg	74	47	19
DDI: Lithium Toxicity PRN meds (Level 1)	48	20	4
TD - Amphetamine IR	20	19	0
Max Dose - Dexmethylphenidate ER > 30mg	25	17	10
Max Dose - Concerta 54mg	7	6	4
DDI: Lithium Toxicity ACEI-ARB (Level 1)	10	4	2
Max Dose - Dexmethylphenidate 10mg	7	4	2
Max Dose - Adderall XR 10g	5	3	0
Max Dose - Concerta 27-36mg	2	2	0
Max Dose - Dexmethylphenidate ER 20-30mg	3	2	0
Max Dose - Methylphenidate 20 mg	3	2	2
DDI: MAOI - Serotonergics (Level 1)	1	1	0
Max Dose - Adderall XR 15 mg	2	1	0

*Adherence - Amphetamine	4445	1683	977
*Adherence - Atypical Antipsychotics	1230	362	177
*Adherence - SSRIs	1096	340	136
*Adherence - Alpha-2 Antagonist	198	60	22
*Adherence - NDRIs	178	55	28
*Adherence - Lithium	68	11	2
*Adherence - Antipsychotics	30	5	0
*Adherence - SNRIs	15	2	2

*Adherence calculates the total days' supply of medication divided by the total days elapsed. A member is considered adherent if they have 80% of the days covered. Adherence is typically measured over 12-18 months

Patient outcomes. As this is a program dealing with children in foster care, the health plan was not capturing or reporting specific patient outcomes.

Module	Targets	# Interventions	# Measureable Interventions	Accepted Recommendations YTD	% of Recommendations Accepted
Adherence		126	1	0	0%
Guidelines		695	N/A	N/A	N/A
Safety		651	378	83	22%
Total	1472	379	83	22%	22%

Clinician outcomes. The health plan tracked alerts sent to clinicians, as well as those sent as a follow-up/refired alerts. Adherence measures were calculated for the medications, as well as safety issues (i.e., maximum dose, children <4 years old on medications, multiple prescriptions for concomitant medications as well as BH medications given by 2 or more MDs).

Clinicians receiving the alerts were educated, and feedback about the program and information provided was uniformly positive and well received. Following the interventions, the health plan realized a reduction in psychotropic medication per member per month (PMPM) for those members and attributed this in part to the alert process. By partnering with providers, the health plan believes that the modified prescription and practice changes, as well as clinical guideline adherence, will be extended to patients across these provider panels.

Community impact. Psychotropic medication nonadherence is a universal public health problem as well as a continued barrier to positive health outcomes. The rising prevalence of the use of psychotropic medications for children with mental health disorders has resulted in several state advisories regarding medication utilization and appropriate prescribing protocols. This program promotes the safe and effective use of psychotropic medications for children across all pediatric populations.

Cost savings. From August through December 2014, total psychotropic medication PMPM was \$33.73. In the period January through July 2015, total psychotropic medication PMPM was \$33.43. This represents a savings of \$.30, equating to a total program savings of \$50,151.43.

Key Components of Success

There has been much attention to the issue of children—particularly in the foster care population—receiving varying kinds and dosages of psychotropic medication. Although the program was constrained by the fact that contact could not be made with parents, fax alerts to providers were well received. The program relied on a collaborative process that leaned on objective standard practices rather than denials.

Kudos To The Team

Team Lead

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Team Members

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School-Based Clinics for Pediatric Care

Keystone First

Description

Keystone First, in partnership with Education Plus, supported the development and implementation of a health initiative in 11 participating public schools in the Philadelphia region where schoolchildren with care gaps received recommended health screenings in a school-based clinic run by registered nurse practitioners. After parental consent was received, Keystone First care management staff screened a student list of Keystone First members to identify and eliminate care gaps in the child and adolescent member population. From October 1, 2014, to June 30, 2015, Keystone First closed 639 out of 1,083 care gaps in participating students (a 59% closure rate), primarily in annual dental and adolescent well-care visits (98% of total), but also in chlamydia screening and asthma medication adherence (remaining 2%).

The population comprised children and adolescents of both genders (N = 849; male: n = 447, 52%; female: n = 416, 48%) with care gaps who are Philadelphia-based students from kindergarten through grade 12 living in Philadelphia County (97%); Delaware County (2%); and Montgomery, Chester, and Bucks Counties (all <1%).

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Reduce disparities in care of racial and ethnic minorities.
- Address social determinants of health to increase access and engagement.

Research

Kaplan, D. W., Calonge, B. N., Guernsey, B. P., & Hanrahan, M. B. (1998). Managed care and SBHCs. Use of health services. *Arch Pediatr Adolesc Med*, 152(1), 25-33.

Key, J. D., Washington, E. C., & Hulsey, T. C. (2002). Reduced emergency department utilization associated with SBHC enrollment. *J Adol Health*, 30, 273-278.

Kisker, E. E., & Brown, R. S. (1996). Do SBHCs improve adolescents' access to health care, health status, and risktaking behavior? *J Adol Health*, 18, 335-343.

Lurie, N., Bauer, E. J., & Brady, C. (2001). Asthma outcomes in an inner-city SBHC. *J School Health*, 71(9), 9-16.

Philadelphia Department of Public Health. (2014). Community health assessment. http://www.phila.gov/health/pdfs/CHAreport_52114_final.pdf

Santelli, J., Kouzis, A., & Newcomer, S. (1996). SBHCs and adolescent use of primary care and hospital care. *J Adol Health*, 19, 267-275.

Walker, S. C., Kerns, S. E., Lyon, A. R., Bruns, E. J., & Cosgrove, T. J. (2010). Impact of school-based health center use on academic outcomes. *J Adol Health*, 46(3), 251-257.

Intervention

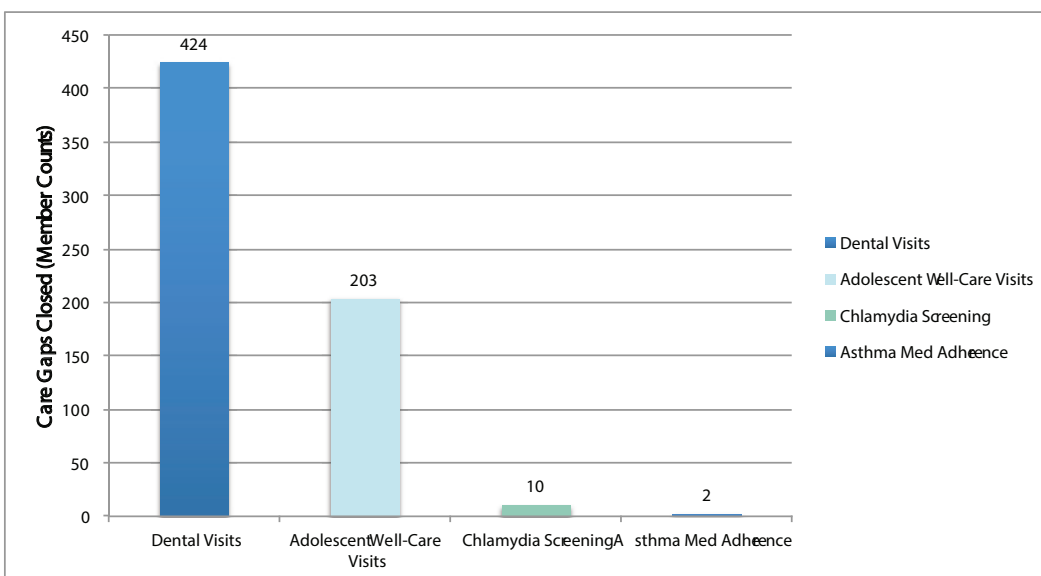
Keystone First's Provider Network Management staff worked alongside the Community Outreach Solution team to investigate the need for this program at individual Philadelphia-area charter schools. Once the need was affirmed, Keystone First staff met with school administration to get buy-in for the initiative and obtain parental consent for participation and the sharing of information on health care coverage. The school administration prepared a list of students identified as Keystone First members and forwarded this list to care management staff. The staff used the list to identify students with care gaps. The clinics operate five days a week during school hours, with extended evening hours as needed. All member care gap services are subject to reimbursement under a flat rate, while sick visits and other nonrelevant care gap services are reimbursed at a fee-for-service rate.

Outcomes

Patient outcomes. Participating schoolchildren and adolescents with care gaps (N = 849) attended one of 10 Philadelphia-area public schools (Table 1) in kindergarten through grade 12, primarily in grades 6 through 8 (37% of total; data not shown). They lived in Philadelphia County (98%), Delaware County (2%), as well as Montgomery, Chester, and Bucks Counties (all <1%). Some schoolchildren had multiple care gaps; 210 had two care gaps (118 of whom had their care gaps closed), and 4 had three or more (3 of whom had their care gaps closed).

Between October 1, 2014, and June 30, 2015, the school-based clinic initiative closed 639 out of 1,083 care gaps in participating students, a closure rate of 59%. The care gap closures were primarily in annual dental visits (n = 424; 66% of total; 60% closure rate) and adolescent well-care visits (n = 202; 32% of total; 56% closure rate), but also in chlamydia screening (n = 10; 1.6% of total; 67% closure rate) and asthma medication adherence (n = 2; 0.3% of total; 50% closure rate).

Number of Care Gaps Closed per Measure



The school-based clinic initiative closed care gaps in 506 pediatric members who receive services from one of 94 Philadelphia-area primary care providers (PCPs), while 343 members await closure of their care gaps. About 57% of participating schoolchildren were served by one of seven regional PCPs. Closing care gaps removes some of the burden from PCPs to deliver these recommended services, allowing for improved management of patient health. Furthermore, parents and caregivers of participating schoolchildren are encouraged to reconnect with PCPs to get all of their recommended annual screenings.

Clinician outcomes. Clinician outcomes were not evaluated as part of this program.

Provider Group Care Gaps	Closed Care Gaps (N)	Remaining Care Gaps (N)
Care Networks Karabot	112 (74)	77 (62)
CHOP Care Center South Philadelphia	82 (57)	63 (48)
CHOP Care Network Cobbs Creek	44 (40)	31 (26)
Nemours duPont Pediatrics PCP at Jefferson	36 (33)	26 (20)
Wilson Park Health Center - Pediatrics	36 (28)	21 (14)
Urban health Initiatives, Inc.	28 (24)	18 (11)
Woodland Ave Health Center - Pediatrics	22 (18)	14 (9)

Community impact. The school-based clinic initiative has been an effective medium to promote student health in 10 Philadelphia-area public schools. Subsequent phases will expand this initiative to closing care gaps in the student’s immediate family, including Keystone First-covered parents and siblings, followed by the development of a community hub to closing care gaps of members in the wider community.

Cost savings. Not applicable.

Key Components of Success

The success of this program is attributable to the establishment of partnerships and collaborative relationships among community institutions. Specifically, collaboration and support from the school administration along with the willingness of Education Plus to partner with Keystone First were vital.

Kudos to the Team

Team Lead

Kimberly Beatty, Director, Provider Network Management (Keystone First)

Team Members

Meg Grant, Director, Public Affairs & Marketing
Steve Dinsmore, Data Specialist (Keystone First)

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Long-Term Care (MLTSS/LTSS) & Transitions of Care for Elderly



Home-Based Primary Care

US Medical Management/Centene

Description

In an effort to reduce unnecessary hospitalizations, the health plan and its affiliated visiting physician association practices provided home-based direct primary care to select at-risk Medicaid beneficiaries with multiple chronic conditions or who are considered homebound by Centers for Medicare and Medicaid Services (CMS) criteria. Services were rendered by a three-role clinical team working off a single electronic health record system: a field-based provider (physician/nurse practitioner) and dedicated medical assistant (making the home visit, evaluating and managing the member as a patient, developing a care plan, and ordering appropriate and necessary tests and therapies), and a remote patient care coordinator who served as the communications hub and information clearinghouse for both provider and patient needs. A case-control study was conducted to evaluate the effectiveness of the program.

The program began in 2014 for high-risk Medicaid adults. Members were risk stratified based on industry-standard utilization risk criteria; additional modeling was completed after the program period.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Promote patient-centered care through engagement and shared decision-making.
- Control or reduce the per capita cost of care or increase efficiency.

Population Characteristics (adjusted for propensity)

	Case Cohort	Control Cohort
Members Assigned	944	9476
Age	51	51
Risk Score (mean, sd)	7.7 (12.3)	7.2 (4.9)
Female/Male Ratio	67/33	67/33

Research

DeJonge, K. E., Kamshed, N., Gildea, D., et al. (2014). Effects of home-based primary care on Medicare costs in high-risk elders. *JAGS*, 62, 1825-1831.

Reckery, J. M., Soriano, T. A., Hernandez, C. R., et al. (2015). The team approach to home-based primary care: Restructuring care to meet individual, program and system needs. *JAGS*, 63, 358-364.

Intervention

Members were determined to be eligible for the program based on their conditions and utilization patterns (according to claims data). Member outreach was conducted to introduce the program and to schedule an appointment during the program period. Members with at least one claim during the six-month program period were assigned to the case cohort; program-eligible members with no claims were assigned to the control cohort.

Members who agreed to a home-based primary care appointment were seen in their homes by the provider-medical assistant team, and, after securing all appropriate consents and notifications, received all medically necessary evaluation and management (E&M), laboratory, diagnostic and imaging services, as well as medication reconciliation, preventive interventions, and any necessary referrals for specialty care. Members were also added to the telephonic Patient Care Center roster. All members were provided an initial plan of care and offered continuity-based services from USMM.

Outcomes

Patient outcomes. Patients who received more than 75% of primary care services from USMM's home-based clinical teams had significantly lower rates of hospitalization and utilization of outpatient and Emergency services than control groups.

The continuity model of care can foster levels of patient engagement, affinity, and trust with the provider-medical assistant team that permits incremental impact on patients' longitudinal health status.

Clinician outcomes. The provider-medical assistant team provided care in members' homes, and once permissions were secured, these members received other medical services at home.

Community impact. Emergency room utilization dropped, meaning the resources there could be employed for other cases. The findings from this program demonstrate the value and power of longitudinal continuity of care achieving "Triple Aim" goals of improving the health of populations, improving the patient experience of care, and reducing per capita costs.

Cost savings. Using expense as an indicator of utilization, the greatest impact of home-based primary care on inpatient (IP) and hospital outpatient (OP) services; emergency Room (ED) utilization was also significantly reduced.

When 100% of primary care was provided by USMM home-based primary care services, there was a

- 58% reduction in inpatient expenses.
- 34% reduction in outpatient expenses.
- 24% reduction in emergency department expenses.

These findings demonstrate the value and power of longitudinal continuity of care in the achievement of “Triple Aim” goals of improving the health of populations, improving the patient experience of care and reducing per capita costs.

	100% USMM	>50% - <100% USMM	<50% USMM
TOTAL	(132)	8	453
IP	(174)	(134)	6
OP	(42)	(34)	29
ER	(20)	2	33
SPC	(6)	3	35
PCP	21	29	69
OTH	54	79	62
Rx	11	44	112

Key Components of Success

The development and achievement of care plans and goals are processes, not events. The continuity model can achieve levels of patient engagement, affinity, and trust with the provider-medical assistant team, which permits incremental impact on patients’ longitudinal health status. A disciplined approach to joint operating planning is required for all collaborators to make their respective contributions to members and the community.

Kudos To The Team

Team Leads

Kevin Murphy, SVP, Business Development, USMM
 Holly Benson, President, Centene Healthcare Enterprises

Team Members

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Bridgeway Enhanced-Care Transition Program: Supporting Members When They Need It Most

Advantage by Bridgeway Health Solutions/Centene

Description

In May 2013, the Bridgeway Health Solutions developed the Transition of Care (TOC) Initiative, an innovative, low-cost, easily operationalized, evidenced-based, telephonic care-transition program designed to help members when they are most vulnerable: during transition of care episodes from the hospital, a skilled nursing facility, acute rehab, or long-term acute care to home. All members discharged to a community setting (not an institution or hospice) are eligible to participate in this value-added activity. The goals are to lower hospital readmission rates, prevent avoidable complications, and improve quality of care. After two years of operation, the all-cause readmission rate has dropped from 22% to 16%. Moreover, the rate of same-cause readmissions decreased from 12% to 7%.

The TOC Initiative is for all members having the health plan as the primary payer of medical services. Members have on average four chronic conditions. Most are female (65%). Approximately 90% are Caucasian and 6% Hispanic. Ages range from 19 to 99 with the median of 76.

The program described is responsive to the following Medicaid priority area:

Priority

- Improve access and health outcomes for vulnerable populations.

Research

Health Research & Educational Trust, Hospitals in Pursuit of Excellence. (2010). Health Care Leader Action Guide to Reduce Avoidable Readmissions.

Academy Health. (2008). Reducing Hospital Readmissions.

Agency for Healthcare Research and Quality. (2009). Implementing re-engineered hospital discharges (Project RED): FAQs. Rockville, MD.

Intervention

The TOC Initiative consists of focused telephonic outreach and meticulous follow-up about identified concerns/issues. The health plan worked hard to locate workable telephone numbers for this population. Within 72 hours of a member receiving a discharge notice, and when the member is back in the community, the transition coordinator contacts the member and/or caregiver to perform a comprehensive discharge assessment. During that conversation, emphasis is given to medication reconciliation and ensuring the member understands and can adhere to discharge orders.

The transition coordinator also assists the member with making PCP and/or specialists' appointments within seven days of discharge (added at the start of the second year) and securing ordered services and equipment. Transportation to appointments, if needed, is also arranged. A copy of the completed TOC/discharge assessment is then forwarded to the PCP and case manager of record for care coordination. This approach helps members achieve a successful recovery while reducing readmissions/associated costs. Another key benefit is increased peace of mind to members and their families.

The rate of readmission is greatly reduced when members visit a health professional within seven days of hospital discharge. At the start of the second year, a post-hospital appointment verification enhancement was added to the Initiative. TOC coordinators document when members are seen by their PCP, specialist, or home health agency within seven days of discharge. Assistance is offered if an appointment is needed, and follow-up calls are made to determine if the visit took place. In addition, clinical information, along with a completed TOC/discharge assessment, is sent to the PCP for the initial post-discharge PCP appointment.

Acknowledging that telephonic programs may not be the preferred method of communication for all members, an enrichment was added to the initiative in April 2015. This pilot program offers face-to-face support to those considered to be at highest risk: members living in their own homes. The enhancement includes visiting the member while in the hospital to get acquainted, arranging and/or providing transportation home, coordinating with family members and caregivers regarding discharge needs, and coordinating with the member's interdisciplinary team to ensure a safe discharge.

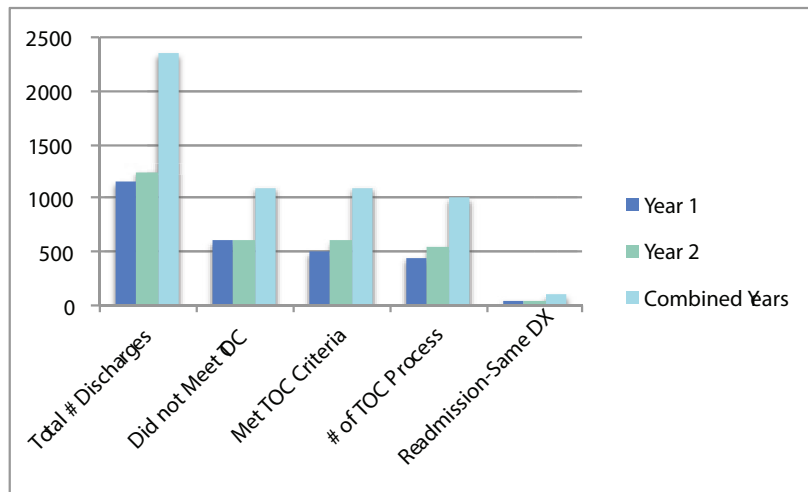
Once the member is home, the transition specialist visits in person, makes certain there is food in the home, prepares a meal as needed, makes sure utilities are on, does light housekeeping as needed, performs a discharge assessment with emphasis on medication reconciliation, assists the member with making PCP and/or specialists' appointments and securing ordered services and equipment, arranges for transportation to appointments if needed, and picks up prescriptions if needed.

Among 2,327 members discharged from the hospital from May 2013 through April 2015, 1,157 qualified for TOC Initiative participation. Of these, 87% (1,001) participated. Reasons for nonparticipation included "unable to contact," "did not return calls," "enrolled in hospice care once home from the hospital," and "readmitted to the hospital before the TOC activity could be attempted."

