



INSTITUTE FOR  
MEDICAID INNOVATION

# Medicaid Managed Care Best Practices Compendium 2016-2017



**Jennifer E. Moore, PhD, RN**

## MESSAGE FROM THE EXECUTIVE DIRECTOR

We are excited to share with you the 2016-2017 Best Practices Compendium, representing the most innovative initiatives in Medicaid managed care that addresses critical health and social issues.

Each year, health plans submit their best practices for consideration of inclusion in this exclusive publication. Through a rigorous process conducted by a panel of national experts, the best practice submissions are reviewed and scored with the best initiatives being selected for inclusion in the annual compendium. The best practices in this year's publication address important clinical topics including trauma-informed, evidence-based treatment for children, adult super-users with substance use issues that utilize mobile technology, and reducing hospital readmissions amongst individuals with multiple chronic conditions. As you will discover, many of the innovative projects connect clinicians, communities, families, and health plans together in addressing issues of access to high quality care.

For each category (e.g., women's health), a winner is selected, highlighting the "best of the best" for that category. Additionally, an overall award is given to the most innovative best practice amongst all of the categories. We are delighted to award this prestigious honor to Cardinal Health Innovations for their Partnering for Excellence initiative in North Carolina.

Congratulations to all of the initiatives selected for inclusion in this year's compendium!

## ABOUT THE INSTITUTE FOR MEDICAID INNOVATION

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

### MISSION

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

### Vision

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

# A C K N O W L E D G M E N T S

The work of this compendium could not be accomplished without the dedication and commitment of our national experts that serve on the Best Practices Review Panel. Their systematic and objective review of the submissions is critical for the success of this project. Additionally, there are many people who work behind-the-scenes to produce this annual publication. Most notably, we want to thank Ashley Hernandez Gray, Nikida Levy, and Shawnise Thompson for their hard work and attention to detail.

## INSTITUTE FOR MEDICAID INNOVATION BEST PRACTICES REVIEW PANEL



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# BEHAVIORAL HEALTH

# Magellan Healthcare of Nebraska (Magellan Health)



## MAGELLAN MOBILE CONNECT

Medicaid-eligible adult super-users of mental health and substance use disorder (MH/SUD) services face multiple barriers to care and recovery. Mobile devices facilitate contact between the members and their providers as well as Magellan’s Recovery Care Management (RCM) team. Most of these members lack the resources for cell phones and mobile services, and many do not have access to land lines. This results in missed (or not scheduled) appointments, as well as low engagement with providers and care managers/health coaches, leading to higher rates of hospitalization and readmission.

Started in 2014, Magellan Mobile Connect distributed over 200 smartphones to adult members with serious mental illnesses and clinically complex profiles, providing the opportunity to open channels for reliable access to care coordination and relevant health-related services. This initiative has led to significantly lower costs, improved community tenure, better appointment attendance, and better medication adherence. Providers, members, and the care management team have found this project extremely helpful and satisfying.

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### Key Priorities

- Identify high utilizers and the impact on their health, well-being, and care.
- Provide members with a vital link to health, well-being, and independence.
- Connect members to providers and support systems—a critical step in recovery.
- Reduce higher levels of care while ensuring members are engaged in treatment.
- Manage cost of care.

## Population

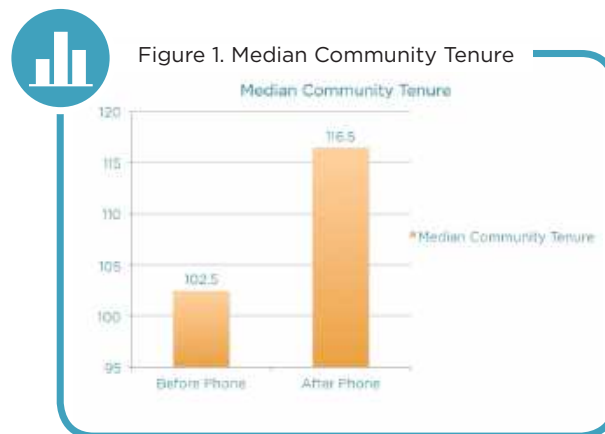
Magellan focused on high-utilizer members with serious and persistent mental illness (SPMI) and substance abuse populations that were very high cost and repeatedly had poor engagement in treatment and difficulty attaining success in the community. The program involved 219 beneficiaries.

## Intervention and Methods

Many barriers to care keep members from accessing services, including lack of resources. Without access to phone service, it can be difficult for individuals with high needs for mental health and substance use disorder services to stay in contact with care managers and providers. Low engagement with these supports and services results in decreased stability and higher rates of hospitalization. The Mobile Connect program is one of the ways Magellan provides members with the care they need, when they need it.

In 2014, Magellan began issuing Samsung Galaxy SII smartphones to members identified as having a high need for services. The plan allows unlimited phone calls, texting, voice mail, 9-1-1 access, and nearly unlimited data. The health plan provides the phone and covers the monthly cost. The phone is delivered to the member preloaded with contact information for Magellan, service providers, and other community supports. Magellan also includes various health and wellness applications to promote self-management and self-advocacy. At the completion of the program, the member owns the phone and can choose to assume the cost of the plan.

Magellan employed its own claims and utilization data to measure admissions, readmissions, and community tenure with the SPMI group before and after they got cell phones. Mobile Connect has helped reduce the need for hospitalization and residential services while increasing the participants' community tenure (Figure 1). The program has also improved member-provider connections, appointment adherence, medication adherence, member-community connections, member digital literacy, provider satisfaction, member satisfaction, self-advocacy, and hope. By improving access to resources and supports, Mobile Connect has had a positive impact on community tenure and inpatient and residential claims spending.





A recovery care manager and peer specialist work with the member to identify the individual's specific needs while focusing on their cultural identity and individual life experiences. The phone becomes a vehicle in developing new and different supports in their wellness journey. Phones were programmed to access interpreter services for non-English speaking.

## Outcomes

**Patient/Family Outcomes:** Among surveyed members, 99.49 percent answered yes to the question: "Do you think you have felt better because of having this phone?" When asked, "Magellan's Mobile Connect goal is to help you connect with providers, support services, peer services, transportation or anything about your health care needs. How helpful has this been to you?" 98.4 percent said "very helpful," 1.02 percent "a bit helpful." When asked about phone usage, 64.02 percent stated they used their phone apps daily, while 19.51 percent used the apps weekly. Members reported an increase in frequency of communication with friends, family, providers, and other community supports. They reported increased digital literacy. Members reported improvement in hope, satisfaction, and self-advocacy.

**Clinician Outcomes:** A random sample of 45 members in the program showed the following for 90 days before and after receiving a smart phone:

- Claims for services went from 4,185 to 2,401.
- Days of inpatient or residential care decreased from 471 to 238.
- Median community tenure increased from 78.53 days to 85.30 days.
- Average inpatient days decreased: four days before a phone and 1.8 days after a phone.

**Community Impact:** Community impact outcomes not measured for this initiative.

**Cost Savings:** Spending has significantly dropped for inpatient hospital care, residential care, and overall claims for services with the implementation of this initiative. Community tenure of the selected SPMI population has increased. A random sample of 45 members in the program showed the following for 90 days before and after receiving a smart phone:

- Cost of services went from \$643,596.57 to \$294,083.95.
- Average inpatient claim spending decreased from \$509.75 to \$88.82, and average residential spend decreased from \$4,857 to \$1,642 (Figure 2 and 3).



Figure 2. Average Inpatient Claim Spend



Figure 3. Average Residential Claim Spend



**Quality Improvement Efforts:** Provider and member satisfaction has been extremely high, as evidenced by provider and member satisfaction surveys.

### Lessons Learned

**Challenges:** One of the biggest challenges was getting the smartphones to the members. The best way to “find” high utilizers is when they are hospitalized. Magellan programmed and activated the phones in its office, then placed them with the work-at-home employees throughout the state to quickly deliver the phone to the member while they are still in an inpatient setting. The other challenge was phones being lost, broken, stolen, or sold. Members were allowed one replacement phone each. Patients were very thankful and responsible with their phones, used them appropriately, and took care of them for the most part.

**Successes:** A decreased level of utilization and a drop in readmission rates in the SPMI population, along with improved member and provider satisfaction, were measures of success. Engaging community stakeholders was critical in the development process. Practitioners were eager to grant greater access to patients with the use of cell phone technology. Magellan's communications department produced excellent infographics to educate members on how to use the phones and the importance of greater communication with their providers.

**Advice:** Organizations should know that they can engage super-users in care management through the use of mobile technology. Individuals that are difficult to reach are difficult to engage in care management, and difficult to engage in the recovery process. This low engagement with care management means a higher rate of hospitalization and readmission. Providing members with smartphones allows for engagement, scheduling of appointments, ability to contact providers, better monitoring of medications, arranging for transportation services, and contacting natural and formal community supports. This empowers the member and leads to better outcomes, while being extremely cost-effective.

### *Key Partners*

Magellan Healthcare of Nebraska  
Recovery Care Management Team  
Providers/care givers  
Health and wellness apps  
Samsung  
Magellan members

### *Kudos to the Team*

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# Enolve (Centene Corporation)

## ENVOLVE'S HEPATITIS C (HCV) MEDICATION ADHERENCE PROGRAM

In 2014, \$374 billion was spent on prescription drugs in the United States, with hepatitis C virus (HCV) medications accounting for more than half. Unfortunately, 18 percent of patients with HCV did not adhere to medications last year; therefore, they were not cured, costly medication regimens were extended, and the likelihood of future health care needs rose. The investment in newer, more-effective therapies is costly, from \$88,000 to \$300,000 for a 12- to 24-week course. In response to this critical cost investment, Enolve saw the opportunity to create a medication adherence program specific to this disease state.

The program was originally developed for substance use disorders and to motivate "resistant" members. Enolve's HCV Medication Adherence Program supports and advocates for consumers, providers, and health care payers. The program began with Centene's Medicaid health plans and achieved promising initial results. Since the HCV Medication Adherence Program inception, 333 members have enrolled.

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### Key Priorities

- Optimize adherence.
- Educate members on condition management.
- Identify adherence risk and red flags early.
- Establish collaboration across the health care team.
- Assess patient satisfaction with program and with treatment.
- Achieve sustained viral response (SVR).



## Population

This is a high-cost group and HCV medication is a costly therapy. Referrals are made to Envolve registered nurses through Centene's specialty pharmacy company after processing the prescription. The average patient age is 57, ranging from 25 to 77 years old.

Among the 333 members enrolled, 51 percent have a behavioral health diagnosis based on specialty pharmacy records. This is probably underreported because codes used to identify members are based on provider notes sent to the pharmacy and have varying levels of completeness. For some, only the HCV diagnosis is known.

## Intervention and Methods

The intervention, which began in 2014 and expanded in 2015, uses the following steps:

- Establish a connection with the patient.
- Build the relationship.
- Provide education and coaching during adherence calls.
- Use motivational interviewing to elicit patient goals and action steps.
- Identify and link patient to provider for treatment questions, concerns, or side effects.
- Outreach support throughout their treatment regimen.

Registered nurses (RNs) initiate outreach to establish a relationship, gather health data, and assess adherence risks based on responses to questions in the health plan's proprietary tool. Outreach continues on a weekly basis for the first five weeks. The patient has a dedicated nurse who works with that patient throughout the program to strengthen the relationship and build trust. The intensive phase at the beginning maximizes the effectiveness of closely monitoring adherence behaviors, identifying potential barriers, and quickly coordinating communication with the treatment team/payer. Outreach continues through the course of the treatment. The patient can be called more frequently or can reach out to the nurse if needed. Any instances of drug therapy issues are escalated to pharmacy, providers, and/or case management. The average therapy duration is 12 to 24 weeks.

Outreach interaction includes questions that help identify risks that may be related to substance abuse and behavioral health. From screening for anxiety, depression, and psychiatric disorders to uncovering the social support system individuals have, the RNs can pinpoint hindrances that may influence a member's ability to stay on track with therapy. With many individuals experiencing certain levels of instability, the outreach and continued support of the nurses and program become even more important in achieving the full benefits of the therapy and, ultimately, better health outcomes.

The primary goal of the HCV Medication Adherence Program is to ensure optimal treatment outcomes for members taking direct-acting antivirals for hepatitis C infection.

The HCV Medication Adherence Program has additional goals:

- Maximize adherence with motivational interviewing to mitigate barriers to adherence.
- Prevent medication waste by ensuring appropriate therapy utilization and treatment duration.
- Provide collaborative care across the health care team by escalating cases across common platforms to pharmacy, case management, and health plan.

A proprietary, validated assessment tool enables predicting adherence through past behaviors and barriers based on medical or psychosocial complexities or both. Taking a nonjudgmental approach promotes adherent behaviors. Frequent contact allows detecting nonadherence signs and escalating incidents to providers/payers.

To integrate culturally competent approaches to delivering care, the program incorporated team training to increase cultural awareness, knowledge, and skills. Half of the program staff is bilingual. Using professional interpreter services ensures that members understand medical information and goals.

## Outcomes

**Patient/Family Outcomes:** Envolve has enrolled 100 percent of contacted members and has received a 98 percent patient satisfaction rate from patient surveys. No members have opted out or discontinued participation in the program.

**Clinician Outcomes:** Only three percent of members have reported missing one or more doses, and no members reported missing more than two doses. The medication possession ratio (MPR) of 103.8 percent supports patient-reported adherence. The MPR goal is 85 to 105 percent. Initial results indicate a 75 percent increase in adherence from baseline and trend toward a better adherence rate.

**Community Impact:** This population has many adherence risks. Roughly one additional coaching session was performed per patient to mitigate barriers to adherence and 50 percent of members required at least one additional session. Among participants, 14 members required collaboration with a case manager or provider to resolve barriers. Members were successfully coached in self-management of side effects, and medication reminders were established, as well as coordinating care for identified issues. Participants include members with co-morbid conditions, with 40 percent having three or more co-morbid factors, including mental health diagnoses. Most importantly, each member in the program is receiving medication refills and reporting continued adherence.

**Cost Savings:** Initial results indicate more than a 75 percent increase in adherence from the baseline and an overall pharmacy services trend toward a better adherence rate. Envolve also achieved a 79 percent reduction in medication waste as a result of adherence interventions.

**Quality Improvement Efforts:** The program coordinates care with specialty pharmacy, providing timely completion of patient assessment (PA), ensuring delivery and timely start of medication. The adherence program intervenes early with noncompliant members and applies behavior change, taking into consideration social determinants, cultural competency, co-morbid conditions, and barriers to compliance.

## *Lessons Learned*

**Challenges:** The main challenge was making contact with the patients and educating them about their medication. Generally, providers prescribe the medication but do not have the time to explain the drug, the importance of taking the prescription as prescribed and at the proper time each day, the impact of the medication, and possible side effects. Provider education was also a challenge during this program. A knowledge gap by providers and lack of education to providers regarding prior authorizations and why they are required resulted in medications often not being approved by health plans as needed.

**Successes:** A decreased level of utilization and a drop in readmission rates in the SPMI population, along with improved member and provider satisfaction, were measures of success. Engaging community stakeholders was critical in the development process. Practitioners were eager to grant greater access to patients with the use of cell phone technology. Magellan's communications department produced excellent infographics to educate members on how to use the phones and the importance of greater communication with their providers.

**Advice:** Organizations should know that they can engage super-users in care management through the use of mobile technology. Individuals that are difficult to reach are difficult to engage in care management, and difficult to engage in the recovery process. This low engagement with care management means a higher rate of hospitalization and readmission. Providing members with smartphones allows for engagement, scheduling of appointments, ability to contact providers, better monitoring of medications, arranging for transportation services, and contacting natural and formal community supports. This empowers the member and leads to better outcomes, while being extremely cost-effective.

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## Anthem, Inc.

### PC-INSITE

Primary care is the major resource for adults and children experiencing signs and symptoms of a behavioral health (BH) condition. Yet many of these individuals go untreated or receive inadequate treatment. Primary care providers (PCPs) are the de facto mental health providers as over half of patients seek treatment for BH conditions from them.

PC-INSITE improves the detection, diagnosis, treatment, and ongoing management of people experiencing depression or substance use conditions. By improving the management of a person's depression/substance use disorder (SUD), overall health is improved, especially for those with co-morbid conditions. The program brings the expertise of BH coaches and supporting psychiatrists into PCP offices to improve the detection, diagnosis, and treatment of BH conditions. By providing combined physical and behavioral care, health experience is enhanced, the PCP's practice improves on Healthcare Effectiveness Data and Information Set (HEDIS) quality scores, and costs are lowered while improving health outcomes for the member.

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#### Key Priorities

- Improve consistency of care.
- Increase member engagement in care plan.
- Provide the "Right Care, Right Place, and Right Time" to reduce unnecessary health care costs.

## Population

The program targets members with complaints like headaches, nausea, and unexplained pains often unrecognized as symptoms of underlying BH conditions. This program allows screening and referral, improving the management of a member's depression/ SUD for individuals not otherwise identified, and PCP referrals as determined by check-ups. To date, 4,215 members have participated in the program.

## Intervention and Methods

PC-INSITE is a program designed to detect, identify, and intervene with individuals experiencing depression within primary health services that may also impact and complicate treatment of other health conditions. Despite the vast array of health care settings, primary care is the site where members with BH conditions seek care: 49.6 percent of people getting BH treatment receive it in primary care. The prevalence of individuals presenting in primary health clinics and the co-occurrence of depression with other medical conditions in part led to the U.S. Preventive Services Task Force (USPSTF) recommendation that adults be screened for depression in primary care settings.

PC-INSITE brings the expertise of BH coaches and supporting psychiatrists into PCP offices to improve the detection, diagnosis, and treatment of BH conditions. In some PC-INSITE programs, PCPs are supported by a co-located BH coach who conducts universal screening, completes an assessment of members scoring in the clinical range, and develops a plan of intervention. Intervention plans include PCP-focused health coaching, prescription drug management, and referrals to mental health specialists. The addition of a depression manager, or health coach, and a consulting psychiatrist with a protocol to engage in systematic screening, identification, and treatment of persons with depression in primary care is found to improve functioning, reduce symptoms, decrease pain, enhance quality of life, and lower overall annual health costs. Treatment of depression includes pharmacotherapy, psychotherapy, and such interventions as life style changes, exercise and diet alterations, and self-help activities. An integrated service model promotes development of innovative and creative approaches to address complex health conditions.

Anthem uses predictive modeling and other methods to enhance treatment of members. The predictive model prioritizes membership and clinical information about the members to drive medical management activities. It also is used to stratify member risk and to standardize service, coordination, and case management.

## Outcomes

**Patient/Family Outcomes:** Six states have enrolled members in patient-centered medical homes (PCMHs). Data was extracted for those members with a diagnosis of depression to compare their total health care costs with other members without a diagnosis of depression. Overall, 5.2 percent of individuals served in PCMHs received a diagnosis of depression, ranging from a low of 1.8 percent in Nevada to a high of

9.7 percent in Tennessee. This rate is lower than an expected rate range of 10 to 26 percent. This may reflect an underdiagnosis of depression by physicians in the Anthem network. The large cost variance for individuals with depression compared with those without points to the significance of depression within Amerigroup members.

**Clinician Outcomes:** PC-INSITE coaches have screened 4,215 members since the launch of the program in four states: 30 percent screened positive for depression and 9 percent screened positive for SUD. Also, 59 percent experienced at least some reduction in symptom severity at follow-up screenings.