Outcomes

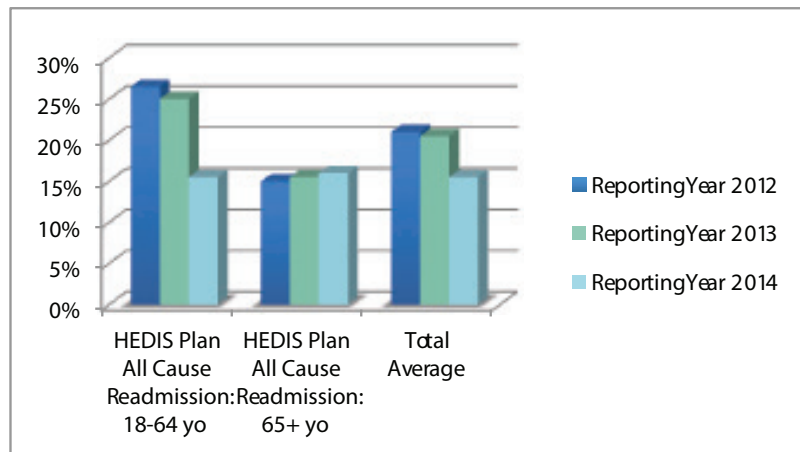
Patient outcomes. Among the 2,327 members discharged from the hospital from May 2013 through April 2015, 1,157 qualified to participate in the TOC Initiative. Of these, 87% (1,001) participated. Reasons for nonparticipation included "unable to contact," "did not return calls," "enrolled in hospice care once home from the hospital" and "readmitted to the hospital before the TOC activity could be attempted." As displayed below in Table 1, same-cause readmission rate came for members meeting TOC Initiative criteria came in at 8%. The remaining 1,170 members (50%) discharged during this 24-month span did not meet criteria for participation. The disqualification was consistently related to discharge to a noncommunity setting and/or hospice involvement.

Same-Cause Readmission by TOC Initiative Participation May 2013-April2015



In addition, the all-cause readmissions also decreased substantially. The HEDIS-determined rate decreased from 21.9% to 16.5% (Table 2).

HEDIS Results- All Cause Readmission by Age



Beginning in Year Two, the identification of high utilizers (defined as a member with 3 or more hospital inpatient admissions during the previous 12 months), an indicator that may contribute to readmissions, was added to the program, with 363 of the 1,235 discharged members (29%) considered to be high utilizers.

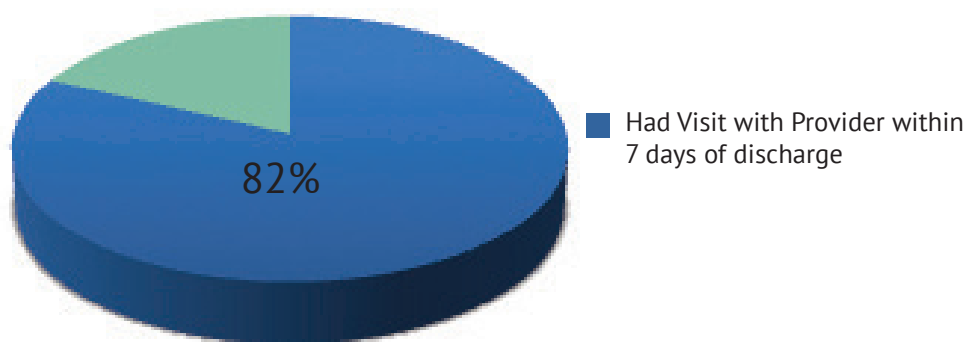
Clinician outcomes. The rate of readmission is greatly reduced when members have a health professional visit within seven days of hospital discharge. At the start of the second year, a post-hospital appointment verification enhancement was added to the initiative. TOC coordinators document if members are seen by their PCP, specialist, or home health agency within seven days of discharge. Assistance is offered if an appointment is needed, and follow-up calls are made to determine PCP/specialist/home health appointment adherence. In addition, clinical information along with a completed TOC/Discharge Assessment Tool, is then forwarded to the PCP to be available for the initial post-discharge PCP appointment.

Of the 569 TOC members, 466 saw their PCP, a specialist, or home health agency within seven days of discharge.

In addition, the authorization process has been streamlined. Discharge orders that require prior authorization (PA) are identified early and communicated to the PA department. Providers are able to initiate authorized services promptly. This also leads to increased provider/vendor and member satisfaction.

Community impact. Bridgeway has improved its presence in the community by identifying and partnering with appropriate resources. The health plan has solidified its relationships with these agencies and provider offices by communicating when members' transitions occur and new services members require. This has resulted in good outcomes for the member.

Post Discharge Follows Up Within 7 Days



Cost savings. To identify cost savings, Bridgeway used the 2013 admits as a base with subsequent year's readmission rate. Using this methodology, readmissions costs would have decreased to approximately \$281,000, a savings of 46% over 2013 costs.

Key Components of Success

Including caregivers and the member's family in the care coordination activity was an essential component for the TOC Initiative's success. However, the chief element for success was linked to the timeliness of calls. Medication issues were resolved within hours, no-show home health visits were swiftly remedied, missing durable medical equipment (DME) was obtained, and follow-up appointments with the PCP or specialist, within seven days from discharge, were made. Also, the added assurance of speaking directly with a transition coordinator from the health plan seemed to have a reassuring and positive effect on members and boosted member and family satisfaction.

Kudos To The Team

Bridgeway Health Solutions Team Lead

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Mental Health & Substance Use

Psychotropic Medication Management Coaching Program (PMC)

Amerigroup Georgia

Description

The use of psychotropic medications with children is a controversial area in children’s mental health. The side effects, potential for misuse or overuse, and potential for drug interaction result in a clear need to provide timely and accurate information to the prescribing physician(s) to ensure the safety of the pediatric patient.

Furthermore, studies have indicated that children in a restrictive placement setting are the most likely to receive psychotropic medications. In a study of Texas children with Medicaid coverage, foster care youth received at least three times more psychotropic drugs than comparable children in poor families. The study also indicated that decisions to give children three or more psychotropic drugs may be largely based on behavioral and emotional symptoms rather than conclusive diagnosis of a specific mental condition. And more than 75% of the psychotropic medication use for children is off-label, a practice of prescribing drugs for a purpose other than the approved use on its label.

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Research

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Texas Psychotropic Medication Utilization Parameters for Foster Children: \\agpcorp\files\VA 1\shared\ESI Files\inbound\MISC

Intervention

The unique Management Coaching Program (PMC) model works with prescription claims to qualify members and identify potential drug therapy problems. SinfoniaRx, operated through the University of Arizona, reviewed the receipt of prescription claims for all eligible members. Pharmacy claims data are stratified to identify prescribing and usage trends, and the physician prescribers who are not following recommended evidence-based psychotropic treatment guidelines are identified.

Prescribers who are deviating from best clinical practices are flagged, and the health plan follows up with these prescribers through routine alerts, educational materials and letters, and peer-to-peer calls as needed. They are encouraged to adjust their prescribing habits, although the program does not infringe on the prescribers' decisions. Allowing them to self-regulate their prescribing patterns avoids the need for many external controls, such as prior authorizations or limit of access to psychotropic drugs.

The program has hundreds of proprietary clinical algorithms, and specific alerts were developed for the health plan's member population to target opportunities to improve medication therapy in the following areas: Adherence (mental health), coordination of care, behavioral health agents from multiple prescribers, members taking more than two behavioral health agents, safety measures such as therapeutic duplication, drug-to-drug interactions, atypical antipsychotics (e.g., diabetes screening and behavioral health max dosing), identifying the need for behavioral therapy in addition to medication, and behavioral health agent use in children younger than 4 years old.

Outcomes

Patient Outcomes/Clinician Outcomes

Alert Name	Total Alerts Sent Since May 2014	May/Jun/Jul/Aug/Sept/Oct/Nov/Dec/Jan Total - Eligible to re-fire	Re-Fired
TD - Antidepressant	184	129	44
TD - Amphetamine ER	122	110	8
TD - Atypical Antipsychotic	139	65	40
Max Dose - Adderall XR > 15mg	74	47	19
DDI: Lithium Toxicity PRN meds (Level 1)	48	20	4
TD - Amphetamine IR	20	19	0
Max Dose - Dexmethylphenidate ER > 30mg	25	17	10
Max Dose - Concerta 54mg	7	6	4
DDI: Lithium Toxicity ACEI-ARB (Level 1)	10	4	2
Max Dose - Dexmethylphenidate 10mg	7	4	2
Max Dose - Adderall XR 10g	5	3	0
Max Dose - Concerta 27-36mg	2	2	0
Max Dose - Dexmethylphenidate ER 20-30mg	3	2	0
Max Dose - Methylphenidate 20 mg	3	2	2
DDI: MAOI - Serotonergics (Level 1)	1	1	0
Max Dose - Adderall XR 15 mg	2	1	0

*Adherence - Amphetamine	4445	1683	977
*Adherence - Atypical Antipsychotics	1230	362	177
*Adherence - SSRIs	1096	340	136
*Adherence - Alpha-2 Antagonist	198	60	22
*Adherence - NDRIs	178	55	28
*Adherence - Lithium	68	11	2
*Adherence - Antipsychotics	30	5	0
*Adherence - SNRIs	15	2	2

*Adherence calculates the total days' supply of medication divided by the total days elapsed. A member is considered adherent if they have 80% of the days covered. Adherence is typically measured over 12-18 months

Patient outcomes. As this is a program dealing with children in foster care, the health plan was not capturing or reporting specific patient outcomes.

Module	Targets	# Interventions	# Measureable Interventions	Accepted Recommendations YTD	% of Recommendations Accepted
Adherence		126	1	0	0%
Guidelines		695	N/A	N/A	N/A
Safety		651	378	83	22%
Total	1472	379	83	22%	22%

Clinician outcomes. The health plan tracked alerts sent to clinicians, as well as those sent as a follow-up/refired alerts. Adherence measures were calculated for the medications, as well as safety issues (i.e., maximum dose, children <4 years old on medications, multiple prescriptions for concomitant medications as well as BH medications given by 2 or more MDs).

Clinicians receiving the alerts were educated, and feedback about the program and information provided was uniformly positive and well received. Following the interventions, the health plan realized a reduction in psychotropic medication per member per month (PMPM) for those members and attributed this in part to the alert process. By partnering with providers, the health plan believes that the modified prescription and practice changes, as well as clinical guideline adherence, will be extended to patients across these provider panels.

Community impact. Psychotropic medication nonadherence is a universal public health problem as well as a continued barrier to positive health outcomes. The rising prevalence of the use of psychotropic medications for children with mental health disorders has resulted in several state advisories regarding medication utilization and appropriate prescribing protocols. This program promotes the safe and effective use of psychotropic medications for children across all pediatric populations.

Cost savings. From August through December 2014, total psychotropic medication PMPM was \$33.73. In the period January through July 2015, total psychotropic medication PMPM was \$33.43. This represents a savings of \$.30, equating to a total program savings of \$50,151.43.

Key Components of Success

There has been much attention to the issue of children—particularly in the foster care population—receiving varying kinds and dosages of psychotropic medication. Although the program was constrained by the fact that contact could not be made with parents, fax alerts to providers were well received. The program relied on a collaborative process that leaned on objective standard practices rather than denials.

Kudos To The Team

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7/30-Day Follow-Up Post-Hospitalization Pilot

IlliniCare/Cenpatico and Thresholds

Description

The 7/30-Day Follow-Up Pilot used a face-to-face case management approach by the health plan's provider partner to ensure that health plan members had successful follow-up appointments at 7 days and/or 30 days post-discharge from inpatient psychiatric hospitalization. The pilot involved high-volume inpatient hospitals, was located on-site, and engaged with members face-to-face during the hospital stay to assess their post-discharge needs.

The provider partner either took the member into its own care, if the person was not already connected with a provider, or helped return the member to the original treating provider. The staff accompanied the member to his or her home environment post-discharge and supplied the follow-up appointment as well as case management and linkage services, as needed, until the member could be connected with the ongoing treatment provider.

The population is a severely mentally ill population, either SSI or Medicaid Expansion lives, all adults. These members have many comorbid diagnoses, often with substance use disorders and housing issues as well.

	7 day % success	30 day % success
Thresholds	72%	82%
Non-Thresholds	33%	48%

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Control or reduce the per capita cost of care or increase efficiency.
- Address social determinants of health to increase access and engagement.

Research

No research studies supplied.

Intervention

Data directed the health plan to the highest-volume hospitals for this project. It is to those hospitals that members with the most admissions and admission-related costs go.

Permission to be on the unit and collaborate with the hospital care team was obtained before starting the pilot. When a member presented to one of the five pilot hospitals, staff would alert the pilot program, which would send a team to the hospital to meet with the member and assess treatment and post-discharge needs. After the team assessed the member's needs and made arrangements for follow-up care, a community engagement team met the member at the hospital at discharge. That team transported the member back to his or her home environment or into the community. A licensed clinician on that team gives the member his or her post-hospital follow-up appointment.

If the member is not already engaged with a community service provider, the health plan takes the member into its care, if the member is agreeable and lives in the service area. If the member already has a community service provider, the pilot team helps to link the member back with that provider and, if an appointment is not immediately available, provides case management services to that member until he or she can be seen, to ensure that the member has the support to prevent a readmission.

The program is not only linking members to behavioral health and substance abuse care, but also linking them to the primary and specialty medical care that they need.

Outcomes

Patient outcomes. There was improvement in members receiving follow-up appointments within 7 and 30 days, when compared with members not in the pilot. Eighty-two percent of members engaged with the pilot program had successful 30-day follow-up appointments, while only 48% of members without that intervention had the same success. By engaging in post-discharge care, members are less likely to readmit to the hospital and are more likely to get other health care needs met, such as physical health needs. The pilot also helped address the social needs members have, as the case management approach assessed for all levels of need.

	7 day % success	30 day % success
Threshold	72%	82%
Non-Thresholds	33%	48%
Pilot Hospitals	89%	88%
Non-Pilot Hospitals	36%	49%

There have been a total of 3835 inpatient psychiatric admissions during the pilot period. (This is NOT 3835 unique members). Of those admissions, Thresholds has responded to 1191 of them and has seen those members face to face. Of those 1191 encounters, Thresholds helped those members achieve a 72% success rate with follow up post hospitalization. Comparatively, the members associated with the 2644 remaining inpatient admissions only had a 33% success rate in completing follow up post hospitalization.

Clinician outcomes. Increased HEDIS rates for the health plan were a positive outcome, meeting state pay-for-performance goals.

Community impact. Decreased readmission and emergency department usage rates helped to get members connected to the appropriate services to meet their needs and also to address the social determinants of care, such as housing and food. The pilot also helped to increase access to services at one of the largest community mental health centers (CMHC) in greater Chicago.

Cost savings. Fewer readmissions and visits to the emergency room result in reduced costs to the health care system. However, this was not specifically measured for this program.

Key Components of Success

The high-touch linkage back into the member's home environment allows the case manager to see firsthand if there are any needs that might be impeding the member from addressing ongoing health needs.

This pilot was paid for utilizing a case-rate model of payment (i.e., instead of paying the provider using a typical fee-for-service payment model, lump sum per member per month payment rates were negotiated with the provider). This model of payment fosters a “relentless pursuit of engagement.” That is, in a typical fee-for-service payment environment, the provider is paid only if it locates members and sees them face to face. A case-rate model allows for some flexibility when the provider attempts to locate the member but is not successful. It allows the provider to continuously try to engage with members who are challenging to locate or to engage into services. The payment model also helps the health plan to build more teams to support expansion of this pilot to other hospitals. That ability to expand the program increases the providers' capacity to service members in the Chicago area, where many CMHCs are already at capacity using their current service model and fee-for-service payment structure.

Using two teams is an essential element—one for the hospital and one for the community—to ensure that they did not miss any members. It is important—but difficult—to keep up with demand and expansion.

This partnership has succeeded because of communication. The pilot struggled with the best way to communicate within itself. Frequent meetings are needed to make sure teams are communicating well and are not duplicating any efforts on member care.

Outcomes

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Behavioral Health (BH) Work Group and Quality Review Program

Amerigroup Georgia

Description

The program began in 2014. The population includes 350,000 members, including people enrolled in Temporary Assistance for Needy Families (TANF), Children's Healthcare Insurance Program (CHIP), foster care (FC), adoption assistance (AA), and Department of Juvenile Justice (DJJ).

After implementing the Georgia Families 360° program and greatly increasing the behavioral health provider network to meet the increased service demands of the FC, AA, and the DJJ programs, the health plan's base TANF/CHIP population experienced a \$7 million trend for behavioral health (BH) outpatient services. As this trend included the same membership the plan had been managing for the past seven years, the impact was startling, and Amerigroup Georgia immediately investigated.

It quickly became apparent that many of the newly contracted BH outpatient providers were not aware of basic managed care operational standards, such as how to properly complete OTRs, use of the provider portal, billing standards, and member record documentation expectations.

The health plan created a multistakeholder leadership group to promote provider awareness, deliver targeted support to providers who were new to BH managed care, and improve overall BH program performance. Goals were set up to ensure appropriate access and quality of care for members; create better education and feedback loop for mental health providers; address current BH trends and forecasts to reduce any unforeseen/unplanned increases in BH unit cost or utilization; monitor progress and update key stakeholders on a variety of strategic programmatic initiatives for Georgia Families (GF) and Georgia Families 360° program; and use results to identify innovations in BH treatment that can be accessed to improve health outcomes.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Control or reduce the per capita cost of care or increase efficiency.
- Address social determinants of health to increase access and engagement.

Research

Federal law requires each state to have a Medicaid Fraud Control Unit (MFCU) unless the state can demonstrate to the satisfaction of the HHS secretary that it has a minimum amount of Medicaid fraud and that Medicaid beneficiaries will be protected from abuse and neglect. According to GA.gov, the MFCU for the state of Georgia has recovered more than \$190 million in taxpayer money, including both state and federal funds since 2011. In fiscal year 2013 alone, the office recovered \$29.4 million. As noted above, the Amerigroup Georgia Health Plan noted a \$7 million trend after significantly increasing the number of Behavioral Health providers in the network. To ensure compliance with fraud, waste, and abuse monitoring and oversight the health plan created the work group to reduce state and health plan exposure.

Intervention

Amerigroup Georgia divided the work into three categories: analytics and reporting, provider education, and fraud control and auditing.

In the area of analytics and reporting, the health plan developed reporting and analytics to identify billing patterns and questionable clinical patterns; created utilization scorecards; and identified outlier providers and key community partners.

The plan developed a BH-specific provider addendum to the manual that outlined and educated the network providers on the specific documentation, quality care, and operational expectations specific to the BH network. It held collaborative meetings with clinical/PR reps with providers targeted as outliers, as well as other high-volume providers, to discuss best practices and provide managed care education. Also discussed was utilization/billing patterns. Updates were distributed on quality expectations and the external audit program. The health plan also established corrective action requirements and worked with identified providers to meet clinical standards.

To take control of fraud and auditing, the plan entered into partnership with an external auditing vendor to provide quality and documentation reviews of BH provider network; developed BH-specific QRC for both GF and GF 360° providers for the health plan’s members involved in foster care, adoptions assistance, and the Department of Juvenile Justice. The health plan incorporated into the audit process work that was done internally. This work focused on quality initiatives and ADHD compliance with clinical practice guidelines and evidence-based medicine. The internal review process for psychological testing was adjusted, changing it from notification only to full medical necessity review. Throughout, the health plan worked closely with state partners and provider associations.

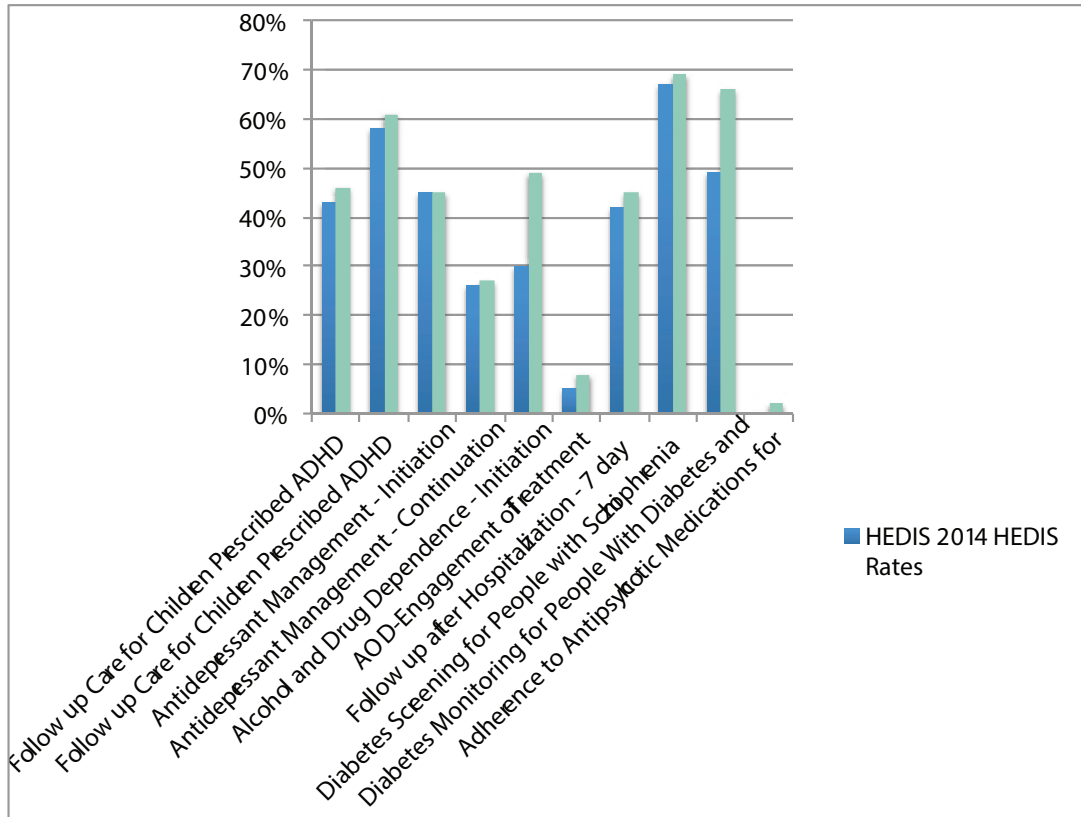
Outcomes

Patient outcomes. The health plan found improvements in 10 HEDIS measures year over year following the rollout of the program to the behavioral health provider network .

	Population	HEDIS August 2015 HEDIS Rates	YOY Change (+/-)
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	3229	47.01%	2.6%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	467	61.88%	3.7%
Antidepressant Management – Initiation	1615	46.75%	-0.4%
Antidepressant Management – Continuation	1615	26.93%	0.3%
Alcohol and Drug Dependence – Initiation	1773	49.63%	19.3%
AOD-Engagement of Treatment	1773	9.7%	3.9%
Follow up after Hospitalization - 7 day	1058	47.07%	4.4%
Follow up after Hospitalization - 30 day	1058	63.72%	3.9%
Diabetes Screening for People with Schizo or Bipolar Using Antipsychotic Medications	365	69.86%	1.7%
Diabetes Monitoring for People With Diabetes and Schizophrenia	12	66.67%	16.67%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	80	1.25%	1.3%

*Internal HEDIS Rates are captured monthly using HEDIS Technical Specifications defined by the National Committee for Quality Assurance (NCQA). These rates are not the reported 2015 Rates and include the total Medicaid population including FC, AA and DJJ.

Clinician outcomes. The health plan saw improvements in billing patterns and clinical guideline adherence in those providers targeted for intervention. Additionally, it is anticipated that educational efforts coordinated with provider associations will result in improvements across the provider community.



Community impact. Providers have expressed, anecdotally, their appreciation and satisfaction with the program’s efforts to inform, support, and collaborate to improve services on behalf of mutual members. The program efforts have also improved relations with community stakeholders.

Cost savings. Savings attributed to the program at the end of May 2015 reached \$1,095,071 with an estimated projection of \$3 million by year-end.

Key Components of Success

This program required relationship building internally and externally, with sensitivity to the Georgia Families 360° population, to provider confusion and education, and to previous processes (in which providers received automatic service authorizations regardless of unique member needs).

Provider support and education were essential elements in the program. All operational areas, executives, and clinical staff needed to be committed to the program because success requires time and resource dedication, enhanced provider engagement, and collaboration with Together GA (a behavioral health care provider networking entity).

In addition, the health plan had to determine how to roll out and administer the audit program—what could be built and what needed to be bought.

Kudos to The Team

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Addiction in Pregnancy Program

Buckeye Health Plan

Description

The incidence of babies born with a diagnosis of neonatal abstinence syndrome (NAS) in the health plan rose from 2.3 per 1,000 births in 2007 to 62 per 1,000 births in 2013. This was a 508% increase. The state of Ohio suffers from five deaths per day from drug overdose. Pregnancy is the time in these individuals' lives where they have the best chance of conquering their addiction permanently.

Babies born with NAS are more likely to be low birthweight babies and are more likely to have respiratory problems. The need for neonatal admission and length of stay is much greater than babies born without NAS. Also, the withdrawal experience for the baby is painful, involving severe central nervous system, gastrointestinal system, and respiratory symptoms.

The Addiction in Pregnancy Program identifies pregnant members known to have addiction problems or suspected to have such problems. Integrated case management is provided through the obstetric care managers and behavioral health care managers. Newly identified members are quickly connected to the appropriate providers to meet their medical and behavioral health needs.

The program began in October 2013 and has enrolled more than 100 women. An eligible member includes any member who is pregnant, planning on pregnancy, or has recently been pregnant and has a current or previous history of addiction. The Addiction in Pregnancy Program uses a matrix of medical claims and pharmacy claims over different time spans that suggest levels of risk of the health plan's pregnant members for addictive problems. An important method of identifying pregnant members is when they present to the emergency department or are admitted to the hospital for addiction-related problems. The health plan's utilization management nurses and medical directors refer these members to the team when they are identified.

Predictive modeling software is used as well. Impact Pro® is used to review current and future risk, identify opportunities to affect utilization, care gaps, claims, and pharmacy information.

The Addiction in Pregnancy Program is available to members in the health plan's Medicaid and Medicaid Expansion populations. The program resulted in shorter (than expected) neonatal hospital lengths of stay and improved HEDIS rates in participants.

The program described is responsive to the following Medicaid priority area:

Priority

- Improve access and health outcomes for vulnerable populations.

Research

Gawronski, K., Lehman, K., Gardner, D., Giannone, P., & Prasad, M. Neonatal outcomes following in utero exposure to buprenorphine/naloxone or methadone. *American Journal of Obstetrics and Gynecology*, 208(1), S68.

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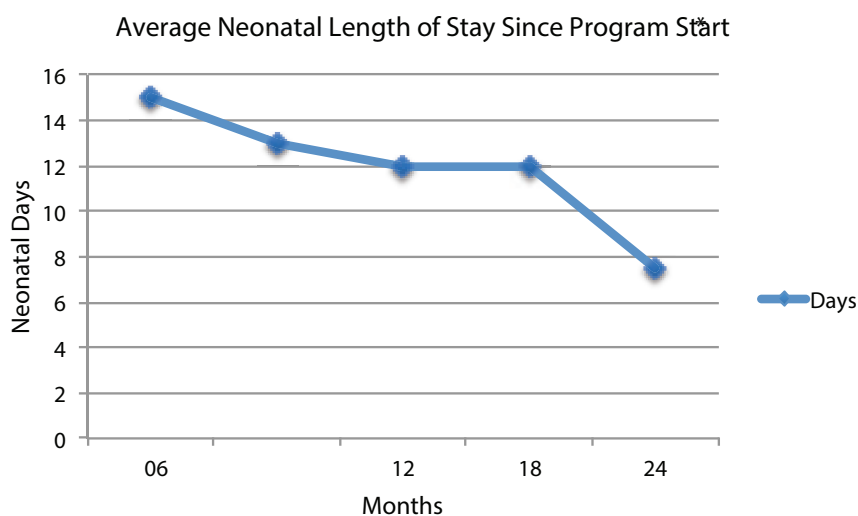
Prasad, M., Calaway, B., & Abdel-Rasoul, M. (2013). Obstetric and neonatal sequelae of buprenorphine/naloxone (B/N) exposure versus methadone maintenance (MM). *American Journal of Obstetrics and Gynecology*, 208(1), S201.

Intervention

The Buckeye Health Plan believed its experiences in outreach, education, care coordination, and a special relationship with obstetric providers put the plan in a position to positively affect these pregnancies. The goals of this program are to maintain enrolled members in the program through delivery, reduce the number of babies born with NAS, reduce the average number of neonatal days for this population, increase the number of mothers who remain drug free or on opioid maintenance therapy 18 months after delivery, and decrease fragmentation of care.

Outcomes

The average inpatient length of stay for NAS infants in Ohio ranged from 20.1 in 2008 to 15.9 days in 2011



Other Key Metrics

Average gestational age	37.8 weeks
Average birth weight	6.6. lbs
Preterm delivery rate	20%
Neonatal admission rate	32%

Patient outcomes. One hundred and fourteen members have enrolled in the program, including 55 who delivered babies. The care management team has been able to maintain 34 members (62%) in the program, with the goal of managing and coordinating care for them up to 18 months post-delivery. There are 4 out of 9 members who remain drug free or on maintenance therapy 18 months after delivery (5 are unable to be confirmed due to disengagement in care management). Of the 55 deliveries, 19 babies (34.5%) had NAS at delivery

Clinician outcomes. HEDIS initiation and engagement measures for substance abuse are improved in health plan enrollees. The HEDIS Initiative IET/ Engagement IET rates for members enrolled in the program are respectively 64.71% and 35.29% compared with 32.26% and 2.27% for the entire health plan population.

Community impact. An expansive program requires local connectivity. A community is only affected when those who are most vulnerable are attached to the services and health care they need. A network of community health workers and “medication support sites” helps the health plan find its members, build trust, and deliver results so that the next individual who is challenged with addiction will take the steps to move forward.

Each time trust is built in a community, it makes it easier for the next member to reach out. Enrolled members often find themselves at a place where they have lost their traditional support systems. Unfortunately, the only people left in their lives’ are ones who still cultivate their addiction habits.

Keeping moms in treatment with Medication Assisted Therapy means fewer newborns in the community will suffer from their mothers’ narcotic addictions. These babies will get a fair start in life. The community, in turn, is one step healthier and has individuals who can pass on stories of hope. This lets this program and similar ones grow.

Key Components of Success

The health plan identified staff members from the medical side and behavioral health side with the capability to lead and organize while interacting with individual members with genuine sympathy. The integrated case work nature of this program demands such a combination. Position requirements were adjusted so that there was manager-level staff who could give full attention to the program.

Success is possible in this population only if the individuals gain a level of trust to work with the doctors, nurses, counselors, social workers, and care managers who are prepared to help them. Addicted members have often lost the important supportive connections they need during this critical time.

Further, the health plan's members with addiction want to keep their babies, and there is disincentive to share their addiction problems with their OB providers. The care management team works with the member and Department of Children and Family Services (DCFS) to engage the member into treatment to potentially reduce the negative impact of opiate use of the baby and keep the baby with the member.

Kudos To The Team

Team Lead

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Modified IMPACT Program

Sunshine Health/Cenpatico and Family Care Partners FQHC

Description

The Modified IMPACT (Improving Mood Providing Access to Collaborative Treatment) program focuses on those who are newly diagnosed, undiagnosed, or have an undertreated behavioral health condition and are at risk of exacerbating a comorbid medical illness such as sickle cell anemia, diabetes, or heart disease. Participants are identified by the primary care provider. Participants must be adults and score 10 or above on the PHQ9 (9-item depression scale patient health questionnaire) assessment or have other unmet behavioral needs.

Once identified, the member is assigned a wellness coach who meets with the member at the primary care practice location (embedded at the PCP location) to complete an initial needs assessment. The PHQ9 score is used to triage the appropriate risk level. Results demonstrate improvement in depression symptoms, increased engagement in behavioral health services as well as overall health care cost reduction.

The initiative began in June 2014.

The program population is SSI or TANF adults in need of behavioral health care coordination and receiving primary services at a federally qualified health center. The average age is 41. The Modified IMPACT program involved 65 members. Predictive modeling was used before the launch to identify gaps and opportunities of the population served at the primary care location(s). Population risk scores as well as primary risk categories were considered when choosing the program location.

The Modified IMPACT program is based upon the IMPACT model of evidenced-based depression care developed at the University of Washington. The program uses several key IMPACT components, such as systematic use of depression scales, and includes targeted primary care physician technical assistance regarding stepped care and the IMPACT tenants of treating to goal. “Stepped care” refers to treatments being actively changed if patients are not improving as expected until clinical goals are achieved.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Control or reduce the per capita cost of care or increase efficiency.
- Address social determinants of health to increase access and engagement.

Research

The Modified IMPACT program is based upon the IMPACT model of evidenced-based depression care developed at the University of Washington. IMPACT is listed in SAMHSA’s National Registry of Evidenced Based Programs and Practices: <http://www.nrepp.samhsa.gov/>.

Intervention

The wellness coach embedded within the primary care practice completes an initial needs assessment then supports the member in the following ways: Educates the member about his or her behavioral health condition and treatment options available; coordinates behavioral health care and community supports; supports antidepressant therapy prescribed by the member's primary care provider if appropriate; educates the member about self-management techniques; meets regularly with the member to monitor for improvement or symptom exacerbation; completes caseload consultations with medical director on members who did not respond to PCP treatments as expected; offers feedback to PCP using the publication Best Practice Psychotherapeutic Medication Guidelines for Adults.

The health plan's chief medical officer met with the team prior to launch to provide education regarding evidenced-based depression treatment.

Outcomes

Patient outcomes. Sixty-seven percent of patients were connected to behavioral health services, nearly double the rate of those identified not engaged in the program.

	Achieved PHQ9 clinical improvement	Average Overall Health Care Cost	Engagement in BH services
Active Participants	32%	\$4,308	67%
Identified (not engaged)	NA	\$6,521	33%

Following 12 months of engagement (June 2014–May 2015)

Clinician outcomes. Nearly 1 out of 3 members achieved the PHQ9 goal (50% improvement, or score less than 10), indicating an improvement in depression symptoms.

Community impact. In the broader community, the program improved access to care and minimized stigma. In addition, the Assistant Secretary's Office of Planning and Evaluation (ASPE), of the Federal Department of Health and Human Services, conducted an in-person site visit on June 25, 2014, to learn more about the program's innovative approach to integration of care.

Cost savings. Health care costs averaged \$2,213 lower than members identified but not engaged.

Key Components of Success

Recruiting the correct individual to embed within the primary care clinic was essential. The health plan was able to recruit an excellent clinician with vast experience in the areas of nursing, counseling, case management, and pharmaceutical sales.

Flexibility was vital. Primary care clinics are fast-paced, ever-changing, and juggling many priorities. Therefore, the program had to be amendable to whatever worked best for them in this environment.

Tracking member outcomes in a database supported the wellness coach and outcomes collection. Also, predictive modeling helped identify population opportunities.

Kudos To The Team

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Opioids 360: From Prescribing to Recovery

CeltiCare Health Plan of Massachusetts, Inc./Centene

Description

Opioids 360 consider the health plan's management of all aspects of opioid use, addressing prescriber behavior, inappropriate member utilization, and the treatment of opioid addiction (leading to recovery). Approaching each of these components systematically allows for multiple opportunities to reduce opioid abuse and best support treatment. The health plan depends upon its award-winning Integrated Care Management Model (Dorland Award, 2015) to serve as the nidus around which it has built provider and community partnerships to expand member access to supports and services. Although the program is in its early stages, having been initiated in 2014, overall emergency department (ED) utilization has dropped since program inception. The health plan expects an increase in community tenure, a decrease in opioid overdose, and improved adherence to treatment and recovery programs.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Promote patient-centered care through engagement and shared decision-making.
- Control or reduce the per capita cost of care or increase efficiency.
- Demonstrate accountability of Medicaid health plans, including addressing fraud and abuse.
- Address social determinants of health to increase access and engagement.

Research

Graham, G. (2015). Opioid epidemic claimed estimated 1,256 lives statewide in 2014, state says. MassLive, August 4.

Nelson, A. K. (2015). One town is going to try not arresting heroin users. New Republic, May 20. <http://www.newrepublic.com/article/121857/massachusetts-police-chiefs-idea-stop-arresting-heroin-addicts>

<https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/Downloads/drugdiversion.pdf>

Intervention

Each of the three intervention domains—provider behavior, member engagement and treatment, and recovery—comprise seven interventions. The foundational programs are, relatively speaking, standard fare, as they build upon efforts commonly found at experienced health plans. The innovative initiatives are those that are generally market leading in the state Medicaid space and, in at least one instance (RxAnte®), will be first in the nation when fully implemented (fall 2015). The 21 initiatives are in varying states of implementation, from active program with outcomes to active work plan.

CeltiCare has limited prescriptions for new short-term opioids to 15 days or less (+1 refill within 60 days), which reduces the opioids available for misuse or diversion; increased use of provider and patient educational tools on standard of care, including the systematic implementation of a provider/member “opioid contract”; and improved the early identification and management of members who are likely to abuse, divert, or overdose before these events occur.

Barriers to care were removed by critically evaluating prior authorization policies governing addiction treatment programs, including medication therapy, and supporting FDA-approved abuse deterrent opioid formulations.

By engaging in successful provider partnerships that already fully support CeltiCare’s efforts or are interested in doing so, and bringing them into Integrated care management team activities, the health plan expanded the reach of its integrated care management capabilities.

CeltiCare expanded access to community-based services by creating housing-first and peer-support initiatives, expanding the availability of these critically valuable services beyond state-sponsored efforts. It also reached out to members identified to be at risk along with a “significant other” to provide access to naloxone and engage the latter in overdose rescue training.

Providers were educated to help them more effectively manage members being prescribed opioids. This included sharing best practice regarding urine drug testing for patients prescribed opioids or who are being treated for addiction. PCPs and other front-line providers in the triage of patients with substance use disorder (SUD) were supported by establishing a Provider Resource Line staffed by subject matter experts who can ensure that a patient leaves his or her provider’s office with a firm plan of care.

Opioids 360 Programs and Initiatives		
I. Provider Behavior	II. Member Engagement	II. Member Engagement
Foundation Programs		
1. Short Term Rx Limits (15 Days) 2. Abuse Deterrent Medicaidions access 3. Prescriber Outlier Management	8. State Prescription Drug Management Program 9. Pharmacy Lock-in Program 10. Integrated Care Management	15. All ASAM Treatment Levels covered without Prior Authorization 16. SUD Disease Management 17. All FDA Approved Medication covered
Innovative Initiatives		
4. Direct PCP Education 5. Member Rx Contracts 6. UDT Pilot 7. Pain Mgmt. Summit	11. MemberConnections 12. Advocates, Inc. pilot; member outreach and engagement 13. Naloxone SafetyNet 14. RxAnte opioid misuse risk stratifier	18. Vivitrol access Pilot 19. Provider SME/Triage Resource Line 20. Housing First Programs 21. Expanding access to SUD Peer Support

The three intervention domains, Provider Behavior, Member Engagement and Treatment and Recovery each are comprised of seven interventions. We consider the foundational programs to be, relatively speaking, “standard fare” as they build upon efforts commonly found at experienced health plans. The innovative initiatives are those that are generally market leading in the state Medicaid space, and in at least one instance (RxAnte®), will be first in the nation when fully implemented (Fall 2015). It should be noted that these 21 initiatives are in varying states of implementation, from active program with outcomes to active work plan.

Outcomes

Patient outcomes. CeltaCare Health clinical staff have become so engaged with members that that these members who previously received little or no individual support services become:

- Grateful: “Why are you paying so much attention to me? No one has ever done that before.”
- Trusting: “I know I need to change my habits but it’s so hard. I am going to do what you suggest because I believe you wouldn’t steer me wrong.”
- Loyal: “After I leave the treatment center, they want me to enroll in XYZ program. I am not leaving here until you tell me that is the best place for me to go.”

Member disenrollment among our Managed members has decreased by 45% over the past 9 months

Clinician outcomes.

- Hospital Case Manager: “You mean you, the health plan CM, has already identified ALL of these resources for this member? You are making my job easy.”
- Treatment Center Physician: “Other health Plans wouldn’t think of allowing this patient to stay at this level care longer than the criteria allow simply to give her the best chance at long-term success.”