**Community Impact:** Of those members screened in clinical range, 60 percent have had at least one follow-up contact and completed a second Patient Health Questionnaire (PHQ-9).

**Cost Savings:** For the health plans that implemented the program, the pre-program per-member-per-month costs (PMPM) amounted to \$999.40. The combined post-program visit spend was \$766.37 (a 23.31 percent decrease) for 1,020 coverage months.

**Quality Improvement Efforts:** Quality improvement outcomes not yet calculated for this initiative. However, Anthem is hoping to see HEDIS data reflect positive changes in treatment adherence, with an increase in the number of acute phase of members prescribed anti-depressant medications, and improvement of HgbA1c scores.

### *Lessons Learned*

**Challenges:** It is important to identify and resolve potential operational/logistical issues related to office space, telephone and internet access, clinical information sharing, documentation, consent forms, and hours of operation. By engaging with the PCP and office staff prior to program implementation, these potential issues are mitigated.

**Successes:** A person's health service experience is enhanced with PC-INSITE health coaches. Anthem is planning to measure quality using HEDIS and evaluate health services costs. Enhancing services for depression treatment in primary health settings has been found to reduce physical symptoms, improve physical functioning, decrease pain, and enhance quality of life. These are all opportunities for improved member care, reduced health care costs, and better member outcomes. Anthem is planning to expand PC-INSITE to five additional markets in 2016 and is exploring how the

program could be expanded to child and adolescent members.

A key element to the program's success is member engagement. The point should be stressed that this program offers one-stop services to the member and has the potential to allow for more services. It also provides enhanced provider collaborations, improves member experience, health, and well-being.

The fact that the program allows for an initial BH/substance abuse evaluation and allows for other services that historically may not have been available to the member is very attractive to members. PCPs also see the value of members receiving collaborative care and member outcomes. Selection and training of BH coaches is vital to work within and adapt to the ever-changing PCP practice.

**Advice:** A health plan should start early in determining sustainability of program as a stand-alone model. Many professionals in counseling and social work profession did not go to school to become health coaches and will not have the ability, drive, or interest to work in a primary care setting, so it is vital to select and train health coaches to partner, collaborate, and work in this environment. Ensure that there is a PCP or administrator to be a supportive champion.

## Research

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### *Key Partners*

Federally Qualified Health Care Partners  
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# UPMC for You

## HIGH-EMERGENCY DEPARTMENT DRUG SEEKING UTILIZATION PROTOCOL (HEDDS UP)

In 2014, the UPMC for You analytic staff observed a rising trend of emergency department (ED) visits linked to opioid use. Excessive and fragmented utilization patterns identified a subgroup of members at risk for opioid dependency, misuse, overdose, and death. Concurrently, overdose deaths were rising in Pennsylvania, increasing 89 percent from 1999 to 2013, with Pennsylvania ninth among the United States in overdose deaths.

As a result, the HEDDS UP program was developed. The program addresses the risk and needs of a subgroup of members with high ED use was associated with multiple opioid prescriptions, prescribing providers, and dispensing pharmacies. The program is designed to identify high-risk members and provide intensive care management including outreach, care coordination, and communication to the member and their providers. High-risk member claims utilization patterns are shared with providers to better inform their treatment decisions at the point of care.

Findings to date include significant reductions in ED visits and CT scans and an increase in referrals to pain management and medication-assisted opioid therapy. Through intensive care management and coordination, HEDDS UP has resulted in safer opioid prescribing, less fragmented care, and more effective care for these vulnerable members.

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### Key Priorities

- Promote safer opioid prescribing and reduce opioid overdose, abuse, misuse, and diversion.
- Reduce unplanned, poorly coordinated care, drug-seeking, and/or doctor-shopping.
- Decrease radiation exposure and costs from unwarranted CT scans, primarily in the ED.
- Increase member engagement, referrals, and evaluation for appropriate therapy, including pain management, behavioral health, medication-assisted therapy, and Magee-Women's Hospital Pregnancy Recovery Center (specializing in the treatment of opioid-addicted pregnant women).

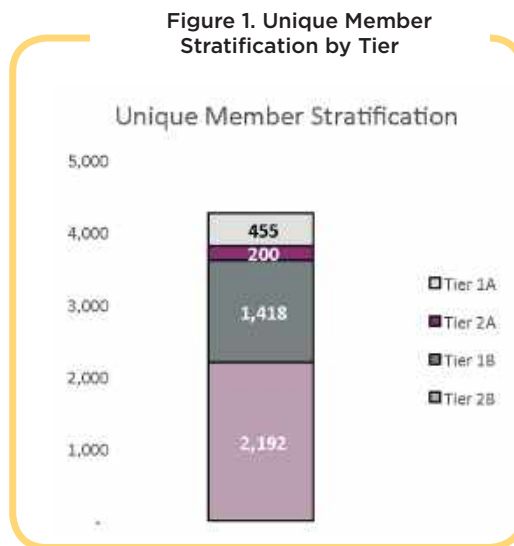
## Population

The health plan identified 4,486 members between July 2015 and March 2016 to participate in the program. Among this group, 80 percent are Caucasian, 18 percent African American, 2 percent Other. The majority of members are female (71 percent) and reside in suburban or rural areas (75 percent). The average age is 36, although 83 percent of members are under age 40.

The initiative focuses on members identified as needing support and who would benefit from care coordination for pain management or potential substance use disorder. The high-risk indicators used to identify the population include at least five ED visits and multiple opioid-prescribing physicians and opioid-dispensing pharmacies in a six-month period.

## Intervention and Methods

A unique and core component of this initiative is the methodology used to identify the targeted population and prioritize which members will be included in the program. HEDDS UP members are identified through monthly stratification with “tiering,” or prioritization (Figure 1). Members with five or more ED visits are divided into the upper and lower 50th percentile of ED visits in the past six months (Tiers 1 and 2 respectively). Further tiering separates those with three or more vs. fewer than three opioid prescribers and/or dispensing pharmacies (Tiers A & B, respectively). Members in Tiers 1A and 2A, who have the highest association of ED visits with opioid use, are referred for intensive care management.



An important feature of the program is that members in all tiers are flagged in the health plan electronic medical record (EMR), and by electronic interface into the EMR for all UPMC hospitals. Information provided with the HEDDS UP flag includes six-month data on numbers of ED visits, opioid prescriptions, opioid prescribers, dispensing

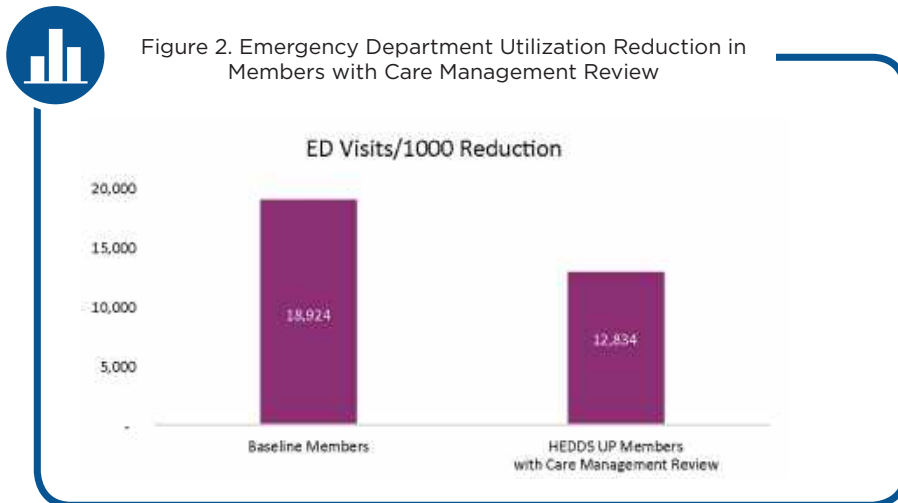
pharmacies, and the lifetime number of CT scans per UPMC claims data. Only the treating ED physicians can open the flag, which helps inform their member discussion, evaluation, management, and referrals. Care managers also use the information to provide telephonic and written notifications to relevant treating UPMC and non-UPMC providers who do not receive the electronic notification in their EMR.

Working with members and providers, the care manager is also armed with this important information to focus their efforts on matching resources to needs, including referrals as indicated to pain management, behavioral health services, medication-assisted therapy, disease management programs, health coaching, and so on. Sharing this information has contributed to highly coordinated plans of care across the healthcare continuum. Key metrics include utilization and per-member per-month (PMPM) costs for ED, urgent care, inpatient and observation encounters, CT and MRI scans, concurrent benzodiazepines, and referrals to pain management, medication-assisted therapy, and behavioral health services.

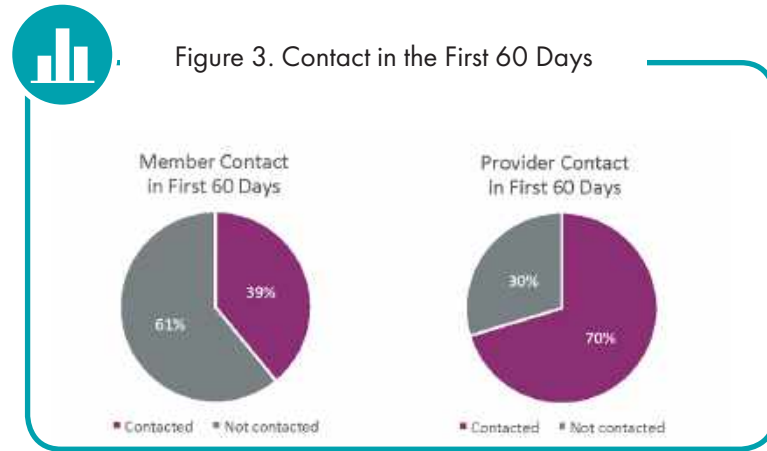
Data warehouse mining identified and quantified patterns to define the parameters and stratification methodology. Monthly data pulls from the warehouse identify, flag, prioritize, and assign key utilization information to each HEDDS UP member to support care coordination. Analytics maintains the data source to measure success and quantify results.

## Outcomes

**Patient/Family Outcomes:** Initial results show reductions in ED utilization against baseline data for members who have been reviewed by a care manager (18,924 visits per 1,000 to 12,834 visits per 1,000; n = 334) (Figure 2). The difference is statistically significant ( $p < 0.000$ ) through the normal theory incidence rate test. Future analysis will include consideration for regression to the mean.



**Clinician Outcomes:** An ED provider survey in January 2016 demonstrated the HEDDS UP flag in the EMR for all UPMC hospitals to be useful (74 percent found it always/usually and 21 percent occasionally) and efficient (60 percent always/usually and 23 percent occasionally). Referrals to pain management and medication-assisted therapy increased, although numbers are still small. Member engagement within 60 days was 39 percent, and provider engagement within 60 days was 70 percent (Figure 3).



**Community Impact:** HEDDS UP is designed to identify members with poorly controlled organic pain and those at risk for opioid misuse. Through engagement, screening, and motivational interviewing, members are referred when appropriate for medication-assisted therapy (MAT). MAT has been found to have personal and community benefits. MAT reduces morbidity and mortality, overdose deaths, and transmission of infectious diseases; improves social functioning and treatment adherence; and reduces criminal activity.

**Cost Savings:** Preliminary results show that for the entire identified population, through December 2015, ED utilization after initial identification for the program reduced by approximately 20 percent from baseline (n = 3,013). Taking into account the estimated costs for staffing and case review, the estimated initial return on invest from this utilization reduction is approximately 1.7.

**Quality Improvement Efforts:** Reduction in ED visits has the potential to affect the ambulatory care (AMB) Healthcare Effectiveness Data and Information Set (HEDIS) measure, which captures both ED and outpatient visits. Final calendar year (CY) 2015 HEDIS rates are still in calculation, for release in the fall of 2016. With greater experience and refinement of the program in 2015, the majority of impact will be seen in CY 2016.

### Lessons Learned

**Challenges:** Implementation challenges included determining information that could be shared in this process. A comprehensive review by privacy and legal experts was performed, and it was determined that claims utilization of the numbers of opioid

prescriptions, ED visits, prescribing physicians, dispensing pharmacies, CT scans, and other basic utilization data could be shared.

Another major challenge was developing an electronic interface to provide the data from the health plan to the health system within the integrated finance and delivery system. Extensive workflow development and care management training was necessary in member engagement, assessment, and motivational interviewing.

**Successes:** Success of the program was measured by utilization reduction, cost savings, and most importantly, by the number of people who begin to receive more coordinated and effective care. Metrics used to determine the success of the HEDDS UP program include the following:

- Decrease in the ED visit rate per 1,000.
- Decrease in the CT scan rate per 1,000.
- Increase in referrals to pain management.
- Increase in referrals to medication-assisted therapy/behavioral health counseling.

Key elements of success include providing information to providers at the point of care, coordinating care among providers, and facilitating referrals to appropriate resources based on members' needs. Claims data are used to fill in provider blind spots across the health system. Knowing about a high-risk utilization pattern at the point of care helps guide more productive patient discussions, assessments, treatments, and referrals. These referrals include pain management, behavioral health, medication-assisted therapy, and palliative care.

**Advice:** Electronic notifications dramatically improve the effectiveness of the program. Development of the interfaces is a major challenge, even within an integrated delivery and finance system such as UPMC. Such interface makes possible, however, the real-time notification at the point of care to the relevant treating provider and significantly decreases the workload of care managers. Mapping out the workflow and member resources for the program was an important step in identifying and sharing best practices and reducing variation among care managers.

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# WellCare of Kentucky (WellCare Health Plans)

## KENTUCKY HOMELESS HEALTH CARE

Health plans have a difficult time reaching members who are homeless. This initiative allowed WellCare to reach and assist members that are difficult to access. Through this initiative, the health plan encouraged homeless members to utilize the case management team. Case managers can give homeless members the support needed to secure housing and ultimately improve their health and quality of life.

WellCare Health Plans is committed to addressing the needs of homeless members. WellCare formed a partnership with Hotel Inc. homeless shelter, WestCare Homeless Shelter and Volunteers of America Homeless Shelter in Kentucky to ensure homeless members are identified and connected to case management. Our overall goal is to locate and identify homeless members, connect them to housing, connect them to healthcare, and address other social service needs.

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### Key Priorities

- Find homeless members and address their social service and health care needs.
- Help members in accessing health care.
- Assist members in removing social barriers to health care.
- Support West Care, Hotel Inc. and Volunteers of America in addressing homelessness.

## Population

WellCare used internal qualitative and quantitative data as well as public health data to determine which communities in Kentucky would be most affected by this initiative. The initiative focused on members who are homeless and ages 18 years and older. There are 281 people enrolled in the program.

## Intervention and Methods

WellCare funded Hotel Inc. Homeless Shelter, West Care Homeless Shelter, and Volunteers of America Homeless Shelter to identify, track, and connect members to case managers. This connection can occur at any time of day, and it results in the connection of the member to social and health care services.

## Outcomes

**Patient/Family Outcomes:** Through this initiative, 2,200 homeless people were identified from these three shelters. Out of this homeless population, 281 were identified as WellCare members. Of these, 122 were referred to WellCare case managers and connected to some type of support, and 76 individuals were moved into housing.

**Clinician Outcomes:** For many of the individuals who have been housed, their overall health has improved. Teams conducted 561 health assessments, screenings, and well-being checks. Individuals with copays were given copay vouchers for care: medical provider (32), pharmacy (21), dental (14), vision (2), and transportation (70). Thirty-two individuals utilized KYnector to obtain health benefits.

**Community Impact:** Through this community collaboration, Wellcare worked with and supported WestCare, Hotel Inc., and Volunteers of America in an effort to address homelessness throughout Kentucky. The partnership enabled homeless organizations in the community to have a deeper impact on the population they support.

**Cost Savings:** Cost savings not yet calculated for this initiative.

**Quality Improvement Efforts:** WellCare referred 122 homeless members into case management and helped 76 members secure housing. Case management also worked to address these members' social and medical needs.

## Lessons Learned

**Challenges:** The biggest challenge was implementation. WellCare created a program and partnership that was the first of its kind in Kentucky. Communication between the health plan and WestCare, Hotel Inc., and Volunteers of America was key.

**Successes:** Success is measured by both community and member impact, including improved health outcomes and increased access to housing and social services. Key elements that contributed to the success of this program were identifying and

collaborating with the correct community partners. WestCare, Hotel Inc., and Volunteers of America are very knowledgeable about their community and the population they treat.

**Advice:** It is vital to work with community organizations that are flexible and willing to adjust when needed.

### *Key Partners*

WestCare  
Hotel Inc  
Volunteers of America

### *Kudos to the Team*

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# Amerigroup Maryland (Anthem, Inc.)

## CORRECTIVE MANAGED CARE PROGRAM (CMCP)

Adverse health outcomes from misuse, abuse, and diversion of pharmaceuticals is a growing problem across the health care system. The Substance Abuse and Mental Health Services Administration (SAMHSA) reported that between 2004 and 2011, emergency department (ED) visits due to misuse or abuse of pharmaceuticals grew by 128 percent. In 2011, roughly 28 percent of all ED visits stemmed from misuse or abuse of pharmaceuticals, especially antianxiety and insomnia medications, opioid pain relievers, and antidepressants. Opioids including prescription opioid pain relievers and heroin killed more than 28,000 people in 2014, more than any year on record. According to the Centers for Disease Control and Prevention (CDC), at least half of all opioid overdose deaths involve a prescription opioid. Monitoring and encouraging appropriate use of controlled substances has the potential to reduce the use of emergency treatment, inpatient admissions, and abuse of controlled substance. This intervention could potentially have significant impact on proxy measures such as reducing crime, overdose, and death related to the inappropriate diversion and use of inappropriate controlled substance.

Starting in 2011, the Amerigroup Maryland health plan developed the Corrective Managed Care Program (CMCP) to reduce ED visits, and the data demonstrates reductions in inpatient, ED, and prescription use. sing, connect them to healthcare, and address other social service needs.

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### Key Priorities

- Reduce emergency room visits caused by misuse and abuse of pharmaceuticals.
- Increase engagement and empowerment of members to manage their pharmaceuticals.
- Reduce inpatient admissions.
- Reduce overall member misuse and abuse of pharmaceuticals.
- Engage members in care.

## Population

The program is targeted for members with patterns of care or prescription drug use that suggests misuse or abuse of pharmaceuticals. Only in situations where misuse or abuse is apparent, and efforts of prescribers and pharmacies to intervene are unsuccessful, are members enrolled in CMCP and restricted to a single pharmacy, prescriber, or both.

Behavioral health and substance abuse benefits for all Medicaid recipients are carved out to an administrative services organization (ASO). This analysis looks at a cohort of 690 members who were assigned a single pharmacy or prescriber, or both, during 2014 and who had at least six months of data available both prior to and after enrollment.

## Intervention and Methods

The Amerigroup Maryland health plan developed CMCP to combat pharmaceutical misuse, abuse, and diversion, as well as to monitor and encourage the appropriate use of controlled substances. Each month, the health plan reviews pharmacy data to identify members who may be duplicating drug therapies, using multiple pharmacies, visiting multiple prescribers for similar medications, or any combination of those. For each identified member who meets certain criteria, the health plan's CMCP case managers conduct a more in-depth retrospective review of utilization and spending patterns from prior months of data. Members whose patterns of care or prescription drug use suggest misuse or abuse of pharmaceuticals are referred to CMCP and, in some cases, the plan's internal fraud and abuse team.

Once a member is referred to CMCP, the Amerigroup Maryland health plan works collaboratively with pharmacies and physicians to address the member's behavior. The CMCP case manager works closely with providers and pharmacies to ensure that all have a complete clinical picture of the member—including issues identified during the retrospective review, such as missing therapies, duplicate therapies, or inappropriate utilization. Members are referred to targeted coordination and services most suited to their needs—whether it is care management, disease management, or pharmacist care management. Only in situations where misuse or abuse is apparent, and efforts of prescribers and pharmacies to intervene are unsuccessful, are members enrolled in CMCP and restricted to a single pharmacy and/or prescriber. The overall goal of assignment is to ensure members have access to the medications and treatment they need while reducing and eliminating the adverse health effects associated with overuse or misuse of controlled substances.

Each month, the health plan reviews pharmacy data to identify members who may be duplicating drug therapies, using multiple pharmacies, or visiting multiple prescribers for similar medications.

## Outcomes

Findings are based on analysis of claims data for Amerigroup Maryland health plan members enrolled in CMCP. Any members enrolled in CMCP but excluded from this analysis did not have enough data pre- and post-enrollment in CMCP at the time of the study to provide a meaningful analysis of the program's impact.

**Patient/Family Outcomes:** Members have had reduced inpatient admissions, ED visits, and pharmaceutical use (opiate and non-opiate prescription drugs).

**Clinician Outcomes:** CMCP has a measurable impact on both health care spending and utilization among enrolled Amerigroup Maryland members. Data demonstrates positive reductions in inpatient admissions, ED visits, and pharmaceutical use (opiate and non-opiate prescription drugs). This analysis looks at a cohort of 690 members who were assigned a single pharmacy and/or prescriber during 2014 and who had at least six months of data available before and after enrollment in the CMCP program.

**Community Impact:** Community impact was not measured for this initiative.

**Cost Savings:** Overall, total spending for these 690 members decreased by approximately 17 percent from approximately \$11.2 million in the six months before enrollment to approximately \$9.3 million in the six months afterward. As expected, spending on opiates decreased considerably (12 percent). The biggest driver of savings was inpatient services, which fell by nearly 25 percent during the study period; the program also reduced ED and non-opiate prescription drug spending, which fell by about 12 percent and 5 percent, respectively. Overall spending for members assigned to a single pharmacy and/or prescriber through CMCP declined by approximately 17 percent; 5 percent of which was driven by a decline in unnecessary pharmaceutical scripts and avoidable medical incidents such as inpatient admissions and nonemergent ED visits.

**Quality Improvement Efforts:** CMCP ensures quality of care for all members and more efficient delivery of services by reducing waste, fraud, and abuse where possible. CMCP has helped improve overall health care for members who were assigned to a single pharmacy and/or prescriber. ED visits dropped by more than 21 percent, likely driven in part by a reduction of 28 percent in prescribing.

## Lessons Learned

**Challenges:** Managing a Medicaid population with behavioral health and substance abuse benefits all Medicaid recipients carved out as an administrative service organization (ASO) is one of the challenges the health plan faced, as is managing substance use disorders or misuse of prescriptions when the benefit is bifurcated. This

makes it difficult to manage a population with an extreme prevalence of substance use disorder (SUD) and behavioral health issues related to opiate addiction. The program also struggled with the lack of educational opportunities and training for providers not in network. It is important, but can be difficult, to coordinate care across several organizations.

**Successes:** CMCP has had a measurable impact on both health care spending and utilization of ED and inpatient facilities while reducing pharmaceutical misuse, abuse, and even diversion of prescribed pharmaceuticals.

As the program was developed, the health plan expected to measure reductions in ED use, inpatient admission rates, and abuse and misuse of pharmaceuticals. Better health outcomes were expected. As a proxy measure, the data showed a reduction in oxycodone, hydrocodone, anti-anxiety and insomnia medications, which are usually overprescribed in EDs. ED visits dropped by over 21 percent, likely driven in part by a reduction of 28 percent in the number of prescriptions written for opiates, and a reduction of 15 percent in scripts for non-opiate prescription drugs.

Key to the success to this program are the internal pharmacy partners managing the data, utilization, and flow of information to the case management team. The integrated behavioral and physical health teams were essential in working with members to ensure the right care, right prescriptions, and right resources for their needs. The plan relies on health care partners, prescribers, and pharmacies that work with the organization to ensure member are not misusing, abusing, or diverting prescriptions or medications and that members can manage their prescribed medications.

**Advice:** Programs like CMPC are difficult to build, resource, and start up, but cost savings, reduced visits to the ED, fewer hospital admissions, and better overall health care outcomes help make the case for such a program. When building this type of program, a health plan should work with state partners to ensure the health plan is in line with Medicaid guidelines and state laws. Collaboration with providers and networks that can support plan members to address SUD issues is important. A plan should count on hiring consultants or subject matter experts who can help manage the program and member needs.

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# LTSS

LONG-TERM SERVICES  
& SUPPORTS



## **Anthem Indiana Medicaid (Anthem, Inc.)**

### *INDIANA CICOA CARE TRANSITIONS PROGRAM*

Care transitions are a major point of confusion and miscommunication for patients, families, and healthcare providers. Particularly, during transition from hospital to home, members are vulnerable to decline in health status. During the discharge period, many patients attempt to transition without adequate understanding of medications, follow-up appointments, and other information necessary to succeed with outpatient care. Consequently, patients often are ill-prepared to adequately care for themselves after discharge. Adverse events, including unplanned hospital readmissions, are common.

In 2014, in partnership with the Central Indiana Coalition on Aging (CICOA), Anthem launched a pilot to provide in-home care coordination to members discharged from the acute inpatient setting with a high risk of inpatient readmissions or emergency department visits. CICOA acted as an extension of the Anthem care management team to stabilize members as they transitioned to home. From January through June 2015, members who were referred by Anthem and experienced a face-to-face care coordination visit had a readmission rate 31.2 percent lower than those referred who did not have a home visit (i.e., refused, were unable to be reached).

#### *Key Priorities*

- Improve member health literacy.
- Review discharge planning instructions and scheduled medical appointments.
- Assess home environment and supports, arrange transport, and review medications and adherence.
- Link members to community resources.

## Population

Members were referred to the program if they were identified as being at high risk of readmission using predictive modeling or assessment by utilization management staff. All 217 members were located in Central Indiana, the catchment area of CICOA. The members were in the acute inpatient setting and referred by discharge planners as having complex needs, including physical health and social supports needs.

Members with medically complex conditions recently discharged from an inpatient setting were targeted for this program, as they were more likely to experience adverse events or unplanned hospital readmissions.

## Intervention and Methods

Anthem Indiana Medicaid entered into a collaborative relationship with CICOA and Area Agency on Aging (AAA) 8 to target high-risk members for home visits by a care coordinator to identify and assist with unmet needs. In Indiana, AAAs are trusted community partners developing and supporting livable communities for all ages. They identify services to support people where they live. Anthem's pilot program targeted members enrolled in Medicaid, without age or other demographic limitations. Referred members were identified through Anthem's discharge planning team with the use of predictive modeling. The health plan regionally assigned care managers in alignment with CICOA's resources to facilitate follow-up case management services for targeted members. These care managers worked with CICOA managed care outreach coordinators (MCOCs) and acted as liaisons to Anthem's other care management team members, including behavioral health and social support staff.

CICOA and health plan staff worked together to coordinate follow-up and documentation. CICOA used an electronic medical record (EMR) system that Anthem accessed to send referrals. The same system was used for tracking and reporting. Initial referrals to CICOA included comprehensive clinical information and identified specific needs of the member. CICOA updated this record in the system with information obtained during the home care visit. Care conferences for enrolled members were held regularly with Anthem care managers, CICOA MCOCs, members of the CICOA and Anthem leadership teams, and Anthem's dedicated CICOA medical management specialist.

There were 217 members referred to CICOA in the initial pilot. Referral was partially driven by predictive modeling, specifically using a scoring system that indicated likelihood of readmission based upon past claims.

## Outcomes

**Patient/Family Outcomes:** From January through June 2015, members that were referred by Anthem and experienced a face-to-face care coordination visit had a readmission rate 31.2 percent lower than those referred that did not have a home visit (i.e., refused, were unable to be reached). This was the result of high-touch member support of some of Anthem's most vulnerable members.

**Clinician Outcomes:** Clinician outcomes were not measured for this initiative.

**Community Impact:** As Anthem has solidified its relationship with members, it has also strengthened its partnership with CICOA and the other AAAs.

**Cost Savings:** Cost savings resulted from a readmission rate that decreased by 31.2 percent.

**Quality Improvement Efforts:** Based on the outcomes of the pilot, Anthem expanded the program statewide, in partnership with the Indiana Aging Alliance (I2A), and has now reached 809 members. Data analysis on this program expansion is pending.

## Lessons Learned

**Challenges:** It was challenging to work with a program partner that was not familiar with plan benefits. Through ongoing interaction and regular, frequent meetings with the partner, Anthem continues to improve the partner's understanding about the nuances of member benefits. Communication challenges were addressed through frequent and regular meetings and case rounds. Operations were refined to achieve a balanced workload, along with improved training tools and record-keeping devices.

**Successes:** One key to success is choosing the right community partner. CICOA (and all the AAAs in Indiana) are perfectly poised to support Medicaid members, with strong ties to resources Anthem members need. Maintaining ongoing and frequent communication fostered a positive relationship between the community partner and Anthem care management staff. Staff training, for both Anthem and CICOA associates, was key to a smooth implementation. In addition, it was imperative to create streamlined reporting and tracking tools, as well as clearly defined roles and responsibilities. Deep knowledge of and access to community supports, and knowledge of managed care covered services is also valuable.

**Advice:** It is imperative to choose a partner or partners wisely. Choose a partner that complements the health plan organization and vice versa. Anthem selected an excellent partner for this project, which was the key to program success. Communication

methods and documentation need to be clearly designed at the beginning of the effort, and it is good to collaborate with the partner on the best means to reduce administrative burden. Members need to be aware of and receptive to the partner, using communication vehicles to best meet the needs of members. Regular communication and collaboration with the partner provides the most seamless care coordination services to members.

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# Amerigroup Florida (Anthem, Inc.)

## LONG TERM CARE (LTC) TRANSITIONS PROGRAM

Transitional care occupies an increasingly important role as home and community-based services (HCBS) replace facility-based care as the preferred way to deliver long-term care (LTC). The managed care organization's role in these successful transitions includes: arranging for comprehensive assessments; a single point of contact, usually a case manager, who is responsible for planning the transition; and, a clearly defined person-centered care plan that includes the individual's goals. Care transitions are not "one size fits all." The LTC Transitions program started in 2015 and uses highly trained case managers to support members in making and maintaining successful transitions.

Transitioning members to HCBS is important to facilitate patient autonomy and improve their well-being. The process seeks to maintain quality of care while elders and persons with disabilities transition from a hospital or nursing home facility to a qualified residence. Key to the success of these transitions is making sure that members can have their health and personal needs met, their environment is safe, medication regimens are adhered to, and follow-up care is coordinated.

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### Key Priorities

- Ensure person-centered service planning and delivery.
- Ensure member access to needed services.
- Ensure network/provider capacity.
- Ensure member safety and satisfaction with outcomes.



## Population

Three distinct groups are served in the Florida SMMC-LTC program: the frail and elderly; the physically disabled; and individuals with mental illness and substance abuse. Approximately 25 percent of the health plan's 1,100 members lived in a nursing facility in 2015. Through individualized service assessments and care plans, each member was reviewed for the opportunity to move into a residential or home setting. In the end, 77 individuals participated in the program.

## Intervention and Methods

Fundamental to the LTC program is helping individuals who have the ability or desire to transition from a nursing facility or other facility setting to a more integrated community setting. Recognizing that most individuals want to remain in or return to their community, the health plan has developed and implemented successful strategies to promote nursing facility transitions. A multipronged program helps individuals achieve their personal goals, using their strengths, and taking into account their autonomy, wishes, goals, and independence. This collaborative initiative provides support to give the member more independence. The program works as a team with the member, family, caregivers, and primary-care provider to reach agreement and identify needs.

The program identifies services and supports needed by each person to transition. Some of these include:

- Assistance with activities of daily living (ADL).
- Nursing facility–based care.
- Occupational/speech/physical therapies.
- Personal attendant services.
- Respite for family members and other unpaid caregivers.
- Environmental/home modifications.
- Adaptive aids/equipment.
- Adult day health care/day activity health services.
- Other rehabilitative and facilitative services and supports.
- Personal emergency response system.
- Assisted living.

Currently Anthem uses a clinical case management solution to support the company's LTC programs. This system supports specialized health risk assessments; service planning tools, integrated with care management and provider information systems; case documentation and tracking; and, automatic documentation of the date and time when the service coordinator conducts a face-to-face interaction with a member, and/or any updates made to member tools and documentation, which are then tracked and reported.

In 2015, 77 members were identified, through service coordinators, as having expressed a person-centered goal to move from a nursing facility setting to HCBS.

## Outcomes

**Patient/Family Outcomes:** The health plan successfully transitioned all targeted 77 members to HCBS. Two members returned to the nursing facility some months later, resulting in a 97 percent success rate.

**Clinician Outcomes:** Clinician outcomes were not measured for this initiative.

**Community Impact:** Community impact outcomes were not measured for this initiative.

**Cost Savings:** Annualized savings associated with 77 nursing facility transitions equaled \$2.7 million.

**Quality Improvement Efforts:** The health plan develops provider networks that honor members' choice and include the full range of care and services to support independent living and improve quality of life. The health plan identifies gaps that may occur in the members' health care delivery system that may affect the members receiving optimal care.

## Lessons Learned

**Challenges:** The program strives to continuously identify the unmet needs of members through regular case finding and the coordination of services for them accordingly. This could involve coordination of care, assisting members in accessing community-based resources, or any broad range of interventions designed to improve the quality of life and functionality of members.

**Successes:** Success was defined as a successful transition of targeted members who had been living in a nursing facility into HCBS. The health plan reviewed the member's ability to live in home- and community-based settings after the transition and compared with other long-term care health plans in the Anthem family. The health plan's tools, tracking mechanisms, and integrated person-centered planning processes, as well as highly trained case managers (service coordinators), contributed to successful transitions.

**Advice:** Transitional care planning must be person-centered, with an interdisciplinary process including members of the facility, the managed care organization, the member, and the caregiver. Health plans will need to complete a comprehensive, and regularly revisited, assessment of the member's medical, physical, functional, and social needs. Additionally, ongoing collaboration between the member, family, and interdisciplinary team to ensure that the member's safety needs and person-centered care plan goals are being met.

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## Key Partners

Central Indiana Center on Aging (CICOA)

## Kudos to the Team

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# Horizon NJ Health

## HORIZON VIEW – MLTSS OPERATIONS PROCESS DASHBOARD

Horizon New Jersey (NJ) Health needed to identify a more effective way to communicate the implementation progress of the managed long-term services and supports (MLTSS) program. Horizon View is a quick-glance dashboard report that allows MLTSS staff to provide up-to-date status reports regarding current membership, progress, and quality of care coordination. The dashboard identifies any process issues so members can continue to receive care in a timely manner. Horizon View was created in July 2014 at the start of Horizon's MLTSS program. The MLTSS population initially started with 5,400 members and has grown to more than 12,350 members as of April 1, 2016.

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### Key Priorities

- Consolidate data with the ability to generate predictive alerts based on the business intelligence.
- Build a user-friendly reporting tool that uses data to support the MLTSS staff in the processing member evaluations through the enrollment and servicing provisioning steps, utilize data consolidation to create predictive alerts regarding members' care, and identify critical paths to prevent issues that might interfere with a member's enrollment or plan-of-care development.
- Analyze aggregated data from all care manager performances to identify individual issues and improve performance.
- Consolidate close to 20 separate reports being used to determine and identify actionable items into one dashboard-reporting tool.

## Population

The 12,356 beneficiaries enrolled in MLTSS are those who qualify for nursing facility–level care, have complex needs, and are the costliest populations within a state. The MLTSS program provides members with the opportunity to remain in their own home or to reside in a community setting rather than a nursing home.

When assessing members the health plan identifies cultural barriers that may affect access to care. The care manager develops individual care plans incorporating members' cultural needs. The health plan is committed to reducing healthcare disparities and increase access to care by providing quality, culturally competent care through strong doctor-patient relationships.

## Intervention and Methods

The core components of this initiative are to efficiently monitor the complexities of the members enrolled in the MLTSS program. Horizon NJ Health's ability to monitor, in real time, each phase of the program provides the care managers the tool for timely intervention, whether it is the initial assessment that needs to be performed within ten days of enrollment, development of the care plan and implementation of services within 30 days of enrollment, reassessing a member seven to ten days after each acute/skilled discharge, or the reassessing the member every 90 days after initial enrollment. These are only some of the assessments that must be completed while the member remains enrolled in the MLTSS program. The Horizon View dashboard provides clear direction for care managers to remain compliant with the MLTSS contractual obligations.

By employing new member assessments and member inpatient/skilled utilization data, the health plan can identify members with cognitive deficits or those who cannot perform three or more activities of daily living. MLTSS members are assigned by county to care managers who are residents of the same county.

## Outcomes

**Patient/Family Outcomes:** Member Outreach and Initial Visit Compliance is a measure used to ensure that Horizon NJ Health is helping the member promptly. This measure allows care managers to assess and ultimately provide the services a member needs. It also determines the members' ability to live in an appropriate community setting. After Horizon View dashboard reports were introduced and implemented, improvements were seen.

**Clinician Outcomes:** Clinician outcomes were not measured for this initiative.

**Community Impact:** Community impact was not measured for this initiative.

**Cost Savings:** The implementation of Horizon View has saved \$750,000 in administrative costs.

**Quality Improvement Efforts:** Horizon performs quality audits on each care manager to ensure there is timely intervention, compliance with program, and coordination of services. The audits also make sure that members are receiving the necessary services to keep them safe and independent within their living arrangement.

### *Lessons Learned*

**Challenges:** The health plan encountered two primary challenges. First, the development of the data set required a detailed process review and documentation effort. Data previously used for reporting was manually entered by clinical staff. The new process involved eliciting data from several different existing systems and reports. By codifying the business rules to get a consistent application, clinical staff performed more efficiently. Second, adoption by clinical staff doing the work was a challenge due to the strict nature of the dashboards. Repeated online meeting sessions were held to assure staff of data accuracy, which reduced the time needed for implementation of Horizon View.

**Successes:** Horizons NJ Health measures success of the program using the MLTSS Dashboard, which tracks all phases of the program. There is a care management dashboard that informs the case manager as to what needs to be completed and whether it is on time. There is also a management dashboard for directors, managers, and supervisors to monitor the daily progress of each team. This management dashboard is used to audit staff, ensure members are authorized for their necessary services, and make sure face-to-face member visits take place on schedule.

The success of this intervention can be attributed to the willingness of the executive team, who agreed to use an entirely different approach to driving process execution and oversight. Additionally, the clinical directors' effort to automate consistently applied business rules based on data attributes was critical. Rather than stay with traditional, manual interpretation by individuals, automatic reporting features led to achieving the same desired outcomes in a much more efficient and effective way.

**Advice:** For a dashboard report of this magnitude to be successful, process and data sources must be well defined. Once the basic elements are clear, any business rules that individuals are asked to apply should be automated. Finally, it's vital that the visualization of the resulting dashboard and reports are easy to use and appropriate for the intended audience.