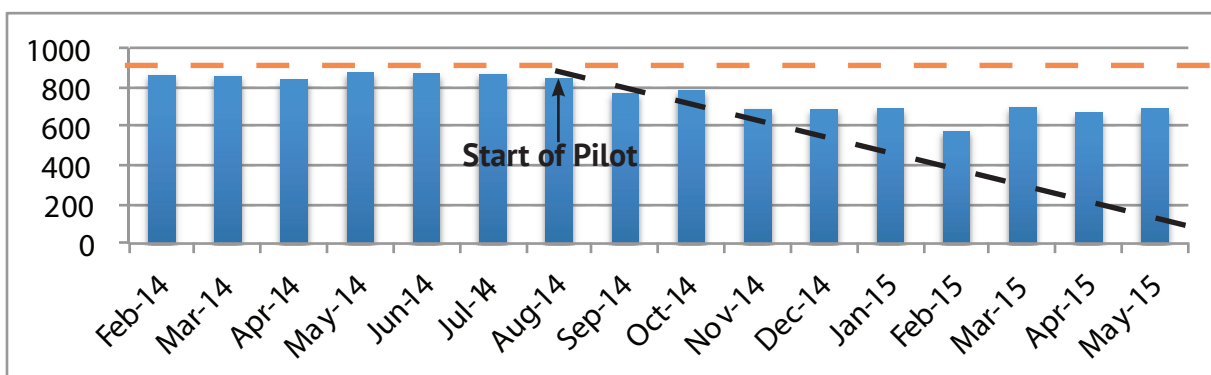
Direct referrals from providers and facilities into our clinical program has increased by 150% over the past 9 months since we have educated them about our efforts and they have experienced firsthand the benefits of our programs

Community impact. MassHealth has expressed interest in replicating aspects of the Opioid 360 initiative across the broader Medicaid program.

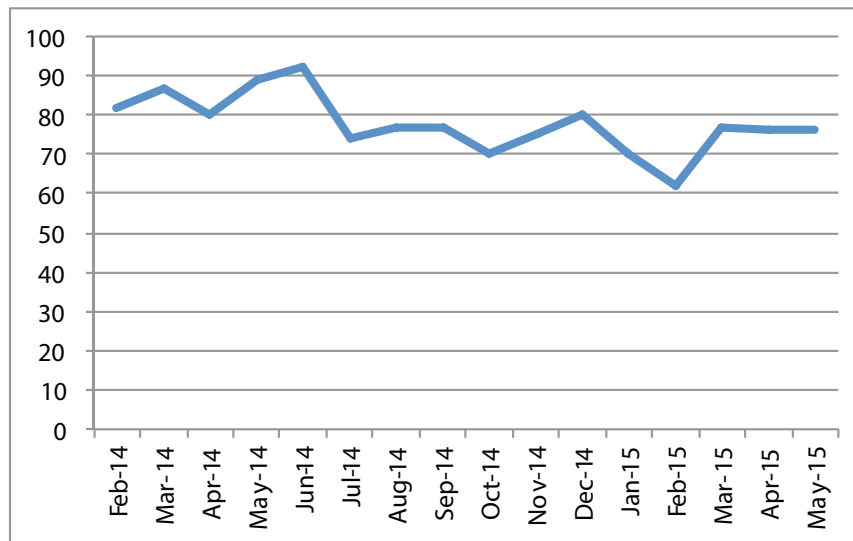
- The state has requested that MCOs eliminate Prior Authorization on medications and services for treatment of SUD consistent with the policies we had already put in place

Cost savings. Emergency department use (and costs) has dropped in the health plan’s overall population.

The savings on ED Utilization accrued from September 2014 through May 2015 = \$1.97M (\$2.63M annualized)



The savings on Inpatient Utilization accrued from Aug 2014 through May,2015 = \$2.08M (\$2.50M annualized)



Key Components of Success

The integration of physical and behavioral health care management is a primary key to success. Organizational integration with the health plan’s behavioral health partner, using a single point of contact approach, and supporting each member holistically in a culturally sensitive manner has allowed the health plan to focus not only on physical and behavioral needs, but also on the social determinants of their health. These efforts have led to a greater level of member engagement and a sense of trust and respect between staff and members. Decreased emergency department use is the first of many positive outcomes the health plan expects to see as it goes forward in this long-term investment in members.

Kudos To The Team

Team Lead

Robert LoNigro, MD, Chief Medical Officer

Team Members

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- Karen Weinberg, LMHC, Director, Behavioral Health Services
- Eric Goldstein, Director, Network Operations
- Candace Reddy, VP, External Relations
- Jay Gonzalez, President and CEO, CeltiCare Health

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Parents in the Know

AmeriHealth Caritas/PCAR/PAAR

Description

Parents in the Know is a parent/caregiver-focused child abuse prevention program that equips parents and caregivers with the knowledge, attitudes, and skills required to prevent child sexual abuse. Participants attended an 8-hour program presented by trained AmeriHealth Caritas-employed facilitators and a representative from a local rape crisis center at 7 community sites between September and November 2014 in southeastern Pennsylvania. After attending the program, participants demonstrated stronger confidence in their ability to identify community resources, increased ability to identify strategies for intervention in potentially problematic adult-child relationships, and increased knowledge of age-appropriate discussions with children.

All interested community parents and caregivers of children ages 18 years or younger were eligible to participate. A majority of the 70 program participants were women (87%) and Hispanic/Latino (54%) or African American (32%), with an average age of 37 (range, 21-75 years). The majority of participants were married (44%) and members of the AmeriHealth Caritas Family of Companies (50%), and their highest level of educational attainment was graduating high school (46%). Almost half of participants had children ages 7-12.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Promote patient-centered care through engagement and shared decision-making.
- Control or reduce the per capita cost of care or increase efficiency.
- Demonstrate accountability of Medicaid health plans, including addressing fraud and abuse.
- Address social determinants of health to increase access and engagement.

Research

Bayard, V. I., Moynihan, M. M., & Plant, E. G. (2007). Sexual violence prevention through bystander education: An experimental evaluation. *J. Community Psychol*, 35(4), 463-481.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *Am J Prev Med*, 14, 245-258.

Finkelhor, D., Omrod, R., Turner, H., & Hamby, S. (2005). The victimization of children and youth: A comprehensive, national survey. *Child Maltreatment*, 10(1), 5-25.

Harris, M. J. 2010. *Evaluating public and community health programs*. San Francisco, CA: Jossey-Bass (John Wiley & Sons), 22-23.

Rispens, J., Aleman, A., & Goudena P. (1997). Prevention of child sexual abuse victimization: A meta-analysis of school programs. *Child Abuse Neglect* 21(10), 975-987.

Intervention

Parents in the Know is an 8-hour program (four 2-hour weekday sessions or two 4-hour weekend sessions), led by trained facilitators (at least one fluent in Spanish) and a representative from a local rape crisis center, that equips parents/caregivers with the knowledge, attitudes, and skills required to prevent child sexual abuse. Sessions included ice breakers, lectures, role-playing bystander intervention strategies, behavioral skills practice, videos, group discussions, group brainstorming, take-home educational material, and self-discovery. The program's content includes addressing challenges in recognizing potentially dangerous behavior toward children and communicating with facilitators and other parents and caregivers about healthy childhood development.

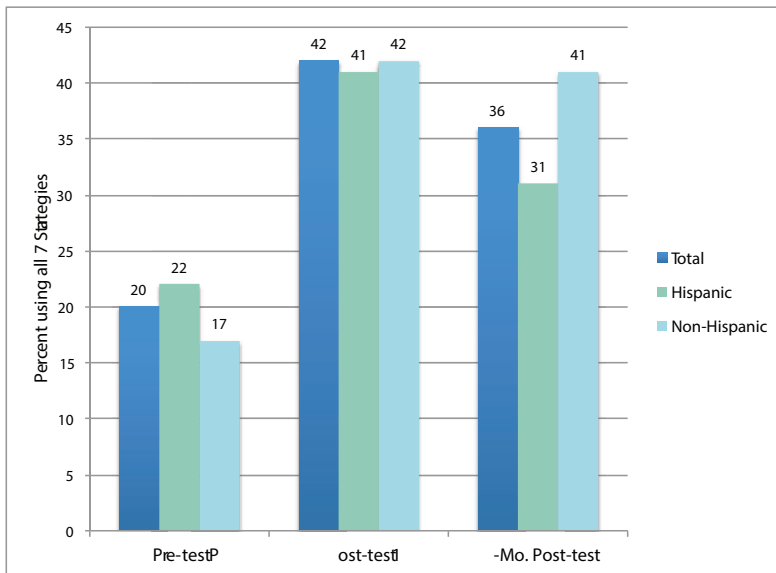
Outcomes

Patient outcomes. Out of 70 attendees, 58 (83%) participated in testing prior to training, 52 (74%) participated in testing immediately following the final session, and 33 (47%) participated in the follow-up survey mailed to participants one month after the final session. After attending the program, participants reported increased parental-child activities, especially playing (80% post-test vs. 69% at baseline), and increased parent/caregiver recognition of having age-appropriate discussions regarding sexual development with their children as "appropriate" (25% post-test vs. 8% at baseline). Participants demonstrated significantly increased ability to identify and apply the 7 strategies for child abuse prevention intervention in a hypothetical test case of a potentially problematic adult-child interaction (42% post-test vs. 20% at baseline; $p < 0.05$). This ability was retained even one month after the program concluded, although a statistically nonsignificant reduction was observed in Hispanic versus non-Hispanic participants (31% vs. 41%). Participants were highly satisfied with the program (over 93%), citing its interactive nature, skill-building activities strengthening parent-child communication, and the program facilitators' exceptional delivery of program material.

Seven Strategies for Child Abuse Prevention Intervention

1. Talk with another parent about the situation.
2. Notify an authority figure at the school.
3. Ask your child what they think about the adult.
4. Talk with your child about what to do if they feel uncomfortable with the adult.
5. Talk with the adult and get to know him/her better.
6. Ask the adult about what he/she is doing.
7. Explain to the adult why you are not comfortable with his/her behavior.

Participants Who Would Use All 7 Strategies to Intervene in Test Case



Clinician outcomes. Clinician outcomes were not measured as part of this program.

Community impact. After attending the program, participants demonstrated stronger confidence in their ability to identify community resources (85% at 1-month follow-up vs. 68% at baseline; $p < 0.05$). Non-Hispanic participants exhibited significantly greater confidence in their ability to identify community resources than Hispanic participants at 1-month follow-up (100% vs. 68%, respectively; $p < 0.05$). After training, participants continued to identify some of the same community-specific resources identified during the pre-test (e.g., police, YWCA, churches, schools, and hospitals), but also identified additional, newly acquainted community-specific resources, such as Women Organized Against Rape.

Cost savings. Not applicable.

Key Components of Success

Core elements deemed essential to the success of the program included convening in small group sessions with scheduling options (i.e., four 2-hour weekday sessions or two 4-hour weekend sessions); culturally competent bilingual trainers with ties to the community and rape crisis centers; empowering parents and caregivers with appropriate materials to protect their children with increasing confidence; teaching parents and caregivers communication strategies to interact with their children; fostering a dialogue between facilitators and participants about barriers to bystander intervention; and emphasizing the importance of parental involvement in modeling to children—through behavior and communication—the importance of personal safety and boundaries.

Kudos To The Team

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Preconception, Prenatal, & Postpartum Care



Addiction in Pregnancy Program

Buckeye Health Plan

Description

The incidence of babies born with a diagnosis of neonatal abstinence syndrome (NAS) in the health plan rose from 2.3 per 1,000 births in 2007 to 62 per 1,000 births in 2013. This was a 508% increase. The state of Ohio suffers from five deaths per day from drug overdose. Pregnancy is the time in these individuals' lives where they have the best chance of conquering their addiction permanently.

Babies born with NAS are more likely to be low birthweight babies and are more likely to have respiratory problems. The need for neonatal admission and length of stay is much greater than babies born without NAS. Also, the withdrawal experience for the baby is painful, involving severe central nervous system, gastrointestinal system, and respiratory symptoms.

The Addiction in Pregnancy Program identifies pregnant members known to have addiction problems or suspected to have such problems. Integrated case management is provided through the obstetric care managers and behavioral health care managers. Newly identified members are quickly connected to the appropriate providers to meet their medical and behavioral health needs.

The program began in October 2013 and has enrolled more than 100 women. An eligible member includes any member who is pregnant, planning on pregnancy, or has recently been pregnant and has a current or previous history of addiction. The Addiction in Pregnancy Program uses a matrix of medical claims and pharmacy claims over different time spans that suggest levels of risk of the health plan's pregnant members for addictive problems. An important method of identifying pregnant members is when they present to the emergency department or are admitted to the hospital for addiction-related problems. The health plan's utilization management nurses and medical directors refer these members to the team when they are identified.

Predictive modeling software is used as well. Impact Pro[®] is used to review current and future risk, identify opportunities to affect utilization, care gaps, claims, and pharmacy information.

The Addiction in Pregnancy Program is available to members in the health plan's Medicaid and Medicaid Expansion populations. The program resulted in shorter (than expected) neonatal hospital lengths of stay and improved HEDIS rates in participants.

The program described is responsive to the following Medicaid priority area:

Priority

- Improve access and health outcomes for vulnerable populations.

Research

Gawronski, K., Lehman, K., Gardner, D., Giannone, P., & Prasad, M. Neonatal outcomes following in utero exposure to buprenorphine/naloxone or methadone. *American Journal of Obstetrics and Gynecology*, 208(1), S68.

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Massatti, R., Falb, M., Yors, A., Potts, L., Beeghly, C., & Starr, S. (2013). Neonatal abstinence syndrome and drug use among pregnant women in Ohio, 2004-2011. <http://www.healthy.ohio.gov/-/media/HealthyOhio/ASSETS/Files/injury%20prevention/NAS%20Report%20FINAL.ashx>. Published November, Accessed August 12, 2014.

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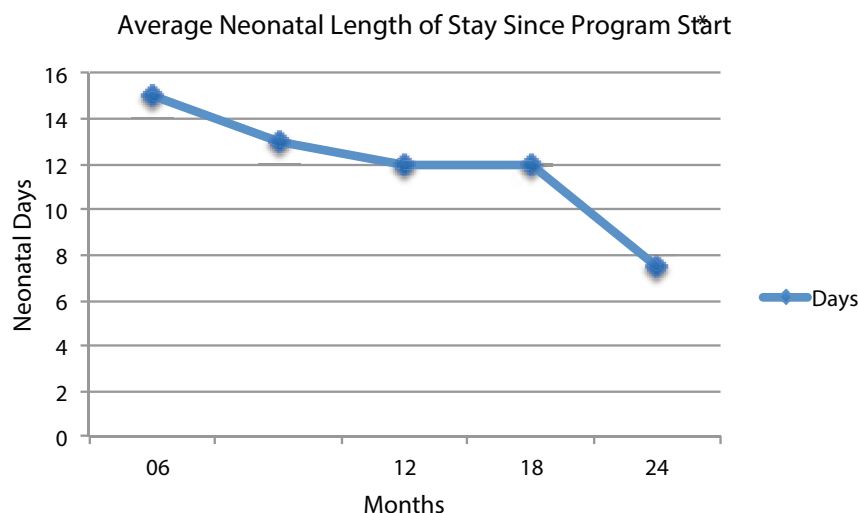
Prasad, M., Calaway, B., & Abdel-Rasoul, M. (2013). Obstetric and neonatal sequelae of buprenorphine/naloxone (B/N) exposure versus methadone maintenance (MM). *American Journal of Obstetrics and Gynecology*, 208(1), S201.

Intervention

The Buckeye Health Plan believed its experiences in outreach, education, care coordination, and a special relationship with obstetric providers put the plan in a position to positively affect these pregnancies. The goals of this program are to maintain enrolled members in the program through delivery, reduce the number of babies born with NAS, reduce the average number of neonatal days for this population, increase the number of mothers who remain drug free or on opioid maintenance therapy 18 months after delivery, and decrease fragmentation of care.

Outcomes

The average inpatient length of stay for NAS infants in Ohio ranged from 20.1 in 2008 to 15.9 days in 2011



Other Key Metrics

Average gestational age	37.8 weeks
Average birth weight	6.6. lbs
Preterm delivery rate	20%
Neonatal admission rate	32%

Patient outcomes. One hundred and fourteen members have enrolled in the program, including 55 who delivered babies. The care management team has been able to maintain 34 members (62%) in the program, with the goal of managing and coordinating care for them up to 18 months post-delivery. There are 4 out of 9 members who remain drug free or on maintenance therapy 18 months after delivery (5 are unable to be confirmed due to disengagement in care management). Of the 55 deliveries, 19 babies (34.5%) had NAS at delivery

Clinician outcomes. HEDIS initiation and engagement measures for substance abuse are improved in health plan enrollees. The HEDIS Initiative IET/ Engagement IET rates for members enrolled in the program are respectively 64.71% and 35.29% compared with 32.26% and 2.27% for the entire health plan population.

Community impact. An expansive program requires local connectivity. A community is only affected when those who are most vulnerable are attached to the services and health care they need. A network of community health workers and “medication support sites” helps the health plan find its members, build trust, and deliver results so that the next individual who is challenged with addiction will take the steps to move forward.

Each time trust is built in a community, it makes it easier for the next member to reach out. Enrolled members often find themselves at a place where they have lost their traditional support systems. Unfortunately, the only people left in their lives’ are ones who still cultivate their addiction habits.

Keeping moms in treatment with Medication Assisted Therapy means fewer newborns in the community will suffer from their mothers’ narcotic addictions. These babies will get a fair start in life. The community, in turn, is one step healthier and has individuals who can pass on stories of hope. This lets this program and similar ones grow.

Key Components of Success

The health plan identified staff members from the medical side and behavioral health side with the capability to lead and organize while interacting with individual members with genuine sympathy. The integrated case work nature of this program demands such a combination. Position requirements were adjusted so that there was manager-level staff who could give full attention to the program.

Success is possible in this population only if the individuals gain a level of trust to work with the doctors, nurses, counselors, social workers, and care managers who are prepared to help them. Addicted members have often lost the important supportive connections they need during this critical time.

Further, the health plan's members with addiction want to keep their babies, and there is disincentive to share their addiction problems with their OB providers. The care management team works with the member and Department of Children and Family Services (DCFS) to engage the member into treatment to potentially reduce the negative impact of opiate use of the baby and keep the baby with the member.

Kudos To The Team

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Mindy J. Crawley, MSW, LSW - Behavioral Health Intensive Care Manager

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Kim Reedy, RN - Case Manager II

Cindy Ringler, RN, CCM - Case Manager II

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Care Rewards for Postpartum Visits

Keystone First – Southeastern Pennsylvania (SEPA)

Description

All Keystone First members who have recently given birth were eligible to receive a \$25 Walmart gift card or two packs of diapers after completing their postpartum visit (three to eight weeks). Upon completion of the examination, the provider ePrescribes or faxes approval for the incentive to a contracted pharmacy services supplier (PSS); the member then receives the gift card or diapers within two to three business days, thereby providing Keystone First almost real-time updates of members' postpartum visits and allowing for rapid follow-up for nonadherent members.

From January 2015 to June 30, 2015, 1,185 postpartum care rewards were distributed, contributing to increased month-vs.-month HEDIS Postpartum Care rates compared with 2014 (ranging from 7.6% in January 2014 vs. 2015 to 12.4% in June 2014 vs. 2015).

Care Rewards Program participants were female Keystone First members (average age, 27 years; range, 11-63 years), primarily African American (55.5%) or Caucasian (27.6%), who have recently given birth, but have not yet performed a postpartum visit within the recommended postpartum visit timeframe. Additionally, 8.8% of participants were Hispanic/Latino.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Address social determinants of health to increase access and engagement.

Research

American Academy of Pediatrics, American College of Obstetricians and Gynecologists. (2012). Guidelines for perinatal care. 7th ed. Elk Grove Village, IL: AAP; Washington, DC: American College of Obstetricians and Gynecologists.