### *Kudos to the Team*

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# WOMEN'S HEALTH



# BlueChoice HealthPlan (Anthem, Inc.)



## REDUCING NEWBORN HOSPITALIZATION COSTS THROUGH INVESTING IN CENTERINGPREGNANCY™ GROUP PRENATAL CARE

In the United States in 2012, 11.5 percent of births occurred at less than 37 weeks of gestation and 8 percent of babies were born with low birthweight. Inpatient costs associated with preterm births exceed \$6 billion annually, representing half of all costs associated with infant births. Increasing access to traditional prenatal care services has not reduced preterm birth and low birthweight, calling into question payers' substantial financial investment of approximately \$10 billion per year in prenatal care services. Many published studies describe the advantages of group prenatal care; however, very limited analysis was available about CenteringPregnancy™'s financial impact on birth outcomes. CenteringPregnancy™ group prenatal care is an innovative model with promising evidence for improving birth outcomes. In 2013, Anthem partnered with an obstetrics care practice with an existing certified CenteringPregnancy™ program to increase access to group prenatal care through provider-enhanced reimbursement, and to compare birth outcomes for those who participated in a prenatal care group with those who received individual prenatal care.



### Key Priorities

- Connect members to a CenteringPregnancy™ program to improve health outcomes.
- Engage members in prenatal care program.
- Improve member health outcomes, demonstrated by reduction in likelihood of neonatal intensive care unit (NICU) admission.
- Improve members' experience and satisfaction.

## Population

To be eligible for CenteringPregnancy™ at the clinic location, members must have started prenatal care before 20 weeks of pregnancy. Medical exclusions include pre-gestational diabetes or hypertension, multiple gestation, and a body-mass-index (BMI) greater than 45. All eligible patients were offered CenteringPregnancy™ for their prenatal care, with a 30 percent adoption rate. There were 107 enrolled in Centering Care, and 85 had four or more CenteringPregnancy™ visits.

## Intervention and Methods

All CenteringPregnancy™ patients in the pilot study began their prenatal care between March and August 2013 at the same high-volume hospital-affiliated obstetrics clinic in an urban setting in southeast South Carolina. The clinic has offered CenteringPregnancy™ since 2008 and has received annual certification from the Centering Healthcare Institute.

Anthem partnered with the clinic to provide financial assistance through provider reimbursement for members actively engaged in the program. This enhanced reimbursement is supported by the state Medicaid agency, contingent upon the clinic's CenteringPregnancy™ certification. In addition to the state reimbursement, Anthem provided an incentive payment intended to support the clinic's necessary supplies, administrative needs, training, and program certification.

All eligible patients were offered CenteringPregnancy™ for their prenatal care, with approximately 30 percent opting for CenteringPregnancy™ instead of individual prenatal care. Three to four CenteringPregnancy™ groups were available each month for every new patient who opted for group care. The clinic provided Anthem with the patient list, number of CenteringPregnancy™ sessions attended, newborn hospitalization type (i.e., well-baby or intensive care admission), and identifiers to link maternal and infant records.

In the CenteringPregnancy™ model, groups of pregnant women due within the same month attend monthly sessions. Each session begins with a brief individual medical assessment followed by a 90-minute facilitated group discussion. Curriculum topics include pregnancy, labor, and delivery; nutrition; stress management; infant care and breastfeeding; and healthy relationships.

Using one-to-many case control matching, each participant was retrospectively matched on propensity score, age, and clinical risk factors to individual care participants. The odds were estimated for newborn hospital admission type (i.e., NICU or well-baby admission) for matched CenteringPregnancy™ and individual care cohorts.

## Outcomes

**Patient/Family Outcomes:** Three newborns in the Centering group had a NICU admission, resulting in a 3.5 percent NICU rate for the study cohort. In comparison, the individual care cohort, after propensity score matching, had a 13.9 percent NICU rate (p-value <0.0001).

**Clinician Outcomes:** This study represents one opportunity for partnership between obstetric care providers and third-party payers in redesigning prenatal care, and it is emblematic of the paradigm shift occurring in the broader healthcare field. The traditional, volume-driven, fee-for-service model of reimbursement is shifting toward a “value-driven” model in which patient outcomes are increasingly important.

**Community Impact:** CenteringPregnancy™ demonstrates the powerful role that community can play in prenatal health. Women actively engage in self-care and participate in group sessions where they support and educate one another, with medical practitioners participating to respond to clinical questions and add clinical perspective as needed without lectures or counseling. This peer support activity can reinforce the pregnant woman’s self-efficacy and self-esteem.

**Cost Savings:** Among CenteringPregnancy™ newborns, 3.5 percent had a NICU admission compared with 13.9 percent of individual care newborns (p<0.001), representing an estimated \$86,015 savings in NICU costs.

**Quality Improvement Efforts:** Investment in programs like CenteringPregnancy™ break down traditional silos of inpatient versus outpatient costs and obstetric versus pediatric outcomes. It is a natural evolution in which third-party payers can help practices deliver the highest quality of care by providing incentives to move to improved care models such as CenteringPregnancy™.

## Lessons Learned

**Challenges:** Although evidence supporting CenteringPregnancy™’s effectiveness in reducing preterm birth is promising, the underlying mechanisms accounting for its impact remain poorly understood. Additional research assessing its effects on maternal health behaviors, stress, patient activation, and cost implications for practices and payers in different practice settings and reimbursement structures is needed to build a greater understanding of the range of positive outcomes and cost implications associated with CenteringPregnancy™.

**Successes:** By conducting a retrospective cohort analysis through one-to-many case control matching on propensity score, age, and risk, Anthem accounted for different attributes between the two populations and ultimately evaluated the cost savings between the group participating in Centering group and the group receiving individual

care. Each participant was retrospectively matched on propensity score, age, and risk to 50 individual care participants. The pregnancy risk-assessment score used in the propensity score matching is a proprietary algorithm developed by Anthem that accounts for factors associated with adverse pregnancy outcomes.

Through the collaboration with the obstetrics practice at Greenville Health System, Anthem was able to develop this study and evaluate the results. Greenville provided data on each Centering patient (i.e., when the patient started the Centering program, how many Centering visits the patient had, result of delivery). The health plan had a trusted partner in the Greenville Health System, both in the quality of care the member was receiving and in the staff's desire to see the Centering program succeed.

**Advice:** Costs incurred by outpatient providers in offering these programs may pose a barrier to adoption of this model of care.

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### *Key Partners*

Greenville Health System  
BlueChoice Health Plan of South Carolina

### *Kudos to the Team*

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# Home State Health Plan (Centene Corporation)

## HEALTHY MOM AND BABY REPORT

Before 2013, notification of pregnancy and provider referrals were the only methods of identifying pregnant members. These methods do not account for alternative means of identification for expectant women with unmet health care needs. In order to decrease health risks, unnecessary trips to the emergency department (ED), and use of the Neonatal Intensive Care Unit (NICU), Home State Health created an automated and systematic method of using all available data to identify and track members through their pregnancy.

Home State Health created its innovative Healthy Mom and Baby Report in 2013. With it, Home State Health now performs data mining to identify women who may have high-risk health issues not otherwise identified. This report uses claims data to sort members into queues based on their diagnosis. Home State Health case managers call members to discuss their specific situations, assist with enrollment in case management, and direct members to additional medical providers and community programs.

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### Key Priorities

- Systematically identify special care needs for expectant mothers and provide specialized care so Home State Health's expectant mothers can deliver full-term, healthy babies.
- Reduce NICU admissions, with associated cost; and reduce unnecessary ED use by pregnant women.
- Use all available data to identify high-risk members and swiftly facilitate their enrollment into case management to increase the percentage of full-term, health babies.

## Population

The program targets Home State Health’s pregnant members.

## Intervention and Methods

The Healthy Mom and Baby Report was conceptualized and created as a collaborative effort between multiple internal Home State Health departments, including Home State Health’s plan president, Medical Management team, Quality team, and Operations team.

This report allows Home State Health to target its telephonic and face-to-face outreach program using member information collected from claims, provider referrals, and medical records. This program uses data analytics to proactively snapshot and flag member behaviors captured in medical visits, and it uses the captured data to disrupt undesirable behaviors and promote more desirable health behaviors.

By implementing automated review and analysis of member claims data, Home State Health’s Healthy Mom and Baby Report captures when a member has yielded a positive screening for substance use and visited a provider or emergency department. The report incorporates all diagnoses from the member’s visit. Claims data retrieved from the member’s visit, medical diagnosis, and provider referrals are evaluated and interpreted with an innovative Centelligence data tool. Based on the issues uncovered by this analysis, members are flagged for follow-up care for both easily treatable as well as high-risk medical conditions like high-blood pressure and preeclampsia. Armed with critical data, case managers can create a customized care plan for each member and recommend that a member enter into case management, with interventions such as regular phone calls, targeted education, and referrals to beneficial resources from a registered nurse.

Home State Health staff attended cultural competency training to develop empathy and understanding of issues, such as poverty training, to better enable them to connect with members on an empathetic level. Health literacy and appropriate reading levels are other examples of methods Home State employs to eliminate barriers to care.

## Outcomes

**Patient/Family Outcomes:** Home State Health’s Healthy Mom and Baby Report led to a number of positive findings and outcomes for the health plan’s members and the Medical Management Department. Despite a sudden increase of more than 50 percent in the number of pregnant members—of which 32 percent were high-risk—Home State Health maintained an 80 percent rate of obtaining a notice of pregnancy (NOP) (Table 1 and Figure 1). Home State Health performed outreach within 7 days



on 92 percent of all high-risk pregnancies. Case management enrolled 20 percent of its high-risk members in a specialized care plan within 30 days of receiving an NOP and enrolled 25 percent in a specialized care plan within 60 days.

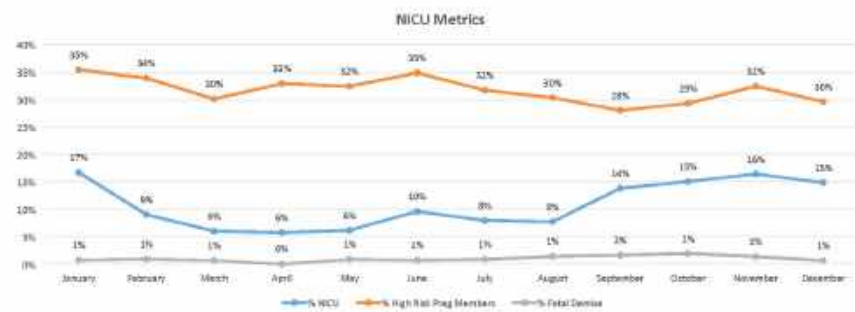


**Table 1. Monthly Enrollment of Pregnant Members and NICU Metrics in 2015**

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
<b>Pregnant Members</b>	401	433	451	419	456	407	454	494	492	525	579	607
<b>High-Risk Pregnant Members</b>	142	147	136	138	148	142	144	150	138	154	188	180
<b>Number of NICU Babies</b>	67	39	27	24	28	39	36	38	68	79	95	90
<b>Fetal Demise</b>	3	4	3	0	4	3	4	7	8	10	8	4



**Figure 1. Monthly Enrollment of Pregnant Members and NICU Metrics in 2015**



**Clinician Outcomes:** As a result of the Healthy Mom and Baby Report, Home State Health is able to identify the need for referrals to health providers, medical specialists, and programs that aid with maternal health. Areas of increased referrals include substance use programs and diabetes, hypertension, and other related maternal health programs.

**Community Impact:** Home State Health increased its partnership and referrals to community groups and services and home nursing programs. Comprehensive Substance Treatment and Rehabilitation (CSTAR) is one example of a program Home State Health has increased referrals to as a result of the report. CSTAR provides a full continuum-of-care approach to substance abuse treatment. The Doula Foundation and Uzazzi Village are two community-based organizations that assist women with

pre- and post-delivery support. Home State Health proactively built relationships with these groups to expand upon services and support available to its pregnant members.

**Cost Savings:** The Healthy Mom and Baby Report allows the health plan to save costs by tailoring resources—both internal and external—toward creating initiatives, programs, and joint partnerships that help high-risk pregnant members decrease or eliminate unnecessary ED visits, access specialized care that increases their likelihood of delivering full-term babies, and programs that will help Home State decrease the amount and length of NICU stays.

**Quality Improvement Efforts:** The Healthy Mom and Baby Report enables Home State Health’s Quality Department to pinpoint care gaps. In turn, the department investigates research studies, care gap letter programs, and community partnerships and events that assisted with addressing and closing care gaps.

## *Lessons Learned*

**Challenges:** Home State Health’s first challenge occurred when ICD-10 was implemented; the report had to be recalibrated to accommodate ICD-10. Since the report was created to data mine claims, changes to the code negatively affected the mechanisms driving report generation. Additionally, having to wait to receive a claim presented an additional issue with how quickly the health plan could evaluate, interpret, and respond to information received through claims. Additional barriers include incorrect contact information and members refusing case management.

**Successes:** The Healthy Mom and Baby Report’s greatest success is the ability to target Home State Health’s telephonic and face-to-face outreach based on data that provides a member’s holistic health status. This allows the health plan to treat every aspect of the member—including physical and behavioral health—with the most appropriate and effective care.

The key element is the health plan’s ability to pinpoint and take an introspective look at a member’s health status. Through utilization of claims data, Home State Health knows what provider a member has seen, which is valuable data if provider communication is needed. This information also allows Home State Health to see specific diagnoses from providers, which lets the health plan know if there are immediate physical or behavioral health concerns. Lastly, case managers can connect with members on a personal level because they have been equipped with key information.

**Advice:** Home State Health would encourage other health plans to consider embracing and using Big Data to take advantage of resources already in operation and within their organization to better understand a member’s current physical, mental, and environmental status. The better a health plan understands how to meet their members where they are to improve their care, the better care the plan can

provide care to members that improves their health outcomes and decreases unnecessary costs.

### *Key Partners*

Home State Health  
Home State Medical Management Department  
Home State Reporting and Analytics Department  
Home State Quality Department  
Home State Operations Department

### *Kudos to the Team*

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# Peach State Health Plan (Centene Corporation)

## FLUVENTION BABY SHOWER VACCINE PROGRAM

There is a misconception and fear among some pregnant women that they will contract the flu from the influenza vaccine or that the vaccine will cause harm to their baby. Centene has been working to combat that misconception through a myriad of influenza education programs, including texting and automated phone calls. At the same time, the health plan has been trying to increase access to the flu vaccine. Centene has seen a steady increase in the flu vaccination rates in its pregnant members. To maintain progress, Centene must continue to innovate to reach this high-risk population, given that the flu vaccine offers a two-for-one benefit for mom and baby while helping to prevent flu-related hospitalizations.

One of the major barriers to obtaining the flu vaccine is access. The Fluvention Baby Shower program aimed to eliminate that barrier by providing no-cost flu vaccines directly to pregnant members at a health plan-sponsored baby shower event. Members in the Southwest region received an invitation letter and phone call promoting the event and encouraging flu vaccines. The shower program group had a 53 percent higher vaccination rate than the control group. Overall, the baby shower program shows that bringing services directly to high-risk populations is effective.

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### Key Priorities

- Increase the number of pregnant members vaccinated against influenza.
- Encourage pregnant members to obtain their flu vaccine during a health plan-sponsored event.
- Educate pregnant women and their families on the importance of obtaining a flu vaccine.
- Inspire members to be proactive with their health by obtaining the yearly flu vaccine.

## Population

This initiative is targeted to pregnant women up to 34 gestational weeks. This population was chosen because flu vaccines for this group represents a two-for-one benefit for mom and baby protecting both against influenza. Additionally, this population has been identified as high-risk by the Centers for Disease Control and Prevention. Among eligible members, 783 pregnant women in the Southwest region of Georgia ranging from the ages of 14 to 47 years have participated. The Southwest region is made up of 35 counties.

## Intervention and Methods

Centene developed a program in 2015 to bring flu vaccines directly to pregnant members while leveraging programs already in operation. The Member Connections Department at Peach State Health Plan (PSHP) hosts quarterly baby showers through the Start Smart for your Baby (SSFB) program. Each quarter, the program targets a different region in Georgia. These events provide PSHP members with information on prenatal and postpartum care. PSHP collaborates with local physicians, health departments, and other community health partners to bring in helpful tips for maintaining a healthy pregnancy.

An analysis of vaccination trends for pregnant women in PSHP revealed that in the 2014-15 flu season, only 13.9 percent of pregnant PSHP women obtained a flu vaccine, compared with 25.5 percent across the Centene enterprise. To improve vaccination rates for this high-risk population, PSHP collaborated with Corporate Medical Affairs to bring vaccinations directly to pregnant women at the baby shower. Walgreens was brought on as a vendor to provide no-cost flu vaccines to all shower attendees, including families and staff. Throughout the month before the event, targeted women were sent an invitation letter and automated phone calls to encourage them to attend the shower. These pieces also educated women about influenza while urging them to obtain a flu vaccine. Once the women got to the event, they were provided flu vaccines on-site if interested.

This program eliminates the barriers to access and cost. The baby shower program includes presentations from physicians, community health leaders, and a Walgreens pharmacist. All presenters address issues relevant to child and maternal health, such as car seat safety, well-child visits, and flu vaccinations.

Flu vaccination claims in the Southwest region (i.e., treatment group) were compared with those in Central (i.e., control group) region. Invitation letters and automated phone calls were distributed to the Southwest region only. The Central region was identified as the most similar region when comparing demographics (e.g., age, race, gender, pregnant) and flu vaccines. All outreach materials were created using state-required standards to meet linguistic requirements (i.e., reading level, Spanish versions).

## Outcomes

**Patient/Family Outcomes:** Outreach from the baby shower program resulted in a 53 percent higher vaccination rate for the treatment group (Southwest region) than the control group (Central region) which received no outreach ( $p < 0.001$ ). Furthermore, those who went to the baby shower were 2.72 times more likely to be vaccinated than those in the control group. Within the treatment group (Southwest region only), those that were invited and attended the shower were 1.43 times more likely to be vaccinated than those that were invited but did not attend the shower.

**Clinician Outcomes:** Clinician outcomes were not measured for this initiative.

**Community Impact:** During the shower, women were encouraged by physicians, pharmacists, community groups, and health plan representatives to get vaccinated on-site. Of the women that attended the shower, 37.88 percent were vaccinated at the event, 13.64 percent were vaccinated in the month before the event, and 15.15 percent were vaccinated after the event. Also, an additional 40 vaccines were given to family and friends on-site.

**Cost Savings:** Cost savings were not measured for this initiative. However, pregnant women are at high risk for complications from influenza that can lead to stillbirth, preterm delivery, low birthweight babies, and even death. Flu vaccinations can help to prevent flu-related complications and hospitalizations. The flu shot also passes on flu-fighting antibodies to the baby until six months after birth. Studies have found significant cost savings and quality-adjusted life years (QALYs) saved from vaccinating pregnant women against flu (Ameel, 2014; Roberts, 2006; Beigi, 2009). Therefore, it is likely that vaccinations at the baby shower event contributed to cost savings and QALYs.

**Quality Improvement Efforts:** Previous efforts (e.g., mailers) to promote the flu vaccine to pregnant women were not effective. This initiative showed that the approach for promoting the flu vaccine to pregnant women should be more direct. Therefore, the health plan's approach to this high-risk population is to bring the flu vaccine directly to pregnant women through events.

## Lessons Learned

**Challenges:** The main challenge that the team encountered during implementation was the manual registration process. All members who entered the building signed in on a paper sheet. In the future, having members sign in using an iPad would ease the registration process by ensuring that accurate registration data is maintained. Additionally, the iPads will obtain real-time information about the member to identify and address any outstanding gaps in care.

**Successes:** To measure success, Centene looked at the percentage of members that obtained a flu vaccine after receiving the invitation letter and automated phone call. Another measurement of success was the percentage of members that attended the shower and obtained a flu vaccine at the event and after the event.

An important element for success in this program was close collaboration between the health plan, corporate teams, and the community partners. Additionally, the automated phone call system provided a relatively low-cost way to reach many members in a short period of time. Other key elements included ensuring that members knew the flu vaccine would be available at the event, encouraging staff members to get the flu vaccines at the same time as members to build trust and be relatable. Lastly, a Walgreens pharmacist presented information about the flu vaccine.

**Advice:** The team would encourage health plans to gain buy-in from in-network providers so they can encourage members to attend the event and obtain the flu vaccine if they have not already. Additionally, it is important to offer a hot and healthy meal at the event and provide gender-neutral items as prizes for the baby shower games. Providing much-needed items such as diapers is ideal.

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### Key Partners

Peach State Health Plan  
Corporate Medical Affairs  
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# Empire Blue Cross Blue Shield HealthPlus (Anthem, Inc.)

## COMMUNITY HEALTH WORKER (CHW) CARE COORDINATION PROGRAM

Empire Blue Cross Blue Shield HealthPlus has long identified the need to better address the needs of chronic disease management members beyond the traditional health plan activities. An in-depth review revealed the following:

- A large number of members were not engaged in traditional case management or care coordination.
- Telephonic outreach had not been successful.
- Only 354 of 8,000 high-utilizing members with chronic diseases had been involved in care coordination.
- Members with high utilization rates may have poor outcomes.
- Members need coaching to increase self-management skills and healthy behavior adoption.
- Disease coaching and social determinants of health may not be addressed.

The health plan implemented a community health worker (CHW) program in 2015, deploying a team of field-based staff to engage, educate, and facilitate care coordination of hard-to-reach members with chronic health conditions. The program was to engage people in their homes to empower them to manage their health and improve their overall quality of life. These high-need members often face social, cultural, and linguistic barriers to improving their health status, and these barriers cannot be optimally addressed with telephonic intervention and translator support. As a result, these members tend to have gaps in care, high utilization of preventable emergency department (ED) visits and hospitalizations, and low-quality outcomes.

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### Key Priorities

- Connect targeted members to health plan services, providers, and community resources.
- Improve disease and health outcomes.
- Locate, engage, and connect members with their benefits, providers, and community resources and services.
- Improve member health outcomes, demonstrated by fewer gaps in care, ED visits, and inpatient admissions.
- Enhance the member's experience and satisfaction.

## Population

The population for this initiative includes adult Medicaid members receiving Temporary Assistance for Needy Families (TANF) with select chronic conditions. They are prioritized using Empire's proprietary predictive modeling algorithms and targeted for intervention by a CHWs in New York City (NYC) and the surrounding boroughs. Chronic conditions targeted by the program include asthma, diabetes, hypertension, and chronic heart failure.

Selection criteria initially identified 8,000 members with chronic diseases, with a combined medical loss ratio (MLR) of 230 percent. Members did not have effective disease control, evidenced by 56 percent higher inpatient admission rates than the control group. Ten percent of this population had no documented primary care provider (PCP). Geo-mapping was used to align CHWs to members in their communities, based on location and language needs.

## Intervention and Methods

The Healthy Mom and Baby Report was conceptualized and created as a collaborative effort between multiple internal Home State Health departments, including Home State Health's plan president, Medical Management team, Quality team, and Operations team.

This report allows Home State Health to target its telephonic and face-to-face outreach program using member information collected from claims, provider referrals, and medical records. This program uses data analytics to proactively snapshot and flag member behaviors captured in medical visits, and it uses the captured data to disrupt undesirable behaviors and promote more desirable health behaviors.

By implementing automated review and analysis of member claims data, Home State Health's Healthy Mom and Baby Report captures when a member has yielded a positive screening for substance use and visited a provider or emergency department. The report incorporates all diagnoses from the member's visit. Claims data retrieved from the member's visit, medical diagnosis, and provider referrals are evaluated and interpreted with an innovative Centelligence data tool. Based on the issues uncovered by this analysis, members are flagged for follow-up care for both easily treatable as well as high-risk medical conditions like high-blood pressure and preeclampsia. Armed with critical data, case managers can create a customized care plan for each member and recommend that a member enter into case management, with interventions such as regular phone calls, targeted education, and referrals to beneficial resources from a registered nurse.

Home State Health staff attended cultural competency training to develop empathy and understanding of issues, such as poverty training, to better enable them to connect with members on an empathetic level. Health literacy and appropriate reading levels are other examples of methods Home State employs to eliminate barriers to care.

## Outcomes

**Patient/Family Outcomes:** Forty-eight of the 219 members with diabetes who had repeat lab tests have improved control demonstrated by HgbA1C. Five of seven Quality Assurance Reporting Requirements (QARR) measures resulted in higher rates in the target population compared to rates for the same group in the previous year. The program has raised member retention rates in the targeted population: 93 percent for reached members compared to 77 percent for general membership.

**Clinician Outcomes:** With the program, 107 members engaged in medical care coordination; seven received nutritionist referrals; 50 members have attended health education classes; 406 were referred to community resources or social services. The program offers providers a care coordination model to support providers in caring for their patients, improving adherence with treatment plans, and achieving improved disease outcomes.

**Community Impact:** Community impact was not measured for this initiative.

**Cost Savings:** Cost savings have not yet been calculated for this initiative. However, members actively engaged in the CHW program had 39 percent fewer inpatient admissions compared with a control group. Members actively engaged in the CHW program had 34 percent lower ED usage than members in the control group.

**Quality Improvement Efforts:** Five of seven QARR measures resulted in higher rates in the target population compared to rates for the same group in the previous year.

## Lessons Learned

**Challenges:** Empire has continually improved the original program design, with opportunities identified to improve targeting capabilities, educational materials, and external partners/community relationships.

**Successes:** Success for this program is demonstrated by improved Healthcare Effectiveness Data and Information Set (HEDIS) and QARR results, member satisfaction, and member retention. Elements of the success included the following:

- Aligning operations and clinical programs for outcome and cost measurements.
- Staffing and training CHWs.
- Supporting the CHW and member with focused tools and resources.
- Using strategic outreach and geo-mapping.
- Providing oversight, governance, and continual improvement to the program.
- Engaging members by building a relationship and maintaining trust; providing health coaching on prevention, disease, and chronic management; medication management guidance; healthy eating; and exercising.
- Connecting members to their PCP.
- Identifying and helping eliminate barriers to care.
- Helping the members understand their health plan benefits.
- Connecting to community resources and health plan resources.

**Advice:** Many organizations can be contracted to provide these services, but having in-house staff familiar with the health plan, internal resources, systems, and benefits will drive success if this is an option. In addition, geography of the health plan and staff, as well as member demographics, should be considered in developing this effort.

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# CHILDREN'S HEALTH



## Cardinal Innovations Healthcare

### PARTNERING FOR EXCELLENCE

Early intervention and treatment is critical for positive outcomes for traumatized youth. Cardinal Innovations recognized that children with significant trauma are often not identified within the system until they had been treated multiple times. Additionally, these children are not receiving targeted evidence-based treatment. Proactive management of behavioral health care and the timely provision of front-end, trauma-informed, evidence-based treatment can forestall more costly and restrictive services and lead to cost containment. Cardinal Innovations sought opportunities such as Partnering for Excellence (PFE) to find modalities through community partnerships to increase screening and use of evidence-based treatment.

In North Carolina, more than 68 percent of children and adolescents report having a potentially traumatic event by the age of 16. PFE is an initiative to improve the behavioral health and well-being of children in the Rowan County child welfare system. This partnership between the Department of Social Services (DSS) and Cardinal Innovations Healthcare ensures that children between the ages of 4 and 18 in the Rowan system are screened for trauma and then linked to appropriate services for treatment. The intent is to identify mental health concerns early and provide trauma-informed services. Early outcomes show reduction in higher levels of care.

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#### Key Priorities

- Develop effective strategies and interventions for working with youth and trauma.
- Ensure youth in the child welfare system receive timely and quality services.
- Build partnerships with key stakeholders.
- Increase access to evidence-based community treatment reducing higher levels of care.
- Decrease entry in to the custody of social services and/or out-of-home placements.



## *Population*

Youths age 4 to 18 years in the Rowan County DSS system in Salisbury, NC are the population for this initiative. It involves 412 youth with 69 percent Caucasian, 23 percent African American, 6 percent Hispanic, and 2 percent biracial. In this group, roughly 56 percent of members are female.

## *Intervention and Methods*

PFE is a program that provides quality, evidence-based trauma assessments and treatment to youth and families and works to reduce behavioral health care costs associated with children in the child welfare system through training and education. Partnerships between the Medicaid behavioral health system and child welfare are an innovative approach to holistic early interventions for children. For youths involved with in-home services or foster care, the DSS social worker screens the youth for exposure to and symptoms of psychological trauma. In late 2015, this was expanded to screen children being seen at the Child Advocacy Center.

After the screening, the youth receives a timely, trauma-informed comprehensive clinical assessment (TiCCA) from a qualified clinician. Trauma-informed care includes cultural and linguistic competency, one of the key principles of a system of care model that integrates providers, managed care, and community stakeholders. The comprehensiveness of this assessment makes it an invaluable tool for DSS social workers and child and family teams to provide appropriate treatment recommendations as well as caregiver recommendations. Seasoned clinicians receive extensive training, coaching, and weekly support to ensure the assessment is completed with fidelity.

Following the TiCCA, comprehensive treatment recommendations are made. A youth may receive evidence-based behavioral health treatment such as trauma-focused cognitive behavioral therapy (TF-CBT) to reduce trauma symptoms and support recovery. The TiCCA and the TF-CBT are standardized across network provider agencies, and the clinician must be rostered by the Child Treatment Program. These clinicians are reimbursed at a higher rate to support this in-depth assessment and treatment, which requires using standardized measures and fidelity to the model. As part of TF-CBT, the parent or caregiver must take part in the therapy.

PFE continues to research trauma assessments for adults to address untreated, generational trauma, a need identified through this project. Prior to implementation, baseline focus groups were conducted and staff regularly train and education the child welfare system staff, community stakeholders, and provider networks. Process and output data is regularly reviewed by the leadership team to identify implementation barriers and strategies for addressing these barriers.

## Outcomes

**Patient/Family Outcomes:** Patient and family outcomes are not yet calculated for this initiative. Formal data analysis is under way to provide more detailed outcome measurement. However, initial data from the program indicates a significant reduction in higher levels of treatment and new child protective service reports. Additionally, preliminary data suggests increased collaboration and planning with family focus between the DSS and the provider community and a reduction in time from identification to treatment.

**Clinician Outcomes:** Since February 2014, 412 youth entered the program and were screened for trauma. Among this group, 90 percent screened positive for trauma and 70 percent were referred for a TiCCA. For a variety of reasons, including already being linked to treatment, 30 percent did not have an assessment.

**Community Impact:** Rowan County DSS and Cardinal Innovations have provided trauma training to Rowan County DSS staff, practitioners in other county systems, foster parents, school social workers, intervention specialists, and others who come into daily contact with children who have experienced trauma. This training provides youth and families with better care and strengthens the community system. The community is now viewing troubling behaviors as symptoms of past or ongoing traumas rather than as defiant behavior. With that understanding comes change in practice that helps move children toward healing rather than triggering past traumas.

**Cost Savings:** Cost savings not yet calculated for this initiative. However, the program is expected to yield cost savings. The average cost of assessment and TF-CBT in the PFE is \$5,000. On the other hand, the average cost of a single Psychiatric Residential Treatment Facility (PRTF) episode is \$97,600 and the average cost of a Level III Group Home Treatment episode is \$45,600. Among those participating in the PFE program, none are currently in PRTF, and only two are in Level III placements. This is a significant reduction in DSS youth that end up in higher levels of care and increased cost savings per treatment episode.

**Quality Improvement Efforts:** Outcomes have increased commitment to high-quality services, fidelity to identified models, and effective communication with DSS, Cardinal Innovations, and other stakeholders. These high-quality services have expanded outside of the PFE initiative and have led to expansion of trained TF-CBT clinicians, with 85 currently in the network.



## Lessons Learned

**Challenges:** Integration of mental health and child welfare faces four key challenges face: interagency collaboration, data sharing, mental health screening, and funding. Continuous improvements in each of these areas was made throughout implementation. It is very important to understand agency readiness to implement and make changes.

Cardinal learned that a spectrum of staff from upper administration to front-line clinicians have to be motivated to fully participate in an initiative of this magnitude. Another challenge was making sure that the health plan had the capacity for clinicians to complete the TiCCA. Finally, when staff turnover was experienced, ongoing support was required for training on protocols.

**Successes:** Measures of success included reduced use of higher levels of treatment (particularly child residential services), more clinicians trained in evidence-based practices, reduction in children entering DSS foster care, or repeated child welfare reports. Key elements that contributed to success were collaboration and communication among stakeholders, willingness to be flexible and make adjustments during implementation, and a strong clinical foundation through use of standardized screening and training, and evidence-based treatment interventions. The Benchmarks organization has been instrumental in leading this initiative and keeping all parties focused on systemic changes. Another reason for the success was Cardinal Innovations' financial support of the TiCCA and treatment at an enhanced rate for the Medicaid recipients. Finally, this initiative has been successful because of Rowan County DSS taking the lead in screening youth for trauma.

The Community Team Program has seen success by creating a team that has both medical and behavioral health expertise. The multidisciplinary team approach included using community health workers, such as behavioral health peer-support specialists. It worked well to engage members in a hospital setting with intensive follow-up in the community after discharge. Finally, the program included members in the development of plans to ensure that their concerns are the primary focus of the team's work.

**Advice:** It is important to assess readiness with all partners at all levels, from administration to the front-line clinicians. Furthermore, changing the approach to working with families saves work and costs; families show more timely improvements because providers use evidence-based treatments. It is also critical to ensure that community stakeholders are aware of the initiative, and the health plan must continue to hold informational sessions to provide updates and gain commitment. PFE is a pilot that has brought changes in internal systems as well as to entire communities as a result of these commitments. Patience is needed as systems evolve and the communities become more trauma aware.

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## Funders

Duke Endowment

## *Key Partners*

Cardinal Innovations – Health Plan  
Rowan County Department of Social Services  
Benchmarks: An Alliance of Agencies Helping Children, Adults, and Families  
Provider agencies/Licensed clinicians  
Duke Endowment

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# Amerigroup Georgia (Anthem, Inc.)

## COACHING AND COMPREHENSIVE HEALTH SUPPORTS (COACHES)

### A HEALTH CARE PROGRAM FOR YOUTH TRANSITIONING FROM FOSTER CARE TO ADULTHOOD

Amerigroup Georgia is the single Medicaid health plan for youth in foster care, adoption assistance, and the juvenile justice system in Georgia. When youth transition from foster care to adulthood and achieve independence from the state, they usually have very poor life outcomes. This population may now remain enrolled in Medicaid until age 26, but have no state support past age 18 (or 21 for some youth). This program seeks to improve their health and well-being outcomes by targeting them for coaching that improves their health literacy and their ability to make decisions about their life.

In 2014, Amerigroup Georgia established a demonstration program to provide care coordination for youth leaving foster care. The demonstration program is called COACHES (COaching And Comprehensive HEalth Supports). The purpose of the program is to develop and implement an innovative approach through personal health coaches to improve health outcomes for these young adults. Improvements were seen in a decrease in psychotropic medication usage, inpatient behavioral health usage, and increased contraceptive care.

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#### Key Priorities

- Reduce utilization of inpatient/residential treatment.
- Improve access to primary care.
- Decrease early pregnancy-related issues.
- Improve employment outcomes.
- Improve educational outcomes.

## Population

There are approximately 130 youth in the program, 52 percent are female and 48 percent male. Among this group, 62 percent are African American, 27 percent Caucasian, 8 percent multiethnic, and 3 percent Hispanic. Additionally, 68 percent of participants reside in urban locations, the remaining residing in rural areas.

The program is for youths leaving foster care as adults, who live in a group or foster home, have been in foster care at least 12 months, have a behavioral health diagnosis, and live in the catchment area. Typically, this is a population has poor health outcomes and are the focus of much state and federal attention for programming.

## Intervention and Methods

Youth who age out of foster care generally have poor outcomes (Reilly, 2003). As a result, there is a strong need for innovative approaches to provide care coordination to youth with complex needs. Amerigroup Georgia is the single Medicaid health plan for youth in foster care, adoption assistance, and the juvenile justice system in Georgia. Amerigroup has created three innovative new programs targeting the needs of these children.

Amerigroup partnered with a nonprofit child service agency and received a three-year grant to establish a youth-driven, coach-based wraparound program: COaching And Comprehensive HHealth Supports (COACHES). The program is for youth who leave foster care to have a “one stop shop” for resources and support as they transition to adulthood. The coach’s responsibilities include: teaching health self-management, coordinating social and health services, and health coaching. While integrating behavioral and physical health needs, incorporating trauma-informed care, and providing peer support, the coach regularly facilitates team meetings to coordinate services and youth needs across systems.

To qualify for the program, the youth must be 17 to 20 years of age, have been in foster care for at least 12 months, have a behavioral health issue, and be in a group or foster home. The program has two demonstration sites: one rural (Macon, Georgia area) and one urban (Atlanta, Georgia area). Once accepted into the program, the participants work with the coach to create a health care game plan. This addresses health literacy, service coordination, and youth empowerment to make their own life decisions and own their healthcare/life plans. The coach follows and continuously reviews the plan with the youth for up to two years. It is important to note that this is a coaching program which focuses on self-empowerment and allowing the youth to learn to take control of their own lives. The coach serves as a constant resource for support, but is not a case manager for the youth.

The agency involved in the program uses culturally response coaching practices. They seek to establish services that match and fit the member so that they are responsive to their needs. This results in greater commitment from the member in maintaining their services because they feel it is oriented toward them.

## Outcomes

**Patient/Family Outcomes:** Patient and family outcomes not yet calculated for this initiative. However, some preliminary outcomes for the program include a 64 percent decrease of total medical spending for program participants. Additionally, psychotropic medication spending decreased by 28 percent while oral contraceptive fills increased. Overall, inpatient behavioral health claims have declined by 99 percent.

**Clinician Outcomes:** Clinician outcomes were not measured for this for this initiative.

**Community Impact:** The program increased access to services for a population that lacks many services and supports. It helps youth maintain a place in the community and build self-sufficiency. The program has received praise from diverse stakeholders such as juvenile court judges, state agency staff, and nonprofits serving children.

**Cost Savings:** Cost savings not yet calculated for this initiative. However, the impact on service utilization and increased contraception usage has been tremendous.

**Quality Improvement Efforts:** This program allows more focus and services to be directed to support youth in the system who are vulnerable. This has shown the need for a program such as this and has spurred more insight into transition-age youth service needs.

## Lessons Learned

**Challenges:** Initially, increasing referral numbers was a problem. The health plan eventually used multiple community stakeholders to connect youth with the program, including juvenile court judges, state agency staff, and community partners. Another difficulty was refining the coaching versus case management model. Amerigroup Georgia had to educate staff, youth, and community members that this is not a case manager for the youth, but a coach to help motivate and guide their development.

**Successes:** The program's effectiveness was to be measured by increases in contraception use, increased educational attainment, increased knowledge and usage of primary care, and reduced inpatient stays. Identifying a challenging population and planning specific interventions to address their needs was a big undertaking. This included researching and working with a local leader in child welfare services to plan the program and apply for the grant.