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Wisconsin Department of Health Services. (2013). Do incentives work for Medicaid members? A study of six pilot projects. Madison, WI: Wisconsin Department of Health Services. <http://www.dhs.wisconsin.gov/publications/p0/p00499.pdf>

Intervention

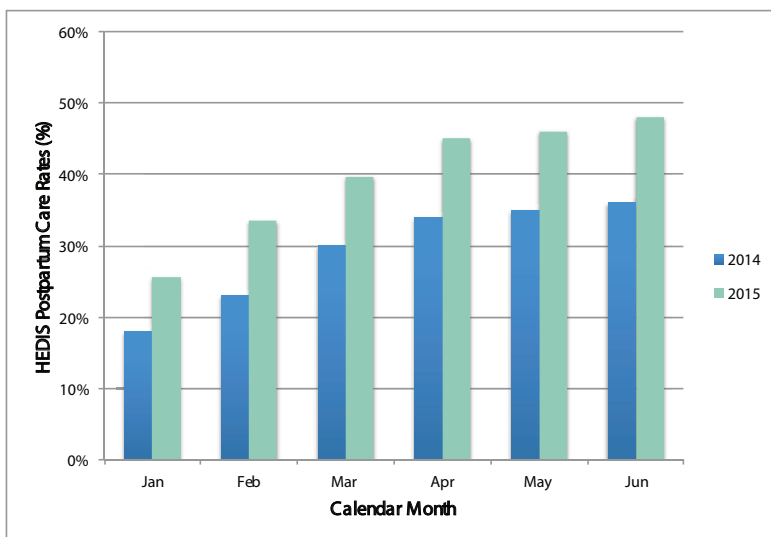
Keystone First members who have recently given birth are contacted by mail introducing them to the Care Rewards Program. Follow-up phone calls from the PSS remind members of their eligibility to receive a \$25 Walmart gift card or two packs of diapers after completion of their first postpartum visit (three to eight weeks after giving birth) and assist the member with scheduling the postpartum visits or transfers her to a Bright Start® maternity care manager for help in addressing barriers to care. Upon completion of the postpartum examination, providers ePrescribed or faxed a completed program fax form to PSS to release the incentives to members. PSS subsequently contacted members to determine the baby's birthdate, weight, and gestational age (in weeks), confirmed their correct addresses, and then informed Keystone First of the postpartum visit date and all of the pertinent aforementioned details of the baby's birth. The member subsequently received the gift card or diapers within two or three business days.care.

Outcomes

Patient outcomes. From January 1, 2014, to June 30, 2015, 1,185 postpartum care rewards were distributed to new moms who received postpartum care (214 diapers and 971 gift cards). The total number of Keystone First members in the SEPA service area who received postpartum care, including those who participated in the Care Rewards Program, increased from 1,228 to 5,768 and from 1,816 to 5,768 in the January to June 2014 and 2015 periods, respectively.

High participation in the Care Rewards Program was also reflected in the Healthcare Effectiveness Data and Information Set (HEDIS®) postpartum care rates for the SEPA service area, which markedly increased in every calendar month of 2015 compared with 2014, ranging from 7.6% in January to 12.4% in June.

Comparison of HEDIS Postpartum Visit Rate Between the Months of January through June of CY2015 versus 2014. The entire 2015 member population (Jan–June) received gift cards.



Clinician outcomes. Clinician outcomes were not measured as part of this program. However, Care Rewards Program encourages and assists members in engaging with their providers, a postpartum-care interaction that might not have otherwise occurred. This includes reducing or removing barriers to provider visits. Past meeting with OB/GYN providers has revealed that providers are eager to assist with any program that encourages Keystone First members in their patient panel to come in for postpartum visits.

Community impact. Postpartum care helps address a number of population health-related issues that are of great concern to the community, including the physical, behavioral, and social health of mothers and their children. An increase in the postpartum-care rates results in healthier mothers and babies, and a lower burden on limited community-based resources. Additionally, new mothers have many questions concerning how to take care of themselves and their children (e.g., breastfeeding, childhood immunizations, etc.) that may be answered during such visits and, thereafter, by Keystone First staff.

Cost savings. Not applicable.

Key Components of Success

Provider buy-in was a concern early during the implementation, and Keystone First made every effort to streamline the process to the greatest degree possible. Patient empowerment, whereby the member visited the provider with the appropriate member incentive forms and eager to receive the postpartum service, went a long way toward achieving provider support.

Four main elements have contributed to the success of this program: Provider satisfaction, especially because patients are coming in for postpartum visits and the initiative is easily incorporated into their existing electronic medical record system; member satisfaction because rewards are so quickly received; an efficient and dedicated PSS; and almost real-time alerting of Keystone First staff of members' postpartum visits, allowing the health plan to more effectively target members and improve

Kudos to the Team

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Nabta Idries, Quality Performance Specialist

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Heather A. Ruszin, COO (StellarRx)

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Teen Education Awareness Movement (T.E.A.M. Outreach Program)

Peach State Health Plan

Description

The T.E.A.M. Outreach Program was designed to reduce teen deliveries and neonatal intensive care unit (NICU) admissions in Dougherty County, a rural area in the southwest region of Georgia. This Medicaid-based program, implemented in 2014, uses a holistic approach in reaching out to, engaging, and educating teens on the importance of pregnancy prevention and making healthier life choices.

In Dougherty County, the volume of teen pregnancies is much higher in African Americans, as they represent 67% of the population, compared with 31% in the state of Georgia. The common thread among teens in this area is a lower rate of education. As a result of these alarming statistics, Peach State Health Plan collaborated with Mirian Worthy Women's Health Center (a federally qualified health center) and the Network of Trust School Program to offer interventions that encourage healthier life choices while focusing on the teen and any influences within their family and community. This intervention was tailored to address the large percentage of African American teens within this rural area.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Control or reduce the per capita cost of care or increase efficiency.
- Address social determinants of health to increase access and engagement.

Research

Georgia ranks among the highest in teen pregnancy rates in the nation. According to the Georgia Oasis Analytical Statistical Information System, in 2013 the state teen pregnancy rate was 20.2 percent while the teen pregnancy rate in Dougherty County was 34.4 percent. Teen pregnancies are a leading cost in medical expense for many health organizations. In 2009, it was reported that teen childbearing in the State of Georgia cost taxpayers approximately \$344 million with \$5.8 million in Dougherty County alone. The high medical costs can be attributed to the lack of prenatal care resulting in undesirable birth outcomes such as NICU admissions and infant mortality.

Intervention

To reduce teen pregnancies and NICU admissions, the program set out three goals: Providing face-to-face education to decrease the number of unintended pregnancies; improving the self-efficacy of teens in this area by encouraging a positive self-esteem and the promotion of self-worth; and ensuring that pregnant teens obtain a diploma by fostering an environment centered on earning high school credits while focusing on choosing healthier behaviors.

Master-level social workers and community sponsors developed an integrated approach focused on self-empowerment, self-efficacy, and self-awareness of the teenage population in Dougherty County. The T.E.A.M Outreach Program worked with the Mirian Worthy Women's Health Center and the Network of Trust School Program to provide culturally diverse interventions intended to promote healthier behaviors. The T.E.A.M. interventions targeted both male and female teens and did the following: Provided in-home learning sessions with the entire family to increase communication between parents and teens on sex education; collaborated with Network of Trust School Program to offer interactive educational courses on teen pregnancy prevention where participants earn credits toward their high school diploma; conducted monthly self-awareness classes designed specifically for teens to build self-esteem; and hosted healthy lifestyle events outlining the benefits of abstinence and various birth control methods.

The health plan also partnered with Taking Time for Teens Coalition and The Boys and Girls Club during National Teenage Pregnancy Prevention Month to host the Teen Maze event in Dougherty County. This interactive event provided real-life experiences and potential consequences of engaging in unhealthy behaviors, such as pregnancy, sexually transmitted diseases, hospitalizations, parenthood, and death. It also taught them about the importance of positive decision-making.

Outcomes

Patient outcomes. The T.E.A.M. Outreach Program monitored its female teen population ages 13-19 in Dougherty County along with that cohort's delivery rate and outcomes in 2013 and 2014. In 2013, there were 1,593 female teens, of which 96 became pregnant and gave birth that year, a 6% delivery rate. Of the 96 deliveries, 14 resulted in a NICU admission (15% NICU rate). In 2014, the female teen population increased by 33%, to 2,072 teens. Even with the increase in membership, only 98 females became pregnant and gave birth, resulting in a 4.7% delivery rate. Of the 98 deliveries, only 10 resulted in a NICU admission (10% NICU rate).

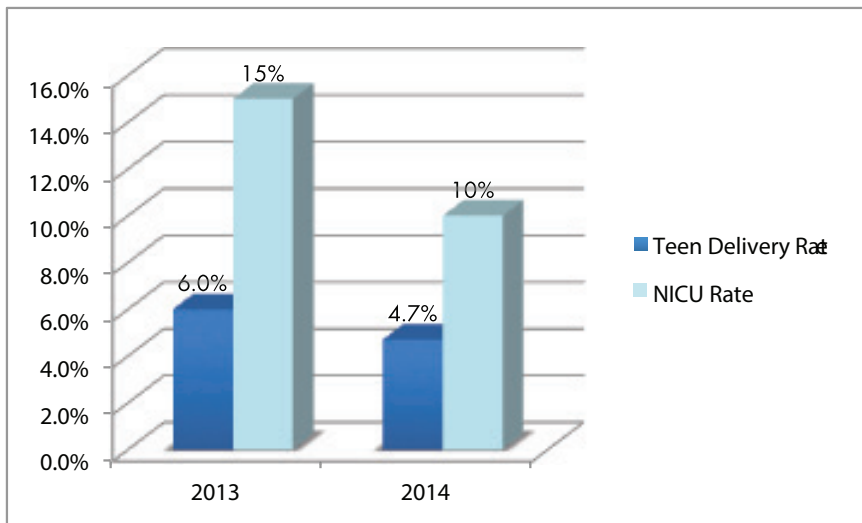
Community impact. In comparing time spans, Dougherty County's teen delivery rate decreased by 22% and the NICU rate decreased by 33%. This program was nationally recognized by winning a Case In Point Dorland Platinum Award in 2015. Peach State Health Plan hopes to expand this program throughout the state of Georgia and continue to combat the teen pregnancy population by creating interventions that are directed at fostering positive influences through role modeling, education awareness, and health promotion.

Cost savings. Overall, Peach State Health Plan's membership in Dougherty County has shown significant improvements related to teens and their delivery outcomes.

The efforts involved with the T.E.A.M Outreach Program not only demonstrate declining trends in teen pregnancies and NICU admissions in Dougherty County but also contribute to the reduction of medical cost with a cost avoidance of nearly \$1 million in 2014.

In 2015, this program was nationally recognized by winning a Case In Point Dorland Platinum Award. It is our hope to expand this program throughout the state of Georgia and continue to combat the teen pregnancy population by creating interventions that are directed at fostering positive influences through role modeling, education awareness, and health promotion.

Teen Delivery & NICU Rate - Dougherty County, GA 2013-2014



Key Components of Success

The health plan understood the needs and disparities of the members for which it was providing services. The program made sure participants had access to services and that materials were culturally relevant and advocated for the member to be at the helm of the decision-making throughout the program. It also helped that the program took a holistic approach and services were provided in the teen's normal environment. Program partnerships in the community were instrumental in the success of the intervention. Local community partners helped link members with resources that addressed the psychosocial needs of the family.

Kudos to the Team

Team Lead

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Team Members

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Teratogenic Drug Safety Program

US Script

Description

The Teratogenic Drug Safety program, initiated in 2012, focuses on women of child-bearing age who may inadvertently receive medications that would be unsafe for their unborn child. The program is a real-time restriction on teratogenic drugs, which are stopped at the point of sale until there is confirmation that the member is not pregnant.

Predictive modeling using drug claims data (i.e., prenatal vitamins) in females receiving teratogenic agents was used to profile the target population.

The program described is responsive to the following Medicaid priority area:

Priority

- Improve access and health outcomes for vulnerable populations.

Research

Chemically induced birth defects, including those associated with drug exposure, probably account for less than 1 percent of all birth defects.

Intervention

A point-of-sale edit is programmed to identify female members of child-bearing age who may be attempting to obtain a teratogenic agent. The claim is stopped until there is verification that the member is not pregnant. This process educates the member about the potential risks that the medication can have on an unborn child. It also coordinates care with member's physician and the dispensing pharmacy to prevent potential drug misadventures.

Outcomes

Patient outcomes. Up to 3% of pregnant women between the ages of 11 and 50 were prescribed a teratogenic agent during the program. These prescriptions were detected and appropriate action was taken at the point-of-sale, preventing teratogenic impact.

Clinician outcomes. More than 230,000 claims were rejected, preventing the dispensing of teratogenic agents, indicating that pregnant women avoided potential risks to their unborn child

Community impact. Pregnant women within their respective communities in the states where Centene operates receive additional safety precautions for their unborn children. If the children were inadvertently exposed to teratogenic agents, they could suffer physical or mental disabilities that could be a financial burden to their communities

Cost savings. Health care savings of 1% of total drug expenditure per year were realized.

Outcome: January 1st, 2015 thru May 18th, 2015

State/Plan	Total Members	Affected Members	Rejects
Ohio	280,746	6,314	17,974
India	48,901	1,100	3,131
Texas	980,485	22,052	62,774
Georgia	391,232	8,799	25,048
Florida	451,208	10,148	28,888
South Carolina	110,877	2,494	7,099
Mississippi	137,719	3,097	8,817
Louisiana	347,819	7,823	22,269
Illinois	175,761	3,953	11,253
Washington	204,030	4,589	13,063
Kansas	145,500	3,272	9,315
New Hampshire	66,998	1,507	4,289
California	177,251	3,987	11,348
Arkansas	45,406	1,021	2,907
Massachusetts	48,780	1,097	3,123
Arizona - Bridgeway	5,651	127	362
Total	3,618,364	81,380	231,660

Key Components of Success

Stopping the dispensing for the teratogenic drug at the point of sale prevents females who may be pregnant from putting their unborn child at risk. A retrospective review may be too late, so early intervention is a key attribute of the program.

Kudos to the Team

Team Lead

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Understanding & Addressing Unique Needs of the Expansion Population



Bridging the Gap: Connecting At-Risk Members to Health Care Services

Health Partners Plans (HPP)

Description

The Bridging the Gap: Connecting At-Risk Members to Healthcare Services program was designed to assist an emerging at-risk population of members with accessing necessary care—specifically, routine diagnostic testing for chronic disease management. Care was coordinated by connecting these members to convenient lab testing in their own homes, encouraging them to return to their primary care physicians, and urging them to opt in for case management services.

By Phase 3 of the program, which included 4,127 members, 79.45% completed their lab work, 76.18% connected with their PCP, 92.66% had a PCP visit, and 22.83% opted in for case management services.

The initiative began in 2013. The plan's Medicaid population in the five-county area around Philadelphia is as follows: 46% black, 32% Hispanic, 15% white, 4% other, and 3% Asian.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Promote patient-centered care through engagement and shared decision-making.
- Address social determinants of health to increase access and engagement.

Research

Heidenreich, P.A., & Trogon, J. G. (2011). Forecasting the future of cardiovascular disease in the United States: A policy statement from the American Heart Association.

Intervention

Health Care Plans developed an outbound auto voice message, approved by OHS, and sent the message to all targeted members. The message notified members of the program, told them when to expect a call from the lab vendor, and gave them a dedicated contact person to call with questions.

Members were further offered an incentive in the form of a reloadable gift card if they completed the blood draw, followed up with one of the health coaches, or enrolled in case management if there were abnormal results, after being contacted by a coordinator.

Through auto-messaging vendors' Smart Append system, the health plan obtained updated phone numbers on 110 (7.1%) of the members identified. This addressed some of the ongoing phone number issues of both the case managers and the network providers. In addition, care coordinators and health coaches manually searched CCMS data to find possible updated contact information from ER admissions, DME referrals, or call-ins by members. These data were sent back to the vendor weekly.

The lab vendor identified members who were hesitant to allow an unknown person into their home or was unsure of what was expected of them; this information was relayed to the health plan. These members were then engaged by health coaches and encouraged to have their labs drawn, to follow up with their PCP, and to join one of the health plan's many Healthier YOU health and fitness programs.

The health plan held weekly teleconferences with the vendor to mitigate barriers and coordinate follow-up and automated calls to engage members.

Outcomes

Patient outcomes. During 2014, the total number of members included in Phase 3 was 4,127. After the interventions were implemented, 79.45% completed their lab work, 76.18% connected with their assigned PCP and also completed their lab work, 92.66% had a PCP visit, and 22.83% opted in for case management services.

This table includes the data from the first phase of this intervention that involved members who had not had lab work completed and who were at risk for cardiovascular complications. Total members included Phase 1 were 1,484 and the timeframe was all of calendar year 2013. Based on the interventions mentioned above, 61.19% completed their lab work, 55.66% connected with their assigned PCP and also completed their lab work, 78.77% had a PCP visit and 24.39% opted in for case management services.

Notes		LDL Lab		Completed LDL & Connected with PCP		PCP Visit		Case Managed	
Yes	14.42%	Yes	61.19%	Yes	56.66%	Yes	78.77%	Yes	24.39%
No	85.58%	No	38.81%	No	44.34%	No	21.23%	No	75.61%

Clinician outcomes. Clinician outcomes were not measured as part of this program.

Community impact. Community impact was not evaluated as part of this program.

Cost savings. Cost savings were not measured as part of this program.

This table includes the data from the second phase of this intervention that involved members who had not had lab work completed in phase one and were still outstanding for completing their lab work and returning to their PCP and additional members who were identified at risk for cardiovascular disease. Total members included in phase 2 were 1,202 and the timeframe was all of calendar year 2014. Based on the interventions mentioned above, 64.14% completed their lab work, 58.74% connected with their assigned PCP and also completed their lab work, 79.45% had a PCP visit and 23.88% opted in for case management services.

Notes		LDL Lab		Completed LDL & Connected with PCP		PCP Visit		Case Managed	
Yes	12.40%	Yes	64.14%	Yes	58.74%	Yes	79.45%	Yes	23.88%
No	87.60%	No	35.86%	No	41.26%	No	20.55%	No	76.12%

This table includes the data from the third phase of this initiative that involved members who had not had lab work completed in phases one and two and were still outstanding for completing their lab work and returning to their PCP and additional members who were identified at risk for cardiovascular disease. Total members included in phase 3 were 4,127 and the timeframe was all of calendar year 2014. Based on the interventions mentioned above, 79.45% completed their lab work, 76.18% connected with their assigned PCP and also completed their lab work, 92.66% had a PCP visit and 22.83% opted in for case management services.

Notes		LDL Lab		Completed LDL & Connected with PCP		PCP Visit		Case Managed	
Yes	13.57%	Yes	79.45%	Yes	58.74%	Yes	79.45%	Yes	23.88%
No	86.43%	No	20.55%	No	23.82%	No	7.34%	No	77.17%

There is not enough evidence at the 0.05 level (95% confidence) to conclude that the phase 2 rate of having both an LDL and PCP visit completed (58.74%) is different than the phase 1 rate of having both an LDL and PCP visit completed (55.66%).

There is sufficient evidence at the 0.05 level (95% confidence) to conclude that the phase 3 rate of having both an LDL and PCP visit completed (76.18%) was greater than the phase 2 rate of having both an LDL and PCP visit completed (58.74%).

There is sufficient evidence at the 0.05 level (95% confidence) to conclude that the phase 3 rate of having both an LDL and PCP visit completed (76.18%) was greater than the phase 1 rate of having both an LDL and PCP visit completed (55.66%).

Key Components of Success

What is perceived as a convenience for members may not actually be seen as a convenience by them. Home blood draws were at times viewed as an invasion of privacy when members did not feel that they had either the backing of their PCP or health plan. The health coaches were essential in addressing those concerns and getting the bloodwork completed. A conversation with health coaches reassured members about privacy issues and encouraged them to have blood drawn at home. That added component of connecting with members and facilitating the follow-up and PCP visits increased member participation in this program.

Additionally, because the original vendor could not keep up with the amount of lab work needed, the program's openness and willingness to address this problem—by finding a vendor that could prioritize the members—was a huge part of the success of this program. The increased home lab testing during the third phase is a direct result of that vendor shift.

Kudos To The Team

Team Leads

Director of Accreditation and Clinical Programs Catherine McCarron and Care Coordination Unit Manager Debra

Team Members

Disease Management staff, Network/ Contract Management staff and Health Care Economics staff

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Community Care Management Team: Philadelphia and Chester Hubs for Superutilizers

Keystone First

Description

The primary goals of the Community Care Management Team (CCMT) program identified prior to implementing the initiative in 2013 were to use a community-based intervention for the following: One, to engage and improve the health outcomes of hard-to-reach members living in Philadelphia and Chester who have fallen through the cracks of our health care system with unmet care coordination needs as evidenced by high utilization rates of acute care services. Two, to facilitate member access to necessary medical and behavioral health services—including all available social support resources—by providing navigational support. Three, to improve the quality of care received by the member through supporting the exchange of information between the health plan and providers (including pharmacy, home health, etc.), and by increasing the members' ability to self-manage and advocate effectively on their own behalf. Four, to reduce avoidable acute hospitalization and associated costs.