**Advice:** To be successful, it is important to understand the needs of the population, find committed community partners, and find funding that allows outside-of-the-box supports.

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## Funders

Center for Medicare and Medicaid Services Innovation Grant

## Key Partners

Amerigroup Georgia  
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# Cardinal Innovations Healthcare

## TRANSITIONAL LIVING SERVICES FOR YOUTH

Services within the North Carolina Medicaid behavioral health system were focused on children and families or adult-based services. Other than outpatient treatment, there were no services focused on young adults to help bridge the gap between child and adult services. Many youth in child residential settings age out of treatment at 18 years with little support or skills in place to navigate independent living, including education, employment, natural supports, and effective crisis plans. Cardinal Innovations, in partnership with Youth Villages, had a unique opportunity to develop a Medicaid service from overall health plan service savings to fill a gap in the continuum.

Youth involved with the mental health system transitioning to adulthood often have complex needs. This unique population often does not have a strong natural support system and many have experienced multiple treatment episodes, including hospitalizations. Cardinal Innovations recognized that when adequate supports and planning were not in place, youth often experience crises as young adults. This initiative, started in 2013, was designed to take a proactive approach in coaching and supporting transition-age youth with mental health needs. Focus was placed on developing skills and making connections to appropriate treatment as a way to maintain stability and reduce negative outcomes.

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### Key Priorities

- Develop a service in the Medicaid continuum to support transitional age youth.
- Improve outcomes for youth age 16-21 years.
- Provide comprehensive multi-systemic treatment approach for youth.
- Develop community connections and support for youth.



## *Population*

Adolescents age 16–21 years with mental health diagnoses were identified as a population that often unsuccessfully transitioned to the adult system or dropped out of treatment when they gained autonomy. This often led to unsuccessful long-term outcomes such as underemployment, crisis episodes, and higher level of care.

Participants in this program include young adults enrolled in Medicaid and residing in one of the 16 counties managed by Cardinal Innovations who are leaving the foster care, juvenile justice, and/or mental health systems and those who otherwise lack skills and resources to transition to adulthood. The program was found to be equally effective for a wide variety of youth and across urban and rural settings. The program has served 191 members.

## *Intervention and Methods*

Core components of the initiative include a high level of intensity, low caseloads, individualized treatment, strengthening family connections, and a structured program model that includes supervision and training. Specialists have a minimum of two contact hours per week with each participant, seeing them at home, work, school, or whatever location is most convenient for them. Specialists are also available 24/7 for crisis intervention as needed. Specialists work with eight young adults at a time, which facilitates the high level of intensity. Young adults drive the treatment planning and goal setting, so that they can work toward objectives they deem most important. Young adults who have aged out of custody often find themselves wanting or needing to reestablish relationships with their family of origin in a way that provides meaningful support and assistance. As a result, working with young adults to make connections and achieve healthy and supportive relationships with their family is a high priority in the program.

The program design begins with a clearly defined logic model and includes specified assessment practices, use of the most effective evidence-based and research-informed practices in each domain (e.g., housing, education, employment, sexual health, physical and mental health, healthy relationships), structured supervision, clinical consultation, and initial and ongoing training that provides intensive support to specialists. The model also includes a comprehensive, multimodal review to assess model adherence in each location. The use of structured processes to scan the literature for new evidence-based practices allows for rapid incorporation of new treatment technologies and for strengthening areas, such as medication compliance, that are important to specific populations. The program ensures that, in addition to an individual's mental health needs, appropriate supports are developed for each life domain necessary to ensure ongoing stability and positive outcomes.

Metrics include clinical and operational implementation of the model, monitored through weekly and monthly processes using a balanced scorecard approach, including outcomes at discharge. Success is measured through post-discharge surveys up to two years after treatment to determine the long-term outcomes. Service utilization is across counties.

Cultural competence is fully integrated into training and implementation. Young adults drive the treatment and goal-setting, so they can work toward objectives they deem most important. This structured yet highly individualized approach encourages effective treatment to be provided within each person's social and cultural context.

## Outcomes

**Patient/Family Outcomes:** Independent evaluation of the program showed that 99 percent of youth enrolled in the program participated in at least one session and about half participated for at least nine months, which is the expected average length of the program. The evaluation showed significant positive impacts in the areas of housing stability, economic security, earnings, mental health, and exposure to domestic violence (Table 1).

**Clinician Outcomes:** For all youth enrolled in the transitional living service, 88.3 percent received at least 60 days of service. Also, 7.3 percent of youth reenter the program within two years. Among youth who completed a satisfaction survey, 90 percent reported satisfaction with the services they received. At one-year post-discharge, 88 percent of youth are living independently or with family, 82 percent report no trouble with the law and 85 percent are in school, have graduated, or are employed.

**Community Impact:** Youth Villages' staff attend community collaboratives in local counties, maintain leadership roles within the independent living provider network as well as within provider associations, participate in juvenile justice treatment continuums, and help plan Real World events throughout the state. After implementation, Youth Villages was able to pass a bill through the North Carolina General Assembly to expand its YVLifeSet model throughout the state and offer it to every young adult aging out of foster care.

**Cost Savings:** Cost savings not yet calculated for this initiative. This program expanded from implementation in five counties served by Cardinal Innovations to implementation in all 16 counties served by Cardinal Innovations. The average cost of treatment is \$7,944 and is significantly less than inpatient treatment or more restrictive residential treatment. The program has demonstrated overall cost savings for the health plan as more members have moved toward independence and have not required inpatient services.

**Quality Improvement Efforts:** Results from the clinical trial showed the program did not significantly affect education or criminal justice outcomes. Further analysis is under way to identify the factors that prevent the program from influencing educational and criminal justice outcomes so that changes to the program are focused on areas most likely to improve outcomes for young adults.



**Table 1. One-Year Impacts on Employment and Earnings, Housing Stability and Economic Well-Being, and Health and Safety**

The Youth Villages Transitional Living Evaluation					
Primary Outcome, by Domain	Program Group	Control Group	Difference (Impact)	Effect Size	P-Value
<b>Employment and earnings (\$)</b>					
Earnings from formal work <sup>a</sup>	4099	3488	611**	0.12	0.043
<b>Housing stability and economic well-being</b>					
Score on housing instability scale <sup>b</sup>	1	1.2	-0.2***	-0.16	0.005
Score on economic hardship scale <sup>c</sup>	1.3	1.5	-0.2**	-0.13	0.022
<b>Health and safety</b>					
Score on mental health problem scale <sup>d</sup>	9.8	11.2	-1.4**	-0.13	0.025
<b>Substance use</b>					
Days of binge drinking in the past month	0.7	0.9	-0.2	-0.07	0.197
Used illegal drugs <sup>e</sup> (%)	31.4	32.8	-1.4	-0.03	0.622
<b>Used a condom during last sexual encounter (%)</b>					
Yes	49.5	47.7	1.8	0.04	
No	36.6	40.3	-3.7	-0.08	
Not sexually active	13.9	12	1.9	0.06	
Was robbed or assaulted <sup>f</sup>	24.4	24.2	0.2	0.01	0.929
<b>Partner violence (%)</b>					
In a violent relationship <sup>g</sup>	15.1	21.5	-6.4	-0.16	
In a non-violent relationship	38.6	36.3	2.3	0.05	F23
Not in a relationship	46.3	42.2	4.1	0.08	
Sample size (total = 1114)	659	455			

SOURCE: MDRC calculations based on responses to the Youth Villages Transitional Living Evaluation 12-Month Survey.

NOTE: This data reflects the larger sample for this service initiative, with the broader population not limited to the Cardinal Innovations Medicaid population

NOTES: Results in this table are regression-adjusted, controlling for pre-random assignment characteristics.

The effect size is calculated by dividing the impact of the program (difference between program and control groups) by the observed variation for that outcome within the control group (the control group standard deviation).

Statistical significance levels are indicated as follows: \*\*\* = 1 percent; \*\* = 5 percent; \* = 10 percent.

<sup>a</sup>This self-reported measure includes only earnings from formal employment and does not include overtime pay, tips, commissions, bonuses, or other types of pay, nor does it include earnings from informal work. For the purposes of this measure, formal employment is defined as ongoing employment with a particular employer, such as working at a restaurant or supermarket. Informal work is defined as independent work for several people, with no specific supervisor, such as babysitting and mowing lawns.

<sup>b</sup>The housing instability scale is the sum of responses to four survey questions that ask whether a sample member experienced homelessness, couch-surfed, was unable to pay rent, or lost housing due to inability to pay rent. The scale ranges from 0 to 4.

<sup>c</sup>The economic hardship scale is the sum of responses to five survey questions that ask whether a sample member was unable to afford clothing or shoes, unable to pay a utility bill, had gas or electricity shut off due to inability to pay, had phone service shut off due to inability to pay, or put off paying a bill in order to have money for food. The scale ranges from 0 to 5.

<sup>d</sup>The mental health problems scale is based on responses to the Depression Anxiety Stress Scales, known as "DASS 21." The scale is calculated using 21 questions that ask how often a person has felt a particular way, ranging from "none of the time" (coded as 0) to "most of the time" (coded as 3). The scale is a sum, ranging from 0 to 63, of the values from those 21 questions.

<sup>e</sup>This measure is based on sample members' response to three questions that ask about their use of marijuana, "other illegal drugs," or prescription drugs without the permission of a doctor.

<sup>f</sup>"Assaulted" is defined as attacked, beaten, or sexually victimized.

<sup>g</sup>A "violent relationship" is defined as one in which either partner has ever hit, kicked, shoved, or thrown something potentially harmful at the other, or forced the other to have unwanted sexual relations.

## Lessons Learned

**Challenges:** Initial service development and approval through the Medicaid system was time-consuming. Once approved as a new community-based service, engagement and education of many new referral sources was necessary. The Department of Social Services (DSS) was a key stakeholder, and regular staff meetings occurred to identify appropriate referrals and update them on progress with existing consumers.

**Successes:** Ongoing outcome evaluation activities measure results in the areas of housing stability, educational and employment status, social support, criminal justice involvement, and receipt of needed mental health and public services. The health plan hopes to pursue innovative strategies to better measure outcomes using administrative data for receipt of health and mental health services as well as prenatal and/or child health services for children of young people served by YVLifeSet.

Key elements of effectiveness include a strong program model with fidelity, continuous measurement and adjustment of clinical and operational processes, and monitoring of outcomes. Collaboration between the Medicaid health plan and the provider was critical for implementation and expansion. Evaluation of the program identified many of the important features of the program, including the individualized nature of the interventions and the commitment of staff to the agency's mission. The impact analysis demonstrated that positive outcomes were found among all groups and geographies, which is a testament to the strength and flexibility of the program.

**Advice:** Achieving strong positive outcomes in a variety of domains with vulnerable transition-age youth requires a strong program model, a high level of intense engagement, and focused targeting of the program to the appropriate population. Systems for continuously monitoring clinical and operational implementation must be in place to help identify areas for improvement and ongoing assessment of the effectiveness of program improvements. Ongoing evaluation to monitor long-term outcomes is essential to determining whether the implementation is achieving expected outcomes.

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## Funders

Cardinal Innovations Healthcare was the first Medicaid funder for this program in the nation. Funding for the YVLifeSet program is provided through donations from Youth Villages' own employees through the Our Family Campaign and support from The Day Foundation. Generous partners like the Phillips Foundation also make program expansion possible. The evaluation of the YVLifeSet program was funded by The Edna McConnell Clark Foundation, the Annie E. Casey Foundation, and the Bill & Melinda Gates Foundation.

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## Anthem Indiana (Anthem, Inc.)

### POST-TRAUMATIC STRESS DISORDER AND PARENTS OF NICU BABIES

The stress of having a critically-ill infant in a neonatal intensive care unit (NICU) can reportedly result in post-traumatic stress disorder (PTSD) symptoms in 20 to 40 percent of parents. In addition to PTSD's harmful impact on adults, children cared for by mothers with PTSD are at higher risk for psychological aggression, child abuse, and neglect; school-age children and adolescents have increase anxiety and conduct disorders. Early diagnosis and intervention reduces parental symptoms and depression, improves parent-infant interaction, and is associated with a decreased length stay in the NICU.

In 2014, the health plan incorporated a PTSD screening tool into its care for mothers and infants' families and referred parents with positive screening to support programs. Anthem Indiana found an incidence of PTSD symptoms in 11.5 percent of families of infants hospitalized in a NICU; 77 percent accepted referrals for treatment; at a one-month follow-up, 80 percent remained engaged in the health care system.

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#### Key Priorities

- Mitigate the impact of PTSD through identification and facilitating referrals to treatment.
- Decrease neonatal length of stay.
- Improve the long-term health of member families and their children.
- Document the incidence of PTSD in families of infants hospitalized in a NICU.

## Population

The targeted population was parents who had babies over one month of age in the NICU with diagnoses associated with increased risk of morbidity and mortality and prolonged length of stay. Anthem hypothesized that these parents would be subject to the most anxiety and stress and more likely suffer from PTSD. Over a six-month period, 113 families were contacted. Thirteen had at least one parent with a positive PTSD screen. Members were screened as well as all family members; age, gender and ethnicity did not impact screening.

## Intervention and Methods

The parents' ability to adapt to having an infant in the NICU can be influenced by three factors: personal/couple resources, quality of relationships with the NICU staff, and presence of social and functional support.

Efforts to familiarize parents with the NICU environment and allowing the parents to have increasing involvement in their infant's care during the first weeks of life has been shown to improve the parents' role perception. These actions are congruent with Anthem's Maternal-Child Services program called You and Your Baby in the NICU.

The incidence of PTSD in parents of NICU patients was previously unknown. Since the severity of PTSD and depression can be lessened by early intervention, Anthem created the NICU PTSD program to determine incidence and foster early identification of parents at risk for PTSD. Risk is determined by neonatal diagnoses and diagnosis-related group (DRG) codes. Once an at-risk parent is identified, further screening is conducted through a primary care PTSD screen that was developed specifically for this program. Case managers received training on tools developed to capture these results and interact with the parents. The following actions describe the process used by review nurses and/or case managers.

1. Identify families at risk based upon infants' diagnoses and clinical course in NICU.
2. While infant is hospitalized, guide parent(s) into hospital-based support programs, if available, as well as targeted support services and referrals to providers.
3. Approximately one month after date of birth, screen parent(s) for PTSD.
4. If screen is positive, review symptoms of PTSD with parent(s) and ask permission to inform member's and infant's case manager of positive screen.
5. Refer parent(s) to outpatient mental health program per availability.
6. Reconnect with families with a one-month follow-up call to assess whether the family received benefit from initial contact and PTSD awareness.

All Anthem associates received annual culturally competency training. This cultural insight is integrated into all aspects of member communication. Staff outreach is done in the member's language with interpreters as needed.

## Outcomes

**Patient/Family Outcomes:** Thirteen of 113 members screened positive for PTSD, with 12 referrals (some members with more than one referral) made for additional services and care coordination. This represents a 11.5 percent positive screen rate, and 77 percent of members with positive screenings accepting referrals. One-month follow-up surveys of members referred as a result of the screening resulted in 100 percent reported improved awareness of PTSD, and 8 of 13 members actively engaged with providers. At the time of the follow-up call, 80 percent of the members who accepted referral attended their provider appointment and were still engaged with the provider.

**Clinician Outcomes:** Of members targeted for PTSD provider referrals, 80 percent attended a provider appointment and continued to be actively engaged at the one-month survey.

**Community Impact:** Parents with undiagnosed and untreated PTSD are at-risk for physical and behavioral health consequences. Children who have parents with undiagnosed PTSD are at risk for health consequences as well, including neglect, abuse, anxiety, aggression, and conduct disorder. Anthem believes outreach will lead to the community impact of healthier families.

**Cost Savings:** Cost savings not yet calculated for this initiative. However, it is clear from the literature that babies with parents with PTSD can have longer length of stay than babies with similar diagnoses whose parents do not have PTSD. Long-term effects of healthier families when PTSD treatment was sought is anticipated.

**Quality Improvement Efforts:** Quality improvement efforts not measured for this initiative.

## Lessons Learned

**Challenges:** All care managers were trained to do the screening. However, limiting the number of care managers reaching out to parents for PTSD led to better results; they more accurately identified and connected with the target population, and it was easier for them to explain and complete the screen. To increase the reach rate, the streamlined team tried to contact the member's parents or guardians multiple times and at different times of the day.

**Successes:** Measurements of success were broken down into short-term and long-term results.

The following were short-term goals:

- Determine existence and incidence of PTSD in parents of NICU patients.
- Educate parents at risk about PTSD.
- Guide parents with positive PTSD screening to obtain health care.
- Document family obtaining intervention for treatment of PTSD symptoms.



In the long term, judging success will involve comparing child health care measures of families with PTSD intervention against national data (i.e., immunization rates, frequency of emergency room visits, developmental outcome).

Elements of success included basing program concept and PTSD screening tool upon evidence-based, peer-reviewed medical literature. It was key to have support and participation by the corporate Maternal-Child Services department—both neonatal and behavioral health specialists. Contributing to success was the development of PTSD training for participating staff, culturally competent and empathetic interaction with members, and developing a software platform to document family responses.

**Advice:** It is useful to educate all utilization management and case management staff that deal with parents of children admitted to the NICU about parental PTSD. Training a core team to do the calls to parents leads to a better reach rate and better connection to behavioral health resources. It is a good idea to collaborate with the plan's behavioral health team in identifying resources for families in locations that have limited access to needed services.

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# UnitedHealthcare Community & State (UnitedHealth Group)

## FOOD SMART FAMILIES – 4-H PARTNERSHIP

In the United States, one-third of youth are overweight or obese. Low-income children are 1.6 times more likely to be obese than children from higher income households. Most U.S. youth do not eat the recommended 2.5 to 6.5 cups of fruits and vegetables daily or the minimum recommended amount of whole grains. Nutrition education has been shown to improve healthy choices among youth.

Food Smart Families (FSFs) addresses childhood obesity and helps low-income youth and families eat better through evidence-based educational programming and a population-health, community-based approach. FSFs uses teens as teachers to provide youths with 10 hours of nutrition, food budgeting, and meal-preparation programming; engages families through events; and addresses the social determinants of health by providing referrals for government nutrition benefits and ingredients for healthy dishes. The program has educated 26,809 youth and families, improved healthy choices among participants, and provided 7,300 referrals to benefits and 7,804 bags of food.

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### Key Priorities

- Educate 50,000 low-income youths and their families on food budgeting and healthy cooking.
- Improve healthy food choices among youth (e.g., 75 percent of children will report eating vegetables and fruit every day).
- Provide 13,100 bags of foods to alleviate hunger and apply new education.
- Refer 10,500 eligible families to food benefits.

## Population

The program has engaged 26,809 youth between the ages of 7-13 years (grades 2–9). Among these participants, 56 percent were girls and 43 percent boys. Additionally, 60 percent of participants were white, 38 percent African American, and 22 percent Hispanic. The program targets youth in schools where at least 50 percent of students are on free and reduced lunch programs, housing projects, and community centers in communities where members and prospective members reside.

## Intervention and Methods

Childhood obesity puts youth at increased risk for cardiovascular disease, social and psychological problems, and obesity in adulthood. Evidence-based policies, including population based education strategies and those that maximize the impact of government benefits, are among recently recommended approaches to reduce diet quality disparities and promote healthy eating. In 2015, UnitedHealthcare Community & State (UHC) realigned its successful three-year Healthy Living Partnership with the National 4-H Council to support a program that demonstrated impactful pilot year results with low-income youth and families. Food Smart Families addresses the prevention of childhood obesity and improved nutrition by bridging health and health care through a community-based approach.