To date, 228 high-risk, Keystone First members have been engaged in the program. The community-based interventions often last for months and are discontinued with a goal of reconnecting members with a functioning care team, including telephonic care managers. Members engaged spanned a wide range of ages (2-91 years), although most were adults (19-55 years; 48%; > 55 years; 34%). The majority of members engaged at both sites were black (Philadelphia, 80%; Chester, 60%), followed by white and Hispanic (Philadelphia, 10% each; Chester, 20% each). Most members have complex comorbidities including uncontrolled chronic illness and behavioral health-related needs.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Promote patient-centered care through engagement and shared decision-making.
- Control or reduce the per capita cost of care or increase efficiency.
- Reduce disparities in care of racial and ethnic minorities.
- Address social determinants of health to increase access and engagement.

Research

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Intervention

The Keystone First CCMT began in 2013 as an initiative to extend the traditional care management continuum by providing community-based, face-to-face, high-touch individualized care management for superutilizers living in Philadelphia and Chester who could not be contacted telephonically or who are engaged telephonically but continue to have unmet needs. The teams are divided into two regional hubs, one per county, consisting of a social worker, nurse, and three or four unlicensed community health workers (CHWs). The team uses ongoing in-person interactions and follow-up care to address a member’s medical, behavioral, and social needs. The CCMT visits members in their homes and out in the community, attends physician appointments with members (where indicated), assists members with transition of care, and connects members to general community-based services (e.g., food, employment and volunteer services; support with utility bill payment).

The CCMT engagement approach is (1) identifying actual or potential superutilizers with unmet needs by referrals from population data mining, telephonic case managers, hospital discharge planners, or primary care physicians; (2) finding and engaging these members in the communities where they live; (3) assessing and addressing immediate medical, behavioral, and social need(s) using a trauma-informed, strength-based approach; (4) establishing a connection to the medical and behavioral health neighborhood and social services; (5) monitoring and supporting execution of a common plan of care by addressing barriers and closing care gaps; and (6) promoting self-management by coaching members to develop problem-solving and self-advocacy skills, helping each member get to his or her highest level of self-management, and having a permanent and effective care team in place, including health plan telephonic care manager.

In this integrated model, CCMT nurses, social workers, and CHWs have distinct yet interconnected roles. CCMT nurses play a key role in mitigating medication confusion for the member and the care team as well as increasing members’ health literacy, coaching, and serving as the eyes and ears for the members’ physicians. CCMT social workers focus on addressing unmet behavioral health needs and highlighting the members’ strengths to support effective self-care and member-centric care plans. CCMT care connectors are essential in building trust, establishing rapport, and supporting members in their navigation through the health care system, as well as ensuring members are connected to community resources to address their social needs.

Outcomes

Patient outcomes. To date, 228 Keystone First members have been engaged by both CCMT hubs, with 79 members currently engaged. During July 2015 alone, the CCMT made 868 phone calls and 317 face-to-face visits to engaged members, as well as coordinated 176 PCP and specialist appointments on their behalf. CCMT also coordinated with behavioral health services, supported vitals monitoring and health coaching, and managed open social services pathways of active members. During July 2015, the average engaged member received the following from CCMT: 3.0 visits, averaging 1 hour in length; 8.3 phone calls; 3.6 coordinating calls to others on their behalf; and 0.5 visits to community-based organizations on their behalf. As barriers were identified and removed, members demonstrated better understanding and capacity to make health choices that measurably improved clinical outcomes such as medication adherence, controlled blood pressure, and blood glucose levels, delivering strong trends in reduced inpatient admissions and stays.

CCMT Engagements During Month of July 2015

Profile Sampling of CCMT Engagements	15Percent of Members
Coordinated with behavioral health services	68
Supported Vitals monitoring:	
• diabetes	35
• respiratory conditions	35
• chronic heart failure	22
• coronary artery disease	20
Supported RN/CHW-led coaching:	
• self-management coordinator	100
• medication management	90
Managed open social services pathways:	
• help with home safety or connection to resources for new housing	29
help with ongoing education or getting a GED*	16
help with transportation to medical appointments	15

Clinician outcomes. Clinician outcomes were not measured as part of this program. However, the CCMT program has fostered opportunities for new types of relationships between payer and provider, collaborating closely with both individual providers and large health systems in managing the care of members with complex chronic conditions.

“The Keystone Community Case Management team has been instrumental in the management of the most medically and socioeconomically complicated patients of our practice. The opportunity to collaborate with nurses, social workers and community care workers from Keystone First, and more closely work with the patients themselves, allows us to better exchange information and combine resources. The results are expanded services and improved coordination of care for our challenging patients.” George Valko, M.D. The Gustave and Valla Amsterdam Professor of Family and Community Medicine and Vice Chair for Clinical Programs and Quality, Sidney Kimmel Medical College of Thomas Jefferson University; Medical Director, Jefferson Family Medicine Associates.

Community impact. The CCMT program has supported and encouraged connections between payer, member, and community-based organizations. Many Medicaid members are only marginally (if at all) connected with community resources that could help them better manage their health care and quality of life. The CCMT has assisted community-based organizations in reaching out to additional members in the neighborhoods they serve.

Cost savings. Although the CCMT is a relatively young program with relatively few members for comparison, 6-month pre/post engagement data shows a double-digit reduction in total costs per member per month, the majority of which can be attributed to avoided inpatient admissions. Program evaluation will continue to monitor for up to 18 months of pre/post engagement data where available.

Key Components of Success

Numerous elements of the CCMT program have contributed to its successful implementation. Extending care management into the community and home setting and developing trust with members through community care connectors and frequent face-to-face interactions has been a top reason it has done well. In conjunction with that is building a safety net of services around the member; establishing coordinated relationships with providers, emergency departments, community resources; and so on.

The initiative takes a trauma-informed approach; shares decision-making with the members, highlighting and building on their strengths; uses an integrated collaborative payer-provider teams working on one common plan of care; commits resources for ongoing training and supervision of community-based teams; and conducts ongoing and thorough program evaluation with the support of the medical economics team.

Kudos To The Team

Team Lead

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Vanessa Dawson, Community Care Management Team Administration Lead

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Hispanic Member Advisory Council

Horizon NJ Health

Description

According to the contract between the New Jersey Department of Human Services and the health plan, the company identifies the most relevant health education needs of its enrollees and implements culturally appropriate programs that will address these needs.

In 2013, Horizon NJ Health implemented a Hispanic Member Advisory Council. Conducted in Spanish, roundtable discussions are held on the most relevant health issues affecting the Hispanic community and what the health plan can do to promote access to health care, improve programs and service, and raise awareness on the most relevant health education issues. Results from council discussions have helped the organization understand how Hispanic members feel about health and managed care. It also helps the organization understand barriers (including social) to getting access to quality care.

The Hispanic Member Advisory Council consists of health plan members aged 18 and older from northern, central, and southern New Jersey. These members could be from any race within the Latino community, including Cuban, Mexican, and Puerto Rican. Each member has an in-depth understanding of Hispanics' health care barriers, health issues, health risks, and social determinants.

The council meetings are hosted in different locations throughout New Jersey. Since its implementation on 2014, the council has met in Newark, Trenton, Asbury Park, Passaic, Union City, Perth Amboy, and Camden City, high Hispanic populated cities in New Jersey.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Reduce disparities in care of racial and ethnic minorities.
- Address social determinants of health to increase access and engagement.

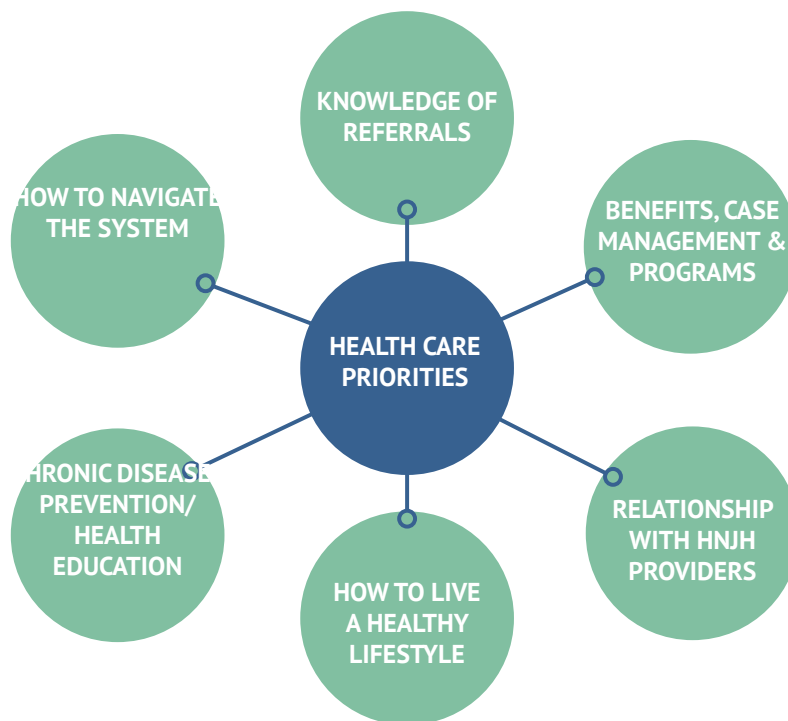
Intervention

The health plan's Member Advisory Council meets at least once every quarter in various counties throughout New Jersey. The meetings are hosted at a community-based organization (CBO) or a federally qualified health center (FQHC). Members invited to each meeting are those who live within the geographic region of the venue.

Extensive outreach was conducted by mail and phone. Each member received a written invitation at least one month in advance. The CBO or FQHC assisted with outreach by inviting members from the community. Approximately one week after the members received an invitation, staff followed up via phone to remind them about the meeting and confirm their attendance.

Community health education consultants moderated the meetings and used a sequence of open-ended questions to guide the discussion; the moderator explained the mission and vision of the health plan, the purpose of the meeting, and the mission of the council. The consultant also shared information on community health promotions, health education programs, changes in the managed care environment such as the integration of managed long-term services and supports into member benefits, and any current initiatives.

Outcomes



Source: Member Advisory Council

Patient outcomes. Since the implementation of the Horizon NJ Health Hispanic Member Advisory Council, five major health care priorities were identified and strategies have been implemented to address each of those areas. Health care priorities for Hispanic members are knowledge of referrals; how to navigate the system; chronic disease prevention and health education; how to live a healthy lifestyle, benefits, case management and programs; and relationship with Horizon NJ Health providers.

- Knowledge of Referrals: Members did not understand why they would need referrals every time they needed to see a specialist. Starting in 2014, a representative from case and care management attended the HMAc meetings. This representative would speak with members about referrals and how important they are to their health care needs.
- How to Navigate the System: Hispanic members had many questions related to eligibility and enrollment for Medicaid and NJ Family Care. In some cases, members were under the impression that managed care companies determine eligibility. In each of the health education programs, participants received an explanation of Medicaid and NJ Family Care, where individuals can apply, and eligibility guidelines. Horizon NJ Health has also created simple and easy-to-read materials in Spanish that explains the information.

- **Chronic Disease Prevention and Health Education:** Members expressed an interest in learning more about preventing and managing chronic diseases. The main topics of interest were nutrition, heart disease, high blood pressure, cancer, and diabetes. Since 2013, Horizon NJ Health has conducted health education programs at community organizations, faith-based organizations, and federally qualified health centers on these topics and many others. How to Live a Healthy Lifestyle: New health education programs on women's health, immunizations, smoking cessation, adolescent health, eating healthy on a budget, and bully prevention were developed. To increase knowledge and awareness among members, articles on these health topics have been included in members' newsletter, posted on Horizon NJ Health's social media channels, and placed on the Horizon NJ Health website.
- **Benefits, Case Management, and Programs:** A representative from case and care management attends each Hispanic council meeting and explains services provided in this program and how members can access the services. Documents were developed with the care and case management information and distributed to members who attend health education programs and community events. The case and care management department has staff in the community to assist members with any questions and inquiries.
- **Relationship with Horizon NJ Health Providers:** Member education efforts have been increased on how to talk to the doctors and how to ask questions to the provider. Horizon NJ Health adopted the "Ask Me 3" patient education program to promote education between members and providers. With this information, health educators encourage members to ask questions and become more proactive.

Clinician outcomes. This program did not measure clinician outcomesCommunity impact. Health education should emphasize the message of prevention; any type of communication should be in Spanish and easy to understand; offer incentives to encourage community members' participation in health fairs and/or workshops, and use other venues, such as social media to advertise events. During roundtable discussions, important qualitative data was collected. Based on the data, Horizon NJ Health received valuable information about each topic discussed during these meetings: what being a member of Horizon NJ Health means; how to access Medicaid, NJ Family Care, and Medicare; health issues in the Hispanic community; how to promote programs and services; and communicating with providers.

As a result of the meetings, the health plan has developed new marketing campaigns. It developed new health education programs including a presentation on Medicaid, Medicare, and NJ FamilyCare. The plan also strengthened outreach efforts for the meetings; and it invited a representative from Care and Case Management and a representative from the Retention Department who could answer members' questions and collaborate with representatives from the health plan to assist families enroll in NJ FamilyCare and the Marketplace.

Cost savings. This program did not measure costs.

Key Components of Success

Attendance can be a challenge. However, collaborations with community-based organizations and FQHCs contribute to the success of the program. These organizations are well known by the Hispanic community, and working with them helped the health plan gain their trust and increase the interest of members. The organizations' outreach efforts helped increase members' attendance.

Transportation is a barrier for many members. The meetings have been in locations that are highly accessible for them. Approximately 80% of the attendees were mothers who take care of their children. To keep this fact from impeding members from attending, most of the community partners offered child care.

It is critical to show continued value toward all those who participate in the council meetings. Be sure to fully engage each member at each meeting; be creative, be encouraging, and welcome participant feedback (positive or negative). During these meetings, members had the opportunity to let their voices be heard, as well as an opportunity to ask questions and receive answers.

Kudos To The Team

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Lose to Win for At-risk Members with Diabetes and Prediabetes

Keystone First/ChesPenn Health Services of Upper Darby

Description

Lose to Win promotes a member-centered combination of professional advice on weight loss, support group opportunities, education on healthy food choices, preventive/disease management, physical fitness, and health screenings (including progress in reaching personal weight loss goals and improvements in clinical lab results). Conducted by Keystone First and ChesPenn Health Services of Upper Darby, the program educated and promoted healthful behaviors in at-risk Medicaid members with diabetes and prediabetes, with the aim of preventing, managing, or even reversing diabetes-related complications and stresses.

Thirty-two Keystone First members who use ChesPenn were screened for gaps in care related to diabetes and/or hypertension medication nonadherence and received personal invitations via outreach calls from ChesPenn staff. Participants were Keystone First members and patients of ChesPenn between the ages of 25 and 49 with type 2 diabetes (HbA1c > 7.5) or prediabetes who were nonadherent with their diabetes and/or hypertension medications. Program participants had low to moderate risk of heart attack and stroke, body fat composition below 35% (for females) or below 30% (for males), completed health assessment surveys, and potential for high-utilization status.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Promote patient-centered care through engagement and shared decision-making.
- Address social determinants of health to increase access and engagement

Research

Haas, L., Maryniuk, M., Beck, J., Cox, C. E., et al. (2012). Standards Revision Task Force. National standards for diabetes self-management education and support. *Diabetes Care*, 35(11), 2393-2401.

National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation. (2014). *National Diabetes Statistics Report, 2014*. Atlanta, GA: Centers for Disease Control and Prevention (CDC).

Intervention

Lose to Win consists of 7 bimonthly workshops over a 6-month period at the Lansdowne YMCA, educating members with diabetes on the topics of living well with diabetes; understanding diabetes; improving medication adherence, stress management, and physical activity; meal planning/diet and nutrition; creating a healthful plate; taking care of feet, teeth, and eyes; and reducing the risk of diabetes-related health complications.

Modeled after educational material from the American Diabetes Association (ADA) and the National Diabetes Education Project, the program was developed in collaboration with ChesPenn Health Services of Upper Darby (a federally qualified health center, FQHC), the Philadelphia Chapter of the ADA, and the Lansdowne YMCA. Members completed a health screening—involving blood pressure, BMI, full lipid panel, and blood glucose—both at baseline pre-program and 6 months post-program.

Lose to Win Program Highlights

- 1. Each session began with a discussion about the importance of making realistic lifestyle changes.*
- 2. The workshop group made suggestions to each other on busting barriers that they faced in keeping their pledges.*
- 3. Conversation Maps, a unique evidenced-based approach developed by the ADA in collaboration with Merck, employs visual and interactive participation to support the learning process.*
- 4. A Jeopardy-like interactive game was used during 2 sessions to reinforce the day's lesson.*
- 5. A 'healthful plate activity' – whereby participants created and rated breakfast, lunch, dinner meals and snacks with food illustrations on 9" plates – was used to help members understand the importance of portion control and healthful eating.*
- 6. A motivational speaker with diabetes who lost 60 pounds and dramatically lowered his glucose and cholesterol levels inspired the group to make healthy life-style changes.*
- 7. The class learned a few stress reducing exercises and participated in a meditation session.*
- 8. Members received the following take-home supportive materials and supplies: the ADA Healthy Calendar Diabetic cookbook, exercise bands, pedometers, fresh vegetables, and a variety of ADA- and American College of Physicians-sponsored diabetes workbooks and guides.*
- 9. Members who completed the health screenings received a \$25 gift card for participation prior to the start of the program (baseline), and a second \$25 gift card for post-screening activity.*

Through personalized wellness coaching, tailored exercise plans, nutrition workshops, and cooking demonstrations, Lose to Win participants learned about healthy choices and diabetes management. Outreach representatives from Keystone First's public affairs department made frequent reminder calls to members about upcoming classes and addressed any barriers to attendance. Members who completed the program participated in a graduation ceremony. Participants also received YMCA memberships to continue their healthy lifestyles.

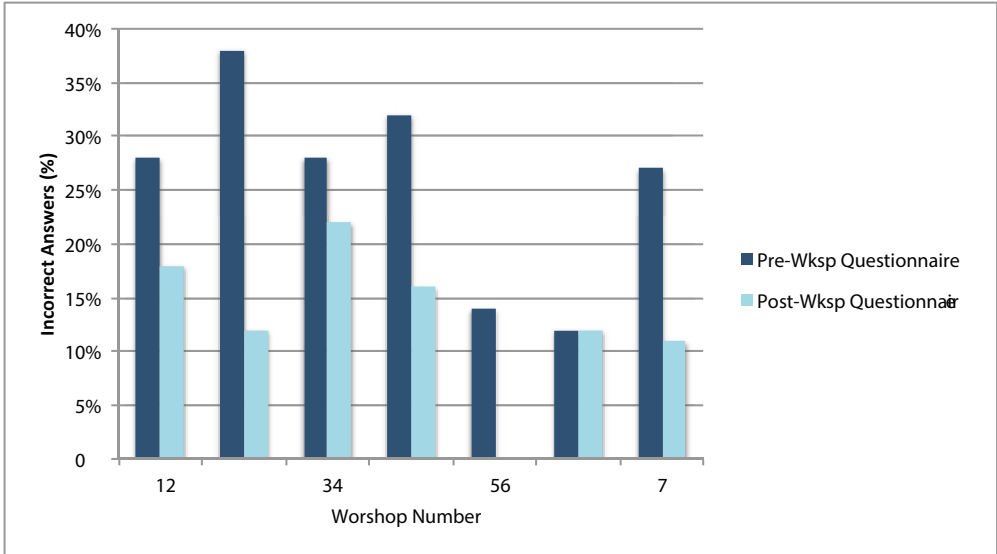
Ten members attended all 7 bimonthly sessions over a 6-month period (between May and November 2014) and received health screenings at baseline and at the final session. Seven of the 10 members lost a total of 89.8 pounds, and many members saw marked clinical improvements in cholesterol, blood glucose, blood pressure, and body-mass index (BMI).

Outcomes

Patient outcomes. Out of the 32 Keystone First members invited to participate, 16 attended at least one workshop, and 10 members attended all 7 sessions. Two members were referred to the community health educator at ChesPenn and Smoke-free Philly (CDC) for smoking cessation. One homeless member was referred to the Single Men Seeking Emergency Shelter program.

To evaluate cognitive gains after participating in the workshop, members completed questionnaires before and after the workshop. In all 7 workshops held, members supplied substantially fewer incorrect answers after participating in the workshop than before participation, with one exception. In the health outcomes evaluation, 7 members lost a total of 87.9 pounds. Additionally, up to half of participants (n = 4-5) saw clinical improvements in their lipid panels and BMI, and a majority (n = 6-8) saw clinical improvements in blood glucose level, glycated hemoglobin (HbA1c), and blood pressure.