Food Smart Families program leaders partner with schools where at least 50 percent of students are on the free and reduced lunch programs, housing projects, community centers, and UHC Community & State target communities to provide youth with 10 hours of programming on the subjects of nutrition, food budgeting, and preparation. Participants are taught how to plan a meal with low-cost ingredients and engage in activities on how to choose healthy options. They also taste-test new, healthy foods. The program trains Teen Healthy Living Ambassadors to teach and serve as community role models for participating youth. Participants' families are engaged through events such as open houses, mid-program meals and snacks, or celebrations.

The program addresses the social determinants of health related to nutrition by providing ingredients for food. The program culminates with a celebration where families receive ingredients for healthy dishes they can make at home. Families receive referrals for and information about government food benefits, such as Supplemental Nutritional Assistance Program (SNAP) and Women, Infants, and Children (WIC) to support families to more sustainably access healthy food.

Programming incorporates preparing culturally relevant recipes and traditional foods in a healthier style. For example, program recipe cards feature simple, kid-friendly recipes such as Brocco-dillas (i.e., Broccoli Black Bean Quesadillas) in English and Spanish. Marketing materials feature diverse youth and are written at fourth-grade level or below.

## Outcomes

**Patient/Family Outcomes:** FSFs has demonstrated successful educational results among participating youths. Given its community-based approach, youths are not necessarily UHC members and results are not tied directly to clinical outcomes. The 2014 program pilot found that 87 percent of participating families purchased healthier foods, 86 percent prepared healthier foods, 86 percent ate fruit for a snack, 82 percent prepared meals together, 78 percent ate breakfast, and 77 percent were physically active most days.

**Clinician Outcomes:** Clinician outcomes were not measured for this initiative.

**Community Impact:** UHC and the National 4-H Council have developed relationships with 78 local community-based organizations. Health education was provided to 26,809 youth and family members and 7,300 eligible families were referred to government food benefit programs. In all, 7,804 bags of nutritious foods and recipes were provided to help participating families prepare meals based on lessons provided during their health education sessions.

**Cost Savings:** Cost savings were not measured for this initiative.

**Quality Improvement Efforts:** Quality improvement efforts not measured for this initiative.

## Lessons Learned

**Challenges:** 4-H is the nation's largest youth development organization, empowering 6 million young people throughout the country, so the program was able to quickly garner great youth participation. However, parental and caregiver attendance at events has been a challenge. Key barriers for parents include transportation and conflicts with work schedules for multiple jobs or jobs with untraditional hours. To address this, program coordinators are now planning events to coincide with others that parents may attend, such as school open houses, or at very convenient locations, like housing project community rooms.

**Successes:** Since 2011, UHC partnered with 4-H to deliver high-quality healthy living programming to more than 200,000 youth in 13 states. 4-H's expertise in youth education and its reach in all 3,007 counties in the United States make it an ideal program partner. Now in its fifth year, the UHC/4-H Healthy Living Partnership, together with additional close community partnerships, has allowed the Food Smart Families to address hunger and obesity among low-income youth.

**Advice:** When implementing new programs for low-income youth and families, it is important to engage community partners and seek to understand and be ready to

adjust to reduce barriers. Programming should be adapted to meet the needs of communities and families, and best practices should be shared to support creative, innovative solutions. Youth and families should be engaged through approaches that are fun, are empowering, promote learning, and address needs.

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## Funders

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ConAgra Foods Foundation

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# EXPANSION POPULATION



# UPMC Health Plan

## COMMUNITY TEAM PROGRAM

High health-care expenditures, resulting from preventable medical hospital readmissions and emergency department use, are associated with a small proportion of the population of individuals with complex needs. The Health Plan Community Team (CT) was created in 2015 to respond to the needs of this challenging population of high-risk, high-cost, and complex high-need members who have a web of physical and behavioral health conditions, and/or severe psychosocial issues. It is an intensive, community-based care management program that consists of clinical nurse care managers, mobile social service clinical case managers, community health workers, a pharmacist, and a Certified Registered Nurse Practitioner (CRNP). The team is dedicated to providing comprehensive targeted interventions and care coordination. It is designed to improve members' quality of life and reduce costs associated with hospital readmissions.

Preliminary findings show an overall reduction of readmission rates as compared with expected rates. UPMC Health Plan is committed to developing innovative programs to improve care, deliver better outcomes, and control costs.

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### Key Priorities

- Identify the root causes of specific members' high medical needs and address them post discharge.
- Reduce 30-day readmissions.
- Engage the members and providers in creating and updating a comprehensive, individualized care and wellness plan that dynamically uses all possible strategies and resources.
- Improve each member's understanding of his or her health status.
- Enhance the member's chronic and acute self-management skills.



## Population

The initiative is targeted specifically toward members age 18 years or older who live in Allegheny (Pittsburgh) and other western Pennsylvania counties. About 600 members account for a majority of high health care expenditures. This population includes members enrolled in UPMC's Medicaid plan as well as Medicare Advantage and commercial products.

## Intervention and Methods

The community team consists of nurses, social workers, a pharmacist, and community health workers who have expertise in physical and behavioral health. The key interventions include meeting members while they are in the hospital and completing a face-to-face home visit 48–72 hours post discharge, which includes a medication reconciliation.

The team uses structured recovery-focused assessments to involve the member in a plan that addresses physical health issues, behavioral health issues, and psychosocial concerns. A comprehensive pharmacy approach includes a pharmacy review, coordination with prescribers, and active engagement with the members in understanding their medications and medication regimens.

Many evidence-based strategies, such as motivational interviewing, are used to engage members in the comprehensive care plan, which aims to enhance the members' understanding of their health condition(s) and increase the use of self-management skills to address acute and chronic risk factors related to their condition(s), especially the factors that have led to recent hospitalizations. Assessment and interventions explore and support the complex social and environmental factors interfering with optimal health and recovery. Members receive help with social and medical challenges such as transportation to appointments and adherence with recommended treatments. Community health workers are especially important in addressing psychosocial concerns such as transportation and housing.

Monthly reports that address items such as engagement rates, post-hospital follow-up, readmission rates, team productivity, medication reconciliation rates, and length of involvement with the team are all used to help assess efficacy and make changes as needed. The staff includes individuals with diverse backgrounds, including community health workers. All staff are provided culturally competency training through UPMC.

## Clinician Outcomes

**Patient/Family Outcomes:** Early findings in outcome data span May 1, 2015 through March 10, 2016. Most of the members (87 percent) had a face-to-face visit

within two weeks of case identification; of these members, about half had home visits within two weeks. The average case length in the engaged members was 85 days (median of 76 days). Members identified physical health care needs (54 percent) and care coordination (29 percent) as the key drivers of care.

**Clinician Outcomes:** Staff engaged members effectively, shown by the following statistics:

- 71 percent of members engaged had a medication reconciliation completed within 30 days of discharge.
- 79 percent of members had coordination of care between the CT staff and primary care provider (PCP) within 30 days of discharge.
- CT staff also identified physical health care needs (64 percent) and care coordination (50 percent) as the key drivers of care. Staff tended to identify these slightly higher than the members. These were followed by caregiver/in-home support needs, behavioral health needs, and self-management skills.

**Community Impact:** Community health workers are focused on connecting members with other community resources. Members of a Community Team Advisory Board composed of community health care leaders; physical health, behavioral health, palliative care experts; and community and social services leaders have provided valuable feedback about effective approaches for this work.

**Cost Savings:** Cost savings not yet calculated for this initiative. However, early results suggest a reduction in 30-day readmission rates.

**Quality Improvement Efforts:** The team continues to develop strategies to increase engagement, shared decision-making, and address gaps in care.

## Lessons Learned

### Challenges:

- Cross training staff in physical and behavioral health conditions, as well as in psycho-social determinants.
- Developing a full training and new hire checklist for on-boarding staff.
- Changing to an integrated team based model and culture.
- Access and reliability of the Member Tracking Board; the management team worked collaboratively with the health plan staff.
- Developing various protocols, workflows, clinical pathways, and training staff.
- Updating member care coordination profile.
- Defining reports and indicators that need to be tracked on the vital signs report; the management team worked with statistician

**Successes:**

Measures of success included both process and outcomes measures:

- Overall reduction of readmission rates compared with expected rates of readmission.
- Number of members engaged.
- Community Team staff engagement within hospital setting; completion of in-hospital assessments.
- Number of medication reconciliations completed.
- Number of PCP visits within 30 days of discharge.
- Number of readmissions of members within 30 days.

The Community Team Program has seen success by creating a team that has both medical and behavioral health expertise. The multidisciplinary team approach included using community health workers, such as behavioral health peer-support specialists. It worked well to engage members in a hospital setting with intensive follow-up in the community after discharge. Finally, the program included members in the development of plans to ensure that their concerns are the primary focus of the team's work.

**Advice:** In considering the design of a similar program, a health plan should do the following:

- Consult with other programs to learn about their challenges and successes.
- Incorporate a very structured approach to program development, and develop a carefully planned assessment to obtain all the information the plan is seeking.
- Make sure there is adequate administrative and clinical support for the program.
- Hire groups of staff at one time so that they can learn and grow together.
- Implement team-building activities and staff trainings.
- Identify a clinical data system that will support systematic data collection and reporting.

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### *Funders*

UPMC Health Plan  
Pennsylvania Department of Human Services (PA DHS)

### *Key Partners*

UPMC Health Plan  
Community Care Behavioral Health Organization  
Community Team Advisory Board

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## PROMISING INITIATIVES

*While initiatives outlined in the previous categories represent programs with demonstrated outcomes, Medicaid managed care organizations are actively designing and implementing new programs for their members. These programs do not yet have data on outcomes but are considered promising on the basis of their robust, evidence-based design and responsiveness to member needs.*

# Harmony Health Plan (WellCare Health Plans)

## ILLINOIS FALL PREVENTION PROGRAM

Seniors are faced with many health issues that can be complicated by falls and injuries. Social services organizations that address the needs of seniors have lost funding and are struggling to address needs in the community. WellCare worked with the White Crane Wellness Center and supported its Matter of Balance program to help seniors in decreasing falls that can lead to major health issues.

WellCare Health Plans partnered with White Crane in 2014 to offer health and wellness services to older adults seeking ways to improve their health, and to serve as model for a new approach to health and aging. Matter of Balance is an evidence-based, structured group intervention using various activities to address physical, social, and cognitive factors affecting fear of falling, while teaching fall prevention strategies.

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### Key Priorities

- Decrease falls among seniors.
- Increase knowledge and comfort of seniors by focusing on fall prevention and balance.
- Expand fall prevention program to underserved neighborhoods.
- Improve knowledge of community resources in Cook County about preventing falls.



## Population

The health plan worked with 184 seniors age 55 and older in this initiative.

## Intervention and Methods

WellCare funded A Matter of Balance to ensure seniors had access to fall prevention programs. The program includes group discussion, problem solving, skill building, assertiveness training, and sharing practical solutions. An exercise component was also integrated into the series. White Crane has implemented this program model at numerous community based venues throughout Cook County in underserved communities.

White Crane also led the coordination for the collection and design of a Falls Prevention directory for northern Illinois in collaboration with the Illinois Falls Prevention Coalition. WellCare assisted White Crane in expanding the A Matter of Balance program to neighborhoods not typically reached.

WellCare used both internal and public health data to determine what communities in Illinois would be most affected by this initiative. This program was also offered in languages spoken in the community where it was being offered.

## Outcomes

**Patient/Family Outcomes:** Outcomes not yet calculated for this initiative. Both WellCare and non-WellCare members were able to access this program to increase knowledge, comfort, and understanding of fall prevention and balance.

**Clinician Outcomes:** As a result of this funding, White Crane was able to offer 10 fall prevention programs throughout underserved communities in Cook County, Illinois. In these programs, 184 high-risk adults were reached. Compared to pre-program surveys, at the close of the program more participants expressed “I can find a way to reduce falls” (43 percent), “feeling steadier on their feet,” (62 percent), and “increase engagement on regular exercise” (76 percent).

**Community Impact:** White Crane created a resource directory that is helping to close the knowledge gap on fall prevention services available in Cook County. White Crane enhanced its outreach model by incorporating a pilot fall prevention screening and education component, which will be aligned with fall prevention classes. A physician will review fall prevention screening materials and provide training and support to team members. An advanced practice nurse will screen at-risk older adults, using a 12-question fall-risk-assessment tool to determine the participant’s biological, behavioral, and environmental risk factors for falls, which will result in improved outcomes.

**Cost Savings:** Cost savings not yet calculated for this initiative.

**Quality Improvement Efforts:** Quality improvement not yet calculated for this initiative.

### *Lessons Learned*

**Challenges:** The biggest challenges involved identifying underserved neighborhoods and the languages that would be addressed by the program. Once the geographical area was selected, implementation was easy.

**Successes:** Success was measured by both community and member impact, and an increase in knowledge and comfort surrounding falls for seniors. Key elements that contributed to the success of this program were identifying and collaborating with the correct community partners. White Crane is very knowledgeable about its community and the population the organization treats.

**Advice:** The best advice is to work with community organizations that are flexible and willing to adjust when needed.

### *Key Partners*

White Crane Wellness Center

### *Kudos to the Team*

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## UniCare Health Plan of West Virginia (Anthem, Inc.)

### SCHOOL-BASED HEALTH CENTER CHECK-UP CONTEST

America's Health Rankings lists West Virginia at 47th out of 50 states in its 2015 analysis of national health trends. Agency for Healthcare Research and Quality's (AHRQ) 2013 National Disparities Report notes that children from poor households were up to 11 percent less likely to have well-child visits than those from high-income households. Well visits are a vital opportunity to screen for physical, mental, and developmental needs and take early action. Fewer than half of UniCare's adolescent members received a well-adolescent exam in 2014; similarly, less than 69 percent of members age 3-6 years received a well-child exam. Both rates are below the national average (9 percent and 2 percent, respectively).

In 2015, to improve statewide use of preventive care by leveraging community-based primary providers, UniCare Health Plan of West Virginia collaborated with the School-Based Health Assembly to increase well-child and well-adolescent checkups. The program is designed as a contest with multiple opportunities to earn incentives boosted engagement. Following the timely submission of each complete medical record (as determined by the national quality standards of Bright Futures/Early and Periodic Screening, Diagnostic and Treatment (EPSDT)) providers earned \$25. The host school of the health center with the highest number of participants was awarded \$2,500. More than 1,200 children and adolescents benefited from receiving preventive health care checkups.

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#### Key Priorities

- Increase well-child and well-adolescent exams to address statewide disparity.
- Engage and reward providers for providing high-quality care with full documentation.
- Provide support to schools for encouraging participation in wellness.
- Reduce the transportation barrier to accessing primary care by providing services in schools.
- Engage and reward members/families for received recommended preventive care.

## Population

The program was operated statewide in West Virginia, where more than 25.7 percent of children were living in poverty in 2015. All participants (4,522 eligible) were UniCare Temporary Assistance for Needy Families (TANF)/Medicaid members and participated in the wellness challenges associated with low socioeconomic status (SES). The population included children ages 3-6 years old and adolescents ages 12-21 of all races and ethnicities.

## Intervention and Methods

The most recent AHRQ Quality and Healthcare Disparities Report (2014) states West Virginia is in the quartile of states with the fewest health disparities by race/ethnicity. Approximately 95 percent of West Virginia residents identified as white in the 2014 American Community Survey. UniCare's current performance rates were compared to national benchmarks available through NCQA's Quality Compass to inform how the program was designed and targeted.

The benefits of well-child visits are well documented by the American Academy of Pediatrics (AAP) and child health advocates of all types. They include the provision of preventive care like immunizations, developmental screenings, and dialogue between parents and providers. After recognizing a disparity in the number of young children and adolescents in West Virginia receiving these important services, UniCare designed a program to operate in school-based health clinics to increase exams. The program ran from September 22 to December 31, 2015 and may be implemented again in future years.

There are 96 school-based health clinics (SBHCs) in West Virginia., covering more than 60 percent of counties. The largely rural geography of the state makes SBHCs an ideal community partner to increase access to high-quality primary care for children and adolescents. Serving youth at school, where they are already spending most of their day, reduces transportation needs and time that kids might miss in the classroom to attend appointments elsewhere.

UniCare offered a variety of incentives. Parents and guardians often qualified for a \$25 gift card for successfully arranging and keeping appointments. UniCare also paid health clinics (i.e., sponsoring agencies) operating SBHCs a \$25 incentive for each completed medical record reflecting a well visit for children in the targeted age categories. To earn the \$25, the provider must have completed the medical record and submitted it within two weeks of the exam or UniCare must have requested a copy of the medical record for exams occurring prior to the September start date.

To encourage participation among the centers, UniCare offered an award of \$2,500 to the host school of the health center with the highest percentage of qualifying medical records. Additionally, sponsoring agencies that submitted at least 75 percent of their collected medical records that met completeness, eligibility, and timeliness criteria were eligible for a bonus incentive of \$5,000 awarded to one winner through random drawing.

## Outcomes

**Patient/Family Outcomes:** A total of 4,522 UniCare child and adolescent members were eligible for the program. After the school-based contest ended, 1,264 exams had been completed and 28 percent of the corresponding medical records were returned to UniCare. Of those, 1,047 (83 percent) met Bright Futures/EPSTD criteria for completion and qualified the provider for a \$25 incentive per record. A total of 575 adolescent members counted towards the Healthcare Effectiveness Data and Information Set (HEDIS) Adolescent Well-Care Visits (AWC) measure; 398 young children were able to be counted toward the Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) measure.

**Clinician Outcomes:** Among a total of 22 eligible providers, 15 participated (68 percent participation rate). Of this group of providers, 73 percent met the quality threshold of having at least 75 percent of their medical records meet the national quality guidelines of the Bright Futures/EPSTD criteria. They were entered in the drawing for the \$5,000 bonus incentive.

**Community Impact:** The SBHC provider that won was FamilyCare HealthCenter and they were awarded \$5,000. The winning school was Summersville Middle School in Nicholas County; they awarded \$2,500. UniCare and the WV School-Based Health Assembly formed a valuable partnership that has strong long-term potential. The WV School-Based Health Assembly is promoting well visits on its website, noting that annual checkups are recommended by the American Academy of Pediatrics and that there is no copay.

**Cost Savings:** Cost savings were not measured for this initiative.

**Quality Improvement Efforts:** After the success of this contest, the health plan intends to continue similar outreach efforts to increase members' use of preventive care.

## Lessons Learned

**Challenges:** The health plan did not record any member identifiers in the results database during data collection. Although this preserved privacy, it limited the plan's ability to educate providers about complete documentation using real-life examples. This field could be added in future years of implementation.

**Successes:** Success was seen in improvements in two key HEDIS measures: AWC targeting ages 12-21 years and W34 targeting ages 3-6 years. SBHCs are a valuable model for delivering preventive care. UniCare also cites the providers' financial incentive of \$25 per complete medical record as motivational to obtain the documentation needed for reliable quality measurement and improvement.

**Advice:** In considering such a program, an organization should plan on capturing more information, including member identifiers and any reason that a medical record submitted did not meet the standards for being complete. It is important to be as proactive as possible in reaching out to the schools to generate even more community involvement. Finally, an organization should add more time for planning and implementing the program to develop and build maximum enthusiasm for participation.

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## Key Partners

UniCare Health Plan of WV  
West Virginia School-Based Health Assembly

## Kudos to the Team

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## Amerigroup Georgia (Anthem, Inc.)

### PATHWAY TO PERMANENCY PILOT: A FOSTER CARE PLACEMENT—SUPPORT PROGRAM

Although Amerigroup Georgia does not determine or have a direct role in placement for youth in foster care, it is recognized that foster youth with complex health care needs are at a greater risk of disrupting their placement and entering inpatient/residential treatment. These youth have complex behavioral health histories (including trauma), the state child welfare agency has challenges in finding placements willing to accept these youth. Hence, when they disrupt their placement, they are often sent to an inpatient facility. This leads to poor outcomes for the youth and to higher costs for the health plan.

Amerigroup Georgia's Medicaid health plan for children in foster care, established an innovative pilot program in 2015 to coordinate care for youth with complex needs. The pilot is designed to provide enhanced services to youth with significant behavioral health challenges that could affect their well-being (including potential permanency goals). Improved outcomes for this population can be seen in increased primary/preventative care usage, reduced inpatient hospitalization, and increased stability in their foster care placements.

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#### Key Priorities

- Reduce utilization of inpatient/residential treatment.
- Increase placement stability.
- Facilitate long-term permanency (for members identified for adoption).
- Increase use of primary and preventative care.

## Population

Youth in foster care who have complex health care needs often have problems in placements that lead to inpatient/residential treatment. This leads to poor outcomes and is expensive for the health plan. It is a priority of both the state child welfare agency and the health plan to make sure youth in foster care remain in the community to receive services. Approximately 62 youth are served by the pilot. They range in age, geographic location, and race/ethnicity.

## Intervention and Methods

There is a strong need for innovative approaches to providing care coordination to youth with complex needs in foster care. Amerigroup created an innovative pilot focusing on the needs of this population. This pilot is unique because of the population as well as the focus of the health plan to support placement stability to reduce inpatient stays.

The Pathways to Permanency (PTP) pilot is designed to provide enhanced services to youth with significant behavioral health challenges that could affect their permanency goals. Amerigroup partnered with three statewide leaders to provide intensive, community-based wraparound services designed to stabilize and assist with permanency. Through innovative funding, the agencies pursue individualized and creative interventions and make a care plan unique to the youth. Throughout the care coordination efforts, the youth is an engaged member in developing his or her health care plan. The pilot focuses on ensuring that these youth access primary/preventative care, targeted behavioral health services, and flexible funding to obtain nontraditional supports for the youth to increase their stability in their placement and avoid inpatient or residential treatment.

The program partners all have unique roles. Amerigroup is the payer and provides ultimate oversight of the program. The Multi Agency Alliance for Children receives the referral for the program, assigns it to one of two pathways, and maintains records and evaluation of each member and their outcomes. One pathway is for children identified as having a potential adoption. This pilot partner works to support the adoption process and help maintain stability in their new home. The other pathway is for youth who are not identified for adoption; it works to maintain their stability in a group home or foster home.

The agencies involved in the pilot all use culturally responsive care coordination practices. They seek to establish services that match and fit the member. This results in greater commitment from the member in using services because they feel it is oriented toward them.

## Outcomes

**Patient/Family Outcomes:** Patient and family outcomes not yet calculated for this initiative. However, some preliminary results indicate 75 percent of youth are in

compliance with their annual health and dental check. Additionally, 96 percent have received a follow-up visit to a behavioral health professional within 7 days of entering a placement and 80 percent have maintained their placement stability.

**Clinician Outcomes:** Clinician outcomes were not measured for this initiative.

**Community Impact:** Of the youth in the program, 80 percent have maintained their placement in the program.

**Cost Savings:** Cost savings not yet been calculated for this initiative. However, it is anticipated that the maintenance of placement will demonstrate a positive financial impact as a result of reducing inpatient hospitalization.

**Quality Improvement Efforts:** More focus has been placed on youth maintaining their placements and the supports they need to do that, which in turn assists the system in allocating resources to the most needed areas.

## Lessons Learned

**Challenges:** The health plan faced initial challenges in defining the different pathways between the agencies and in marketing so that enrollment numbers increased. By focusing on the specializations of the agencies, the pathways were more clearly defined. By advertising through the state child welfare agency and juvenile court judges, the program was able to get the word out on the program.

**Successes:** The health plan is measuring the success of the program through data on increased placement stability for pilot participants, reduced inpatient/residential stays, and improved use of primary care. The program was helped by working with nontraditional partners who are experts in this population and using funding to allow creativity and individualization of services.

**Advice:** To start such a program, it is a good idea to understand the needs of the population, find committed community partners, and find funding that allows outside-the-box supports.

## Research

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### *Key Partners*

Amerigroup Georgia  
Multi Agency Alliance for Children  
Chris Kids  
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## Centene Corporation

### NO BULLYING ZONE

Bullying is a significant problem in the United States:

- Every seven minutes a child is bullied.
- Over 3.2 million students are victims of bullying.
- 1 out of 10 students drop out of school because of repeated bullying.
- Harassment and bullying have been linked to 75 percent of school-shooting incidents.

Despite these numbers, few parents, teachers, and other authorities are educated on how to intervene and stop bullying. As a result, children suffer from negative side effects such as significant grade decline, increased anxiety, loss of friends, and poor social life.

Centene Corporation and its subsidiary, Cenpatco, teamed up in 2013 with Children's National Health System and Howard University to create the No Bullying Zone. This program educates students, teachers, and parents across the country on how to prevent, identify, and appropriately intervene with bullying in school-aged children. The campaign takes multiple approaches, including the creation of a children's book and parent/guardian guide, book readings, the development of an iPad application, and the introduction of anti-bullying lesson plans in grade schools around the country. This program was designed to increase a student's understanding of the ill effects of bullying.

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#### Key Priorities

- Create an open environment for grade-school students to learn about and discuss bullying.
- Develop anti-bullying educational materials for educators, parents and guardians, and children.
- Increase children's awareness about bullying and effective behavior modifications.

## Population

The program targeted grade school students, parents/guardians, and educators around the country in over 20 regions with schools that have greater than 50 percent free and reduced lunches. This overlaps with states where Centene manages care of Medicaid recipients. The program targeted 50,000 grade school students, parents/guardians, and educators around the country in over 20 regions with schools that have greater than 50 percent free and reduced lunches. This overlaps with states where Centene manages care of Medicaid enrollees.

## Intervention and Methods

This program used educational databases to identify grade schools with students receiving free and reduced lunches. In the first year, Centene used its established adopt-a-school program that allowed children's author Michelle Bain to conduct assemblies in grade schools across the country. Bain read her new book *Splotch the Madpole Does a Whole Lot of Bullying* and brought mascot Darby and the traveling anti-bullying graffiti wall for students to take the pledge. During the first year, the graffiti wall traveled more than 16,000 miles and visited 19 grade schools. To celebrate the first year, a well-attended expert panel of health professionals, educators, governmental agencies, and community stakeholders were brought together in Washington, D.C. An anti-bullying song, written by a child psychiatrist, was introduced at this meeting.

The second and third years focused on educational training for school teachers, administrators, and support staff that enabled them to prevent and intervene when they notice bullying and identify the early signs of bullying between students at school. The third year marks the introduction of a curriculum developed by educators that can be taught in the classroom to pre-kindergarten through fifth grade.

An iPad anti-bullying application has been developed and was introduced at the Auburn Anti-Bullying Conference in June 2015. This app is based on the *Splotch the Madpole* book and teaches both parents and children about bullying, the negative health effects it causes, and how to cope with bullying. Targeted venues for this traveling iPad application include hospitals, federally qualified health center services (FQHCs), and conferences.

## Outcomes

**Patient/Family Outcomes:** Participants in the program completed a five-question pretest that assessed prior knowledge and awareness of key bullying issues. Students in the program ranged from kindergarten through fifth grade across 11 states. At the conclusion of the program students repeated the assessment, creating a measure of pre- to post-test enhancements in accuracy and awareness of bullying concepts. While every answer improved in the post-test, nine percent of children tested improved their scores from pre- to post-test regarding the key issue of "Leaving someone out of a game or group can be bullying."

**Clinician Outcomes:** Working with schools and pediatrician offices, the program has distributed over 46,000 children's books and 42,000 parent/guardian guides since the program began three years ago. At the end of year three, the program will be surveying educators and physicians on overall satisfaction with the materials and the program.

**Community Impact:** Community impact was not measured for this initiative.

**Cost Savings:** Cost savings were not measured for this initiative.

**Quality Improvement Efforts:** Quality improvement efforts were not measured for this initiative.

### *Lessons Learned*

**Challenges:** Demonstrating the impact of the program on return on investment and improved access is difficult. However, the health plan believes that educating communities as a whole is critical to raising the awareness to bullying. Centene continues to look for ways to demonstrate the impact of these programs, such as monitoring pediatric emergency room visits, pediatrician appointments, and school attendance due to health issues caused by bullying. Collecting attendance records, school nurse/doctor visits, and grades measure how the anti-bullying campaign is improving the lives of elementary school students.

**Successes:** The involvement of educators and health care professionals, interacting with health plan outreach teams, was key to the success of this program. Also, developing a program based on the vehicle of a children's book and author to deliver the anti-bullying story and message resonated not only with the children, but with the educators and parents/guardians as well. The health plan believes that educating children and educators in their school community, along with helping parents/guardians reinforce the message at home, was key to the success of this program and the increase in knowledge demonstrated on the pre- and post-tests.

**Advice:** Do not underestimate the impact a program can make on young children. Although most anti-bullying programs are targeted toward children in middle school and high school, this initiative saw an amazing response to anti-bullying messages in children as young as five years old. This model was used to educate children on various disease states and public health issues, and it works well, especially when using a children's author and character/mascot.

## *Key Partners*

Centene Corporation  
Howard University  
Children's National Health System  
Cenpatico, a Centene subsidiary

## *Kudos to the Team*

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## UnitedHealth Group

### JOIN FOR ME, A WEIGHT MANAGEMENT PROGRAM FOR KIDS AND TEENS

During the past three decades, the prevalence of obesity has more than tripled among U.S. children and adolescents and is now almost 17 percent of those ages 2 to 19 years. As a result, millions of children suffer from a host of significant medical consequences, including type 2 diabetes, hypertension, sleep apnea, and orthopedic complications. Moreover, the adverse psychosocial consequences of childhood obesity are significant and lead to increased likelihood of obesity and co-morbidities in adulthood. Childhood obesity also represents a significant financial cost to families, communities, employers, and the health care system.

Join for Me, which began in 2012, is an empirically informed, scalable, weight-management program for overweight and obese children and teenagers. The program is a group intervention model, delivered in a community setting, where a child and parent participate together. The program focuses on helping children reach a healthier weight, underscoring the importance of cultivating a healthier environment and behaviors at home with the entire family. Outcomes indicate that this intervention can produce clinically significant reductions in the percentage of enrollees with body-mass-index (BMI) scores above the 85th percentile and improve quality of life.

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#### Key Priorities

- Develop a community-based behavioral lifestyle improvement program for children screened and identified with BMI at or above the 85th percentile, indicating overweight or obesity.
- Provide trained facilitators and evidence-based tools and strategies to help families adopt healthier habits that lead to lifelong healthy weight and lifestyle.

## Population

Join for Me participants include children ages 6–17 years old, who are overweight or obese (at or above the 85th percentile for BMI) and one parent or caregiver. The program is being delivered commercially through UnitedHealthcare Community in Texas and Kansas, and through grants in Rhode Island and Minnesota to 50,000 children.

In 2010, the U.S. Preventive Services Task Force (USPSTF) provided a Grade B recommendation that clinicians screen children ages 6 to 17 years for obesity and, if appropriate, refer them to behavioral interventions that promote improvement in weight status. This was similar to previous recommendations for screening and treatment by the American Academy of Pediatrics (AAP).

## Intervention and Methods

Join for Me participants include children ages 6 to 17 years old, who struggle with extra weight (at or above the 85th percentile for BMI) and one parent or caregiver. Join for Me is a 12-month community-based lifestyle improvement program for children and teens with overweight or obesity. Children and a parent attend a series of 16 weekly, one-hour group classes at local YMCAs, Boys & Girls clubs, Federally Qualified Health Centers (FQHCs) or other community locations. Participants are introduced to evidence-based tools and strategies, as well as incentives to adopt healthier habits that lead to lifelong healthier weight. Sessions are led by a trained facilitator and cover topics such as reducing intake less healthy food and drinks, getting and staying active, managing screen time, improving sleep habits, increasing in consumption of fruits and vegetables, eating breakfast and the link between mood and foods. The children set weekly goals, with the support of the group facilitator and track weekly progress. After the completion of 16 sessions, the kids and parents are encouraged to attend monthly maintenance sessions for an additional eight months.

Community partners, who deliver the program within their communities, include the YMCA of the Greater Twin Cities, Doctor's Hospital at Renaissance (TX), Spring Branch Community Health Center (TX) and the Greater Wichita YMCA (KS). Join also works locally with physicians, pediatricians, and school nurses to refer children and teens who qualify for the program, based on BMI percentile. The program included call campaigns, local community outreach, and provider awareness education based on age and radius of class locations. Join for Me is currently covered with no additional cost to participants by payers including UnitedHealthcare Community & State.

## Outcomes

**Patient/Family Outcomes:** Participants were 155 children and their parents or guardians. After six months of participation in the program, children experienced a 3.4 percentage point reduction in percentage overweight ( $p=0.001$ ). Children under

13 years had a 4.3 percentage point reduction in percentage overweight, whereas those older than 13 years had a 1.0 percentage point reduction. Attendance continues to be the largest predictor of success, and 77 percent of today's Join for Me families are attending more than four sessions. Those who attended more face-to-face group sessions experienced greater changes in weight. There were significant improvements in quality of life among children as reported by both children and their parents.

**Clinician Outcomes:** Clinician outcomes were not measured for this initiative.

**Community Impact:** Partnering with community providers and pediatricians was instrumental to providing a resource for an effective and accessible childhood obesity intervention program available to their patients. The dilemma for practicing pediatricians was that, despite their well-established efficacy, few childhood obesity programs are available to the public. Historically, programs are limited to tertiary-care centers, available only to research participants, or have prohibitive costs or access barriers. Join for Me provides a much-needed treatment to address childhood obesity.

**Cost Savings:** Cost savings were not measured for this initiative.

**Quality Improvement Efforts:** Quality improvement efforts were not measured for this initiative.

### *Lessons Learned*

**Challenges:** Although Join for Me is held in geographic area close to members, transportation was a barrier for some families. This was addressed by providing transportation from the Unitedhealthcare Community and State Plan transportation vendor.

**Successes:** The largest predictor of success is attendance to weekly groups, as well as reduction in weight (BMI percentile). In addition, adoption of healthy lifestyle nutrition and activity habits in children and families.

In 2010, the U.S. Preventative Services Task Force (USPSTF) provided a Grade 8 recommendation that clinicians screen children aged 6 to 17 years old for obesity and, if appropriate, refer them to behavioral interventions that promote improvement in weight status. This was similar to previous recommendations for screening and treatment by the American Academy of Pediatrics. The Join for Me program provided an affordable, effective, and accessible treatment option to address childhood obesity in a community-based setting, and the Join for Me program curriculum is based on the AAP guidelines for healthy habits in children regarding healthy eating and physical activity.

**Advice:** An in-person program is difficult to fill. Virtual programming would allow for more participation.

## Research

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## Funder

UnitedHealthcare Community & State

## Key Partners

YMCA of the Greater Twin Cities  
Doctor's Hospital at Renaissance (TX)  
Spring Branch Community Health Center (TX)  
Greater Wichita YMCA (KS)

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# Empire BlueCross BlueShield HealthPlus (Anthem)

## LET'S MOVE 2B FIT

The New York State Prevention Agenda (2013-17) identified childhood obesity as one focus area in its long-term prevention agenda. Obesity affects 40 percent of New York City (NYC) public school students ages 6–12 years. Successful prevention efforts will require multiple strategies that promote and support healthy eating and active living and that reach large numbers of children and adults. Empire BlueCross BlueShield (BCBS) has forged strong partnerships with multiple sectors, including city agencies, public schools, and community resources that foster collaborative strategies implemented at the school setting. This initiative expands the role of the health plan in obesity prevention.

Let's Move 2B Fit is an innovative school-based, childhood obesity prevention program led by the health plan in collaboration with NYC public schools, school-based health centers (SBHCs), a federally qualified health center (FQHC), city agencies, and community-based organizations. It launched in 2015. The initiative promotes healthy eating, increased physical activity, and linkage to community resources. The initiative aims to expand the role of the health plan in obesity prevention by collaborating with community partners to create healthier school environments, promote healthy behaviors, prevent onset of obesity, and improve access to quality care following Healthcare Effectiveness Data and Information Set (HEDIS) well-child visits, body mass index (BMI), and adherence to asthma medications.

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### Key Priorities

- Promote healthy eating and healthy beverage choices.
- Increase physical activity through innovative and engaging activities.
- Expand health plan member-driven obesity prevention activities aligned with HEDIS measures (e.g., access to Care).
- Expand role of health plan in obesity prevention through collaborative partnerships.

## Population

The initiative affects more than 1,500 NYC public elementary school children in grades three through five (per school year), and parents/adults at target schools. The program is implemented at schools in South Brooklyn neighborhoods with high plan membership. The ethnicity of most beneficiaries is Hispanic, followed by small percentages of Asian and Middle Eastern. An estimated 21 percent of Sunset Park (Brooklyn) residents between the ages of 5 and 14 years have obesity, and many of these children receive care at the FQHC (NYU Lutheran FHC); this FQHC serves a high volume of Empire BCBS members.

## Intervention and Methods

The Let's Move 2B Fit Program has several components. The first component is physical activity and school administrators are connected to the Mighty Milers Running Program (NY Road Runners (NYRR)), a free physical activity program tailored for elementary school students. Additionally, there is an "Olympic Mentality" school assembly program for students in target grade are facilitated by an Olympic Gold medalist from the NYRR program. The next major component addresses healthy eating. The health plan facilitates a healthy eating workshop series (5 sessions) for parents and adults in participating schools, and one-time nutrition workshops as requested by schools. These workshops are facilitated in English, Spanish, and Chinese by diverse health plan health educators.

The program utilizes community resources in two ways. The health plan promotes and connects program participants with nutrition and exercise programs offered by city agencies, such as the Food Box Program, Farmer's Markets, Health Bucks Program, and Shape up NYC. Additionally, the health plan forges strong partnerships with city agencies like the New York City Department of Education (NYCDOE), New York State Department of Health (NYSDOH), and NYRR.

Empire BCBS promotes clinical services available for health plan members and connects school-based health centers with services available at the health plan for members participating in the program. Additionally, Empire BCBS collaborates with school-based health centers and NYU Lutheran Health Center. Geo-mapping is used by the health plan to identify neighborhoods in target intervention geographic area with high plan membership, and with school-based health center affiliated with NYU Lutheran FHC (FQHC).

Prior to program implementation, the health plan met with School Principal, Nurse, and other administrators to assess the ethnicity and cultural background of program beneficiaries. The health plan utilizes culturally sensitive health education curricula and educational materials.

## Outcomes

**Patient/Family Outcomes:** In 2015, the first year of program launch, four public schools in target geographic area participated and continued participation in the next school year. School administrators, program participants (both students and parents), and community partners have provided feedback showing high satisfaction with the program, especially with the Olympic Mentality Assembly Program (by NYRR