Percent Incorrect Answers in Pre-Versus Post-Worshop Questionnaires



Screening Type	Summary*	Avg. Improved Percent Change (Percent Range)	Avg. Total (N=10) Percent Change
TC	4/10 members improved	-8.59 (-5.59 to -11.24)	+9.49
HDL	5/10 members improved	-10.70 (-2.70 to -25.00)	+6.47
LDL	5/10 members improved	-22.33 (-1.36 to -38.46)	+10.50
Cholesterol ratio	4/10 members improved	-21.57 (-13.33 to -25.32)	+9.81
TG	4/10 members improved	-22.68 (-1.36 to -38.46)	+30.63
Glucose	7/10 members improved	-29.15 (-2.78 to -58.42)	-17.73
HbA1c	6/10 members improved	-18.51 (-3.28 to -33.33)	-9.57
BP Systolic	8/10 members improved	-8.32 (-0.71 to -31.01)	-6.29
BP Distolic	6/10 members improved	-8.76 (-1.15 to -20.20)	-1.00
Weight	7/10 members improved (total 89.8 lbs. lost)	-4.58 (-0.41 to -12.39)	-2.30
BMI	4/10 members improved	-8.55 (-5.77 to -12.75)	-1.00

* Confounding factor that impacts outcomes: Some members fasted prior to pre-screening, but not prior to post-screening, thereby potentially confounding some of the post-program variables. TC, total cholesterol; HDL, high-density lipoprotein (“ Good Cholesterol”); LDL, low-density lipoprotein (“ Bad Cholesterol”); cholesterol ratio (HDL/TC); TG, triglycerides; HbA1c, glycated hemoglobin (average plasma glucose concentration over time); BP, blood pressure; BMI, body-mass index.

Clinician outcomes. Clinician outcomes were not measured as part of this program. However, the program provided additional PCP-member touchpoints that may not have occurred without the program, thereby helping to connect members and their clinicians.

Community impact. Not applicable.

Cost savings. Not applicable.

Key Components of Success

Lose to Win used incentives, transportation services, and childcare to address barriers to member participation in the program. The program included a relevant and diverse curriculum and an intensive, member-engaging strategy to encourage and remind participants of upcoming classes. Additionally, the high-touch and flexibility of the trainer—who was available from 9 a.m. to 5 p.m. to answer questions, remain after class, and provide make-up sessions—encouraged positive change in member health and wellness.

The choice of program partners is vital to the success of the program, which here included an FQHC that encouraged patient participation; the Lansdowne YMCA, which taught private classes for our participants; and the American Diabetes Association, which provided expertise and educational materials.

Kudos To The Team

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Opioids 360: From Prescribing to Recovery

CeltiCare Health Plan of Massachusetts, Inc./Centene

Description

Opioids 360 consider the health plan's management of all aspects of opioid use, addressing prescriber behavior, inappropriate member utilization, and the treatment of opioid addiction (leading to recovery). Approaching each of these components systematically allows for multiple opportunities to reduce opioid abuse and best support treatment. The health plan depends upon its award-winning Integrated Care Management Model (Dorland Award, 2015) to serve as the nidus around which it has built provider and community partnerships to expand member access to supports and services. Although the program is in its early stages, having been initiated in 2014, overall emergency department (ED) utilization has dropped since program inception. The health plan expects an increase in community tenure, a decrease in opioid overdose, and improved adherence to treatment and recovery programs.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Promote patient-centered care through engagement and shared decision-making.
- Control or reduce the per capita cost of care or increase efficiency.
- Demonstrate accountability of Medicaid health plans, including addressing fraud and abuse.
- Address social determinants of health to increase access and engagement.

Research

Graham, G. (2015). Opioid epidemic claimed estimated 1,256 lives statewide in 2014, state says. MassLive, August 4.

Nelson, A. K. (2015). One town is going to try not arresting heroin users. New Republic, May 20. <http://www.newrepublic.com/article/121857/massachusetts-police-chiefs-idea-stop-arresting-heroin-addicts>

<https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/Downloads/drugdiversion.pdf>

Intervention

Each of the three intervention domains—provider behavior, member engagement and treatment, and recovery—comprise seven interventions. The foundational programs are, relatively speaking, standard fare, as they build upon efforts commonly found at experienced health plans. The innovative initiatives are those that are generally market leading in the state Medicaid space and, in at least one instance (RxAnte®), will be first in the nation when fully implemented (fall 2015). The 21 initiatives are in varying states of implementation, from active program with outcomes to active work plan.

CeltiCare has limited prescriptions for new short-term opioids to 15 days or less (+1 refill within 60 days), which reduces the opioids available for misuse or diversion; increased use of provider and patient educational tools on standard of care, including the systematic implementation of a provider/member “opioid contract”; and improved the early identification and management of members who are likely to abuse, divert, or overdose before these events occur.

Barriers to care were removed by critically evaluating prior authorization policies governing addiction treatment programs, including medication therapy, and supporting FDA-approved abuse deterrent opioid formulations.

By engaging in successful provider partnerships that already fully support CeltiCare’s efforts or are interested in doing so, and bringing them into Integrated care management team activities, the health plan expanded the reach of its integrated care management capabilities.

CeltiCare expanded access to community-based services by creating housing-first and peer-support initiatives, expanding the availability of these critically valuable services beyond state-sponsored efforts. It also reached out to members identified to be at risk along with a “significant other” to provide access to naloxone and engage the latter in overdose rescue training.

Providers were educated to help them more effectively manage members being prescribed opioids. This included sharing best practice regarding urine drug testing for patients prescribed opioids or who are being treated for addiction. PCPs and other front-line providers in the triage of patients with substance use disorder (SUD) were supported by establishing a Provider Resource Line staffed by subject matter experts who can ensure that a patient leaves his or her provider’s office with a firm plan of care.

Opioids 360 Programs and Initiatives		
I. Provider Behavior	II. Member Engagement	II. Member Engagement
Foundation Programs		
1. Short Term Rx Limits (15 Days) 2. Abuse Deterrent Medicaidions access 3. Prescriber Outlier Management	8. State Prescription Drug Management Program 9. Pharmacy Lock-in Program 10. Integrated Care Management	15. All ASAM Treatment Levels covered without Prior Authorization 16. SUD Disease Management 17. All FDA Approved Medication covered
Innovative Initiatives		
4. Direct PCP Education 5. Member Rx Contracts 6. UDT Pilot 7. Pain Mgmt. Summit	11. MemberConnections 12. Advocates, Inc. pilot; member outreach and engagement 13. Naloxone SafetyNet 14. RxAnte opioid misuse risk stratifier	18. Vivitrol access Pilot 19. Provider SME/Triage Resource Line 20. Housing First Programs 21. Expanding access to SUD Peer Support

The three intervention domains, Provider Behavior, Member Engagement and Treatment and Recovery each are comprised of seven interventions. We consider the foundational programs to be, relatively speaking, “standard fare” as they build upon efforts commonly found at experienced health plans. The innovative initiatives are those that are generally market leading in the state Medicaid space, and in at least one instance (RxAnte®), will be first in the nation when fully implemented (Fall 2015). It should be noted that these 21 initiatives are in varying states of implementation, from active program with outcomes to active work plan.

Outcomes

Patient outcomes. CeliCare Health clinical staff have become so engaged with members that that these members who previously received little or no individual support services become:

- Grateful: “Why are you paying so much attention to me? No one has ever done that before.”
- Trusting: “I know I need to change my habits but it’s so hard. I am going to do what you suggest because I believe you wouldn’t steer me wrong.”
- Loyal: “After I leave the treatment center, they want me to enroll in XYZ program. I am not leaving here until you tell me that is the best place for me to go.”

Member disenrollment among our Managed members has decreased by 45% over the past 9 months

Clinician outcomes.

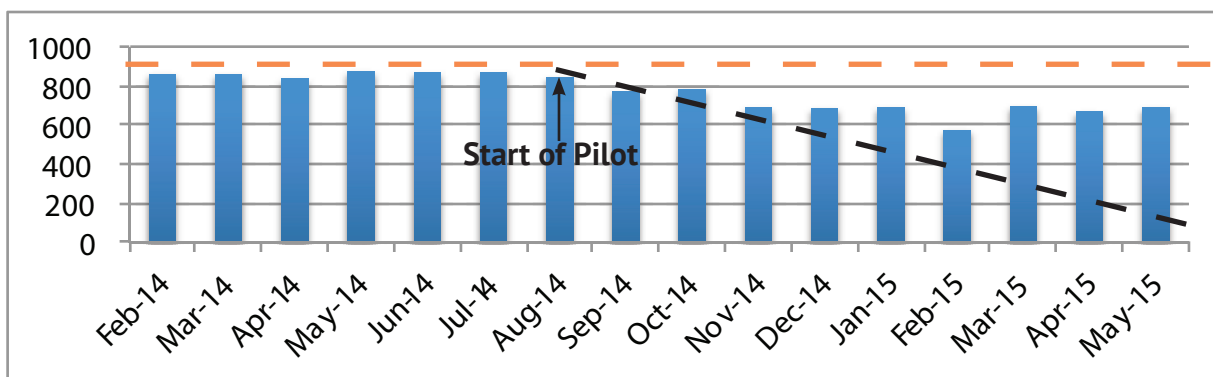
- Hospital Case Manager: “You mean you, the health plan CM, has already identified ALL of these resources for this member? You are making my job easy.”
- Treatment Center Physician: “Other health Plans wouldn’t think of allowing this patient to stay at this level care longer than the criteria allow simply to give her the best chance at long-term success.”

Direct referrals from providers and facilities into our clinical program has increased by 150% over the past 9 months since we have educated them about our efforts and they have experienced firsthand the benefits of our programs

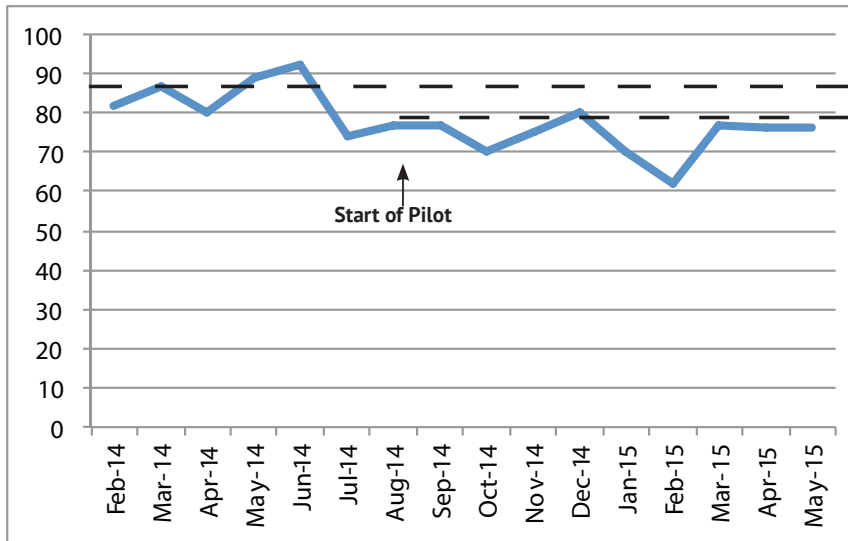
Community impact. MassHealth has expressed interest in replicating aspects of the Opioid 360 initiative across the broader Medicaid program.

- The state has requested that MCOs eliminate Prior Authorization on medications and services for treatment of SUD consistent with the policies we had already put in place

Cost savings. Emergency department use (and costs) has dropped in the health plan’s overall population.



The savings on ED Utilization accrued from Sept, 2014 through May, 2015 = \$1.97M (\$2.63M annualized).



The savings on Inpatient Utilization accrued from Aug 2014 through May, 2015 = \$2.08M (\$2.50M annualized)

Key Components of Success

The integration of physical and behavioral health care management is a primary key to success. Organizational integration with the health plan's behavioral health partner, using a single point of contact approach, and supporting each member holistically in a culturally sensitive manner has allowed the health plan to focus not only on physical and behavioral needs, but also on the social determinants of their health. These efforts have led to a greater level of member engagement and a sense of trust and respect between staff and members. Decreased emergency department use is the first of many positive outcomes the health plan expects to see as it goes forward in this long-term investment in members.

Kudos To The Team

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Psychotropic Medication Management Coaching Program (PMC)

Amerigroup Georgia

Description

The use of psychotropic medications with children is a controversial area in children’s mental health. The side effects, potential for misuse or overuse, and potential for drug interaction result in a clear need to provide timely and accurate information to the prescribing physician(s) to ensure the safety of the pediatric patient.

Furthermore, studies have indicated that children in a restrictive placement setting are the most likely to receive psychotropic medications. In a study of Texas children with Medicaid coverage, foster care youth received at least three times more psychotropic drugs than comparable children in poor families. The study also indicated that decisions to give children three or more psychotropic drugs may be largely based on behavioral and emotional symptoms rather than conclusive diagnosis of a specific mental condition. And more than 75% of the psychotropic medication use for children is off-label, a practice of prescribing drugs for a purpose other than the approved use on its label.

The health plan’s behavioral health (BH) team—a component of the Georgia Families 360° program—deployed a program to monitor prescriptions of psychotropic drugs for youth in foster care who receive one or more of these medications. The use of psychotropic medications is an integral part of treatment for people receiving care for behavioral health conditions, and the health plan’s goal is to ensure that youth in foster care are treated safely and effectively—not overprescribed medications or receiving inappropriate medications.

Description of the Population

Program	Member Count
Adoptive assistance	12,063
Foster Care	11,420
Juvenile Justice	214
CHAFFEE	200
Temporary Member	1

23,898* Adoptive Assistance (AA), Foster Care (FC) and the Department of Juvenile Justice (DJJ) program members

* Approx. 7,237 on members are currently using at least 1 psychotropic medication.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Promote patient-centered care through engagement and shared decision-making.

Research

Governing.com. (n.d.). How America's overmedicating low income and foster kids. www.governing.com/topics/health-human-services/gov-america-overmedicating-poverty.html

Illinois Department of Child and Family Services. Guidelines for the Utilization of Psychotropic Medications for Children in Foster Care.

Improving the lives of foster children through evidenced-based interventions. (2009). NIH Public Access Manuscript, 4(2).

Nauert, R. (2008). Psychotropic medications overused among foster children. Psych Central. Retrieved on September 2, 2015, from <http://psychcentral.com/news/2008/08/04/psychotropic-medications-overused-among-foster-children/2688.html>

Ohio Minds Matter: Improving the Appropriate Use of Psychotropic Medication for Children in Foster Care. (2013, September). Presented at the Center for Health Care Strategies.

Texas Psychotropic Medication Utilization Parameters for Foster Children: \\agpcorp\files\VA 1\shared\ESI Files\inbound\MISC

Intervention

The unique Management Coaching Program (PMC) model works with prescription claims to qualify members and identify potential drug therapy problems. SinfoniaRx, operated through the University of Arizona, reviewed the receipt of prescription claims for all eligible members. Pharmacy claims data are stratified to identify prescribing and usage trends, and the physician prescribers who are not following recommended evidence-based psychotropic treatment guidelines are identified.

Prescribers who are deviating from best clinical practices are flagged, and the health plan follows up with these prescribers through routine alerts, educational materials and letters, and peer-to-peer calls as needed. They are encouraged to adjust their prescribing habits, although the program does not infringe on the prescribers' decisions. Allowing them to self-regulate their prescribing patterns avoids the need for many external controls, such as prior authorizations or limit of access to psychotropic drugs.

The program has hundreds of proprietary clinical algorithms, and specific alerts were developed for the health plan's member population to target opportunities to improve medication therapy in the following areas: Adherence (mental health), coordination of care, behavioral health agents from multiple prescribers, members taking more than two behavioral health agents, safety measures such as therapeutic duplication, drug-to-drug interactions, atypical antipsychotics (e.g., diabetes screening and behavioral health max dosing), identifying the need for behavioral therapy in addition to medication, and behavioral health agent use in children younger than 4 years old.

Outcomes

Patient Outcomes/Clinician Outcomes

Alert Name	Total Alerts Sent Since May 2014	May/Jun/Jul/Aug/Sept/Oct/Nov/Dec/Jan Total - Eligible to refire	Re-Fired
TD - Antidepressant	184	129	44
TD - Amphetamine ER	122	110	8
TD - Atypical Antipsychotic	139	65	40
Max Dose - Adderall XR > 15mg	74	47	19
DDI: Lithium Toxicity PRN meds (Level 1)	48	20	4
TD - Amphetamine IR	20	19	0
Max Dose - Dexmethylphenidate ER > 30mg	25	17	10
Max Dose - Concerta 54mg	7	6	4
DDI: Lithium Toxicity ACEI-ARB (Level 1)	10	4	2
Max Dose - Dexmethylphenidate 10mg	7	4	2
Max Dose - Adderall XR 10g	5	3	0
Max Dose - Concerta 27-36mg	2	2	0
Max Dose - Dexmethylphenidate ER 20-30mg	3	2	0
Max Dose - Methylphenidate 20 mg	3	2	2
DDI: MAOI - Serotonergics (Level 1)	1	1	0
Max Dose - Adderall XR 15 mg	2	1	0

*Adherence - Amphetamine	4445	1683	977
*Adherence - Atypical Antipsychotics	1230	362	177
*Adherence - SSRIs	1096	340	136
*Adherence - Alpha-2 Antagonist	198	60	22
*Adherence - NDRIs	178	55	28
*Adherence - Lithium	68	11	2
*Adherence - Antipsychotics	30	5	0
*Adherence - SNRIs	15	2	2

*Adherence calculates the total days' supply of medication divided by the total days elapsed. A member is considered adherent if they have 80% of the days covered. Adherence is typically measured over 12-18 months

Patient outcomes. As this is a program dealing with children in foster care, the health plan was not capturing or reporting specific patient outcomes.

Module	Targets	# Interventions	# Measureable Interventions	Accepted Recommendations YTD	% of Recommendations Accepted
Adherence		126	1	0	0%
Guidelines		695	N/A	N/A	N/A
Safety		651	378	83	22%
Total	1472	379	83	22%	22%

Clinician outcomes. The health plan tracked alerts sent to clinicians, as well as those sent as a follow-up/refired alerts. Adherence measures were calculated for the medications, as well as safety issues (i.e., maximum dose, children <4 years old on medications, multiple prescriptions for concomitant medications as well as BH medications given by 2 or more MDs).

Clinicians receiving the alerts were educated, and feedback about the program and information provided was uniformly positive and well received. Following the interventions, the health plan realized a reduction in psychotropic medication per member per month (PMPM) for those members and attributed this in part to the alert process. By partnering with providers, the health plan believes that the modified prescription and practice changes, as well as clinical guideline adherence, will be extended to patients across these provider panels.

Community impact. Psychotropic medication nonadherence is a universal public health problem as well as a continued barrier to positive health outcomes. The rising prevalence of the use of psychotropic medications for children with mental health disorders has resulted in several state advisories regarding medication utilization and appropriate prescribing protocols. This program promotes the safe and effective use of psychotropic medications for children across all pediatric populations.

Cost savings. From August through December 2014, total psychotropic medication PMPM was \$33.73. In the period January through July 2015, total psychotropic medication PMPM was \$33.43. This represents a savings of \$.30, equating to a total program savings of \$50,151.43.

Key Components of Success

There has been much attention to the issue of children—particularly in the foster care population—receiving varying kinds and dosages of psychotropic medication. Although the program was constrained by the fact that contact could not be made with parents, fax alerts to providers were well received. The program relied on a collaborative process that leaned on objective standard practices rather than denials.

Kudos To The Team

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Reducing Hospital Readmissions for Individuals with Impactable Chronic Conditions

AmeriHealth Caritas Family of Companies

Description

The objective of the Reducing Hospital Readmissions initiative was to significantly reduce 30-day hospital readmissions for at-risk members in 6 AmeriHealth Caritas managed care organizations (MCOs). Thirty-day all-cause hospital readmission rates were measured for members with one or more dominant chronic conditions or a single chronic condition of asthma at the baseline period (January 1, 2013–December 31, 2013) versus the intervention and follow-up period (January 1, 2014–December 31, 2014). We report a statistically significant enterprise-wide reduction in weighted 30-day readmission rates of 10.1% in 2014 versus 2013, along with an associated 4.8% reduction in readmission expenditures, resulting in an estimated total cost savings of \$2.7 million.

AmeriHealth Caritas members with one or more dominant chronic conditions (average, 68%) or a single chronic condition of asthma (32%) in the 2013 baseline period were subject to follow-up in 2014. The majority of participants were female (54%), English-speakers (80%), Supplemental Security Income recipients (52%), and white (40%) or black (37%). The age groups represented (in descending order) were 18 years or younger (41%), 40- to 64-year-olds (28%), 18- to 39-year-olds (20%), and 65 years and older (19%). A relatively small percentage of the population was Spanish-speaking (3%). All of the percentages above are the total unweighted averages (i.e., not accounting for the plans' membership sizes) of all plans.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Control or reduce the per capita cost of care or increase efficiency.

Research

Boutwell, A., Maxwell, J., et al. (2013). Reducing hospital readmissions for Medicaid patients through a patient-centered and community-based approach: Final report to the Agency for Healthcare Research and Quality. Boston, MA: John Snow.

Elixhauser, A., & Steiner, C. (2003). Readmissions to U.S. hospitals by diagnosis, 2010. HCUP Statistical Brief #153. Rockville, MD: Agency for Healthcare Research and Quality.

Regenstein, M., & Andres, E. (2014). Reducing hospital readmissions among Medicaid patients: A review of the literature. *Q Manage Health Care*, 23(1), 20-42.

Trudnak, T., Kelley, D., Zerzan, J., Griffith, K., Jiang, H. J., & Fairbrother, G. L. (2014). Medicaid admissions and readmissions: Understanding the prevalence, payment, and most common diagnoses. *Health Affairs*, 33(8), 1337-1344.

Wier, L. M., Barrett, M. S., Steiner, C., et al. (2011). All-cause readmissions by payer and age, 2008. HCUP Statistical Brief #115. Rockville, MD: Agency for Healthcare Research and Quality.

Intervention

This multifaceted program consisted of more than 60 different interventions to reduce hospital readmission rates, ranging from in-person and telephonic member outreach to hospital and primary care physician (PCP) engagement. Members were contacted following discharge, especially those with the highest risk of readmission, as were hospitals with the highest readmission rates. Care management/care coordination decisions were made based on the member's diagnosis, readmission risk factors, and available home supports, as well as individual health management barriers identified by speaking with the patient, the patient's family, and/or PCP as indicated. Interventions focused on ensuring the member understood discharge instructions, including medication schedules, and facilitating a physician visit as soon as possible after discharge. The study period ran from January 1 to December 31, 2014.

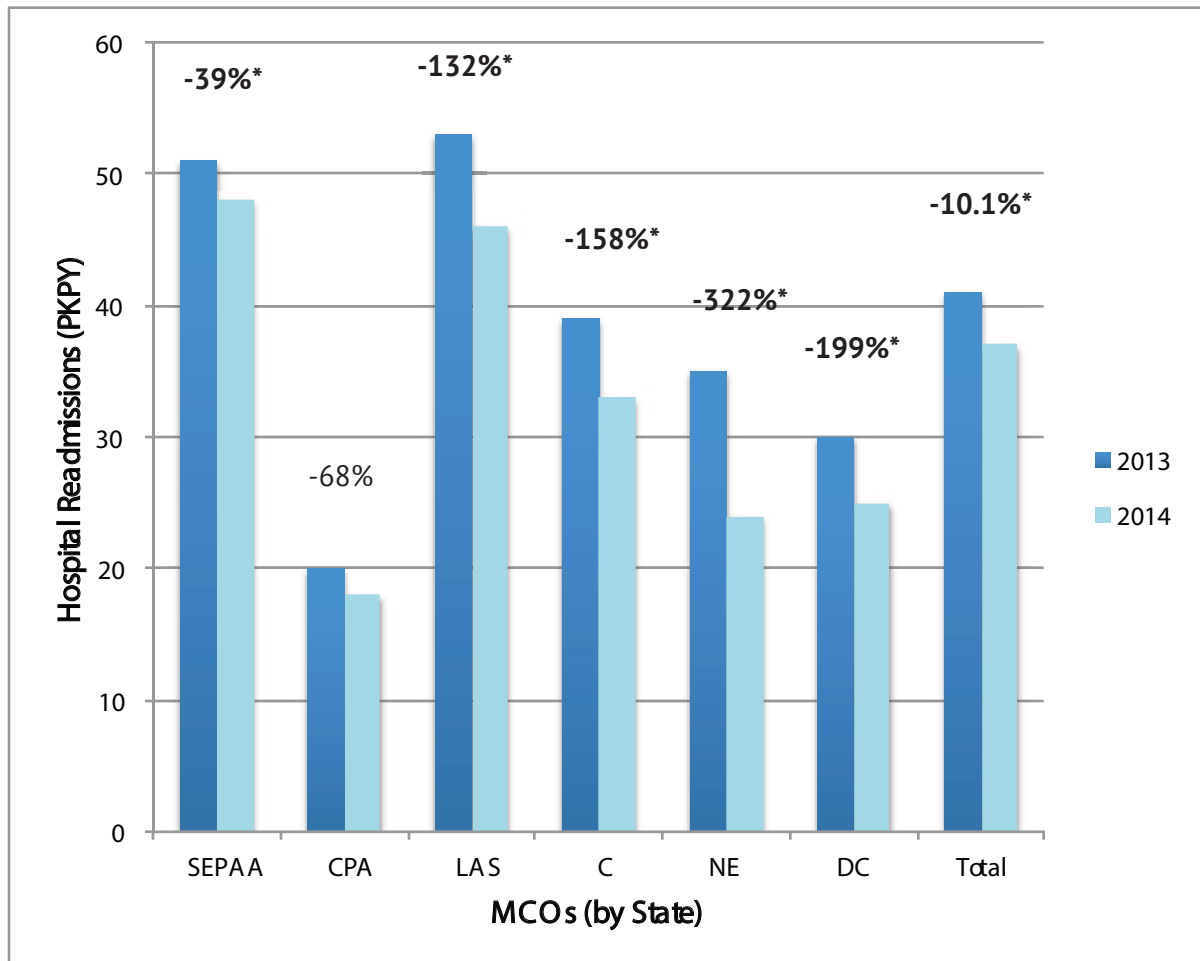
Interventions to Reduce Hospital Readmission Rates

Category	Initiatives
Member	Educational communications including a discharge letter, Welcome Home Card, transition brochure and Urgent Need contact magnet; Home visits from Community Outreach Solutions (COS) staff with leave-behind gift packets and educational material; Phone outreach and follow-up appointment coordination; and Targeted Health Education Material for high-volume readmission diagnoses (e.g., sickle cell disease, tips for staying healthy and out of the hospital).
Provider	Discharge Communications Preferences Survey; PCP Notification of Admission; Educational Mouse Pad outlining information available through the plan's provider portal; Readmissions Lunch and Learn Presentations; Dedicated Readmission Prevention Web Page; Continuing Medical Education (CME) Webinars on Reducing Readmissions; Reducing Avoidable Admissions Flyer and Leave-Behind Brochure; and meetings with facility staff to share data and collaborate on transition pathways. Provider Incentive Payment (for transition management codes).
Internal	Associate education through Online Newsletter; LCD Panel Messaging in Company Lobby; Readmissions Lunch and Learn Presentation, System Flag for high-risk members; Sentinel Rule to alert care managers of an assigned member's admission; Implementation of a focused transition workflow and documentation checklist; Reporting to track transition management process; home health agency contracts for additional in-home follow-up.
Pharmacy	Pharmacist CME Series; Pharmacy-related Member Newsletter Articles; Academic Detailing to Pharmacies; Pharmacy Promotional Items.

Outcomes

Patient outcomes. After accounting for plan membership sizes, AmeriHealth Caritas achieved a statistically significant enterprise-wide reduction in 30-day readmission rates of 10.1% in 2014 versus 2013 ($P < 0.01$; Figure 1). Three of the seven MCOs displayed statistically significant reductions in hospital readmissions (southeastern Pennsylvania, Louisiana, and South Carolina; $P < 0.01$). Despite considerable sociodemographic variation, all six plans met or exceeded the targeted goal of a 4% reduction in hospital readmissions.

Figure 1. Hospital Readmissions Rates (PKPY) by MCO



*statistically significant

Clinician outcomes. Clinician outcomes were not measured as part of this program. However, clinicians and pharmacists received targeted material to help practices be better at engaging their patients. The material included recommendations on how to keep their patients healthy and out of the hospital. In Pennsylvania, provider incentive payments for transition management codes, rewarding PCPs for caring for AmeriHealth.

Community impact. Reducing hospital readmissions has a substantial impact on the community. It results in improved population health (physical and behavioral); fewer missed work and school days; and lower health care costs, which saves money for state Medicaid budgets.

Cost savings. Reductions of 30-day readmission rates were accompanied by a statistically significant reduction of 4.8% in 2014 readmission expenditures enterprise-wide ($P = 0.05$) compared with 2013, at an estimated total savings of \$2.7 million.

Key Components of Success

The Reducing Hospital Readmissions initiative was a multifaceted, multidisciplinary, and collective effort among multiple lines of business. No single effort by itself would likely have accomplished what the multiple, related efforts achieved. Multiple staff with the requisite expertise should be assigned to champion, implement, and manage every individual component of the initiative to maximize effectiveness of the initiative both plan-wide and enterprise-wide. Regular communication among leadership staff of every initiative in every MCO is essential. It is important to avoid overcentralization, allowing individual MCOs to develop and implement effective plan-specific solutions where appropriate.

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Wellness Circle

AmeriHealth Caritas District of Columbia/SHIRE

Description

AmeriHealth Caritas District of Columbia and Summit Health Institute for Research and Education (SHIRE) developed and implemented a Metabolic Syndrome Wellness Circle program for helping Ward 8 District of Columbia residents with diabetes and hypertension increase their awareness, knowledge, and commitment to improve the management of their chronic condition, incorporating fun activities, fitness and healthy food preparation demonstrations, menu planning, games, and skits and role-playing. In both 2014 and 2015 (SHIRE 1 and SHIRE 2, respectively), the majority of participants lost weight, improved body-mass index (BMI), increased understanding of diabetes and hypertension, and, for participants with diabetes, saw measurable stabilization or improvements in average blood glucose (HbA1c) levels. Finally, greater overall improvements in medication adherence rates were observed for both SHIRE 1 and SHIRE 2 cohorts when compared with control cohorts, and no emergency department (ED) visits took place during the initiative.

In spring 2014, 10 AmeriHealth Caritas District of Columbia members residing in Ward 8 between the ages of 45 and 70 years with diabetes, prediabetes, and/or a risk for hypertension participated in most or all sessions of the program. Some were past due for their annual retinal eye examinations or HbA1c check. In spring 2015, another 11 AmeriHealth Caritas District of Columbia members with ages ranging from 33 to 65 years with the same preconditions participated in most or all sessions of the program. For both groups, all participants were African American, and most (about 65%) were female.

The program described is responsive to the following Medicaid priority areas:

Priorities

- Improve access and health outcomes for vulnerable populations.
- Reduce disparities in care of racial and ethnic minorities.
- Address social determinants of health to increase access and engagement.

Research

2014 Evidence-based guideline for the management of high blood pressure in adults: Report from the panel members appointed to the Eighth Joint National Committee (JNC 8). (2014). *JAMA*, 311(5), 507-520.

American Diabetes Association. (2014). *Standards of medical care in diabetes—2014*.

American Diabetes Association. (2015). *Diabetes clinical practice guideline. Clinical practice recommendations 2015*.

Craig, C., Eby, D., & Whittington, J. (2011). *Care coordination model: Better care at lower cost for people with multiple health and social needs*. IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement.

District of Columbia Department of Health (DC DOH). (2011). *Behavioral Risk Factors Surveillance System (BRFSS); 2011 annual health report*. Washington, DC: Center for Planning, Policy, and Epidemiology.

Intervention

AmeriHealth Caritas District of Columbia and SHIRE created and implemented the SHIRE Metabolic Syndrome Wellness Circle program to improve the health predicaments of Ward 8 District of Columbia residents. This health education initiative incorporated 6 interactive workshops on managing hypertension and diabetes, where participants were educated on causes and risk factors, as well as strategies for controlling their condition and the importance of physical activity.

In 2014, 6 Wellness Circle sessions were held over 3 months at the easily accessible Mary Virginia Merrick Center in Ward 8. In 2015, the program was repeated for new participants at the Allen Chapel African Methodist Episcopal Church. In 2014, members were enrolled in the program between April 1 to May 31, ranging between 46 and 60 member days. In 2015, members were enrolled in the program between April 21 to June 30, ranging between 56 and 70 member days.

Each session incorporated a healthful food preparation demonstration, a nutritious meal, health education, and exercise or low-impact fitness instruction. Guest speakers educated participants on related health topics; in 2015, guest speakers included an emergency room physician, a licensed nutritionist, and a stress management and breathing coach. During the first and last sessions, members were screened for HbA1c, blood pressure, waist circumference, height, and BMI for pre-intervention testing (HbA1c was screened in the first session and after the last session after the recommended 90 days from the last reading).

All participants were recognized in a closing ceremony, with those who made the greatest improvements on particular measures given special recognition. Finally, participants with diabetes who had made the greatest improvement in their HbA1c test in the spring 2015 program were specifically recognized during an add-on 6th session, timed to take place concurrent with the kick-off of the next series of SHIRE Wellness Circles.

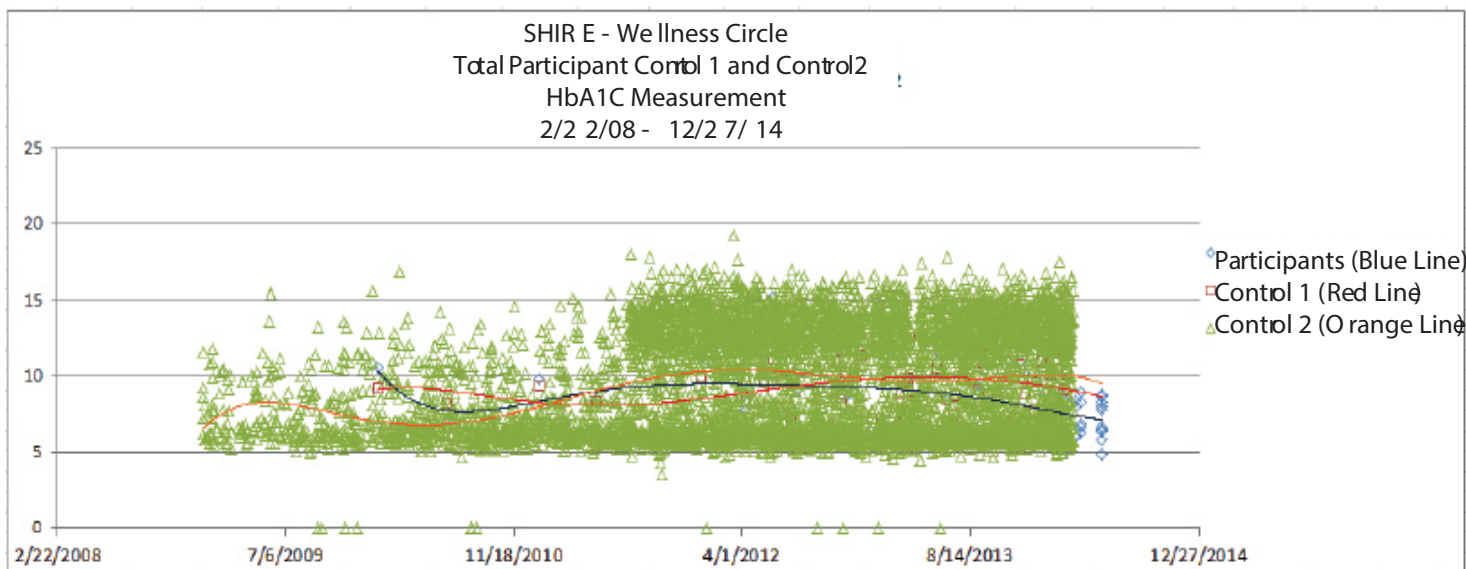
Outcomes

Patient outcomes. Both SHIRE 1 participants (N = 10) and SHIRE 2 participants (N = 11) experienced stabilization or reductions in their HbA1c levels, along with the benefits associated with such reductions, compared with the control groups. A comparison of HbA1c measurements for SHIRE 1 versus matched and unmatched control groups showed a trend of marked reductions in HbA1c levels over time (Figure 1). Marked reductions in HbA1c levels were also observed both at comparative endpoint (March 12, 2014) and projected endpoint (May 29, 2014), indicative of the persistence of the intervention (Table 1). The average pre- and post-intervention HbA1c for SHIRE 1 was 7.3 and 7.4, respectively, and the average pre- and post-intervention HbA1c for SHIRE 2 was 7.18 and 6.5, respectively (Table 2). By contrast, the HbA1c levels of the matched control group during the same before and after periods in 2014 were 8.88 and 9.35, respectively. Additionally, the average changes in HbA1c levels pre- and post-intervention were +0.12 for SHIRE 1, -0.67 for SHIRE 2, and +0.47 for the 2014 matched control.

For antihypertensive drugs, the Wellness Circle cohort showed improved medication adherence, displaying a 1.24% increase in proportion of days covered (PDC) from the pre-period (June 1, 2013, to May 28, 2014) to post-periods (June 1, 2014, to May 31, 2015; Table 1). By contrast, both matched and unmatched control cohorts reported worsening medication adherence rates (13.95 and 2.90% decreases in PDC, respectively).

For hypoglycemic drugs, the Wellness Circle cohort showed improved medication adherence, displaying a 3.64% increase in PDC from pre- to post-periods. By contrast, the unmatched control cohort reported worsening medication adherence rates (8.11% decrease in PDC; no matched control members were taking diabetes medication). Furthermore, there were no diabetes-related emergency department visits by Wellness Circle participants during the reflection period (April 1 to July 10, 2014).

HbA1C Measurements for 2014 Wellness Circle Participants and Control Cohorts



HbA1c and PDC Measurement for SHIRE 1 Participants Versus Control Cohorts

Measures	WC participant	Matched Control	Unmatched Control
No. Members	10	30	2000
Avg. HbA1c per test	8.66	9.06	9.64
HbA1c (comparative EP)	7.5	9.2	10
HbA1c (projected EP)	7.3	8.8	9.5
BP PDC (Pre/Post; %)	+1.24%	-13.95%	-2.9%
T2D PDC (Pre/Post; %)	+3.64%	NR*	-8.11%

* Not Reported (no matched control members were taking diabetes medication)

EP, Endpoint; HbA1c, Glycated Hemoglobin (average blood glucose levels); BP, Blood Pressure; T2D, Type-2 Diabetes

SHIRE HbA1c Measurements Pre- and Post-intervention Vs. Matched Control Cohort

Time Period	SHIRE 1		SHIRE 2		Matched Control 1	
	Pre	Post	Pre	Post	Pre	Post
HbA1c	7.3	7.42	7.18	6.51	8.88	9.35
Avg. Change	+0.12		-0.67		+0.47	

Clinician outcomes. Clinician outcomes were not measured as part of this program.

Community impact. The SHIRE Metabolic Syndrome Wellness Circle sessions have already had a significant impact on the community in benefiting not only the 2014 and 2015 participants, but also the approximately 15 peer educators over the course of the two programs who helped recruit and lead the sessions. Furthermore, based on knowledge tests given to both participant groups before and after the sessions, all participants increased their knowledge and confidence regarding how to manage both hypertension and diabetes. These participants will, in turn, serve as subject matter experts and walking resources for their families and the larger community.

Cost savings. Cost savings have not been evaluated at this time. However, some level of cost avoidance is expected based on the likelihood that each of the program participants is less likely to suffer from diabetes- and hypertension-related complications and hospitalizations than their matched peers who have not undergone comparable education.

Key Components of Success

The health plan attributes success of this intervention to the deep knowledge and commitment of the SHIRE partners, Ruth Perot and Canary Girardeau, respectively. Care was taken with selecting an accessible location. Additionally, the use of peer educators serving as both recruiters and accountability partners made a huge difference in the level of commitment and engagement of the participants. The peer educators were people living in the community, some of whom were AmeriHealth Caritas District of Columbia members; some 2015 peer educators were former participants in the 2014 program. The peer educators provided consistent and persistent engagement with their assigned participants between sessions, and checked in with participants regularly to ensure they were on-track with the program. Finally, offering a nutritious meal at each session provided participants with an incentive to return and remain connected.

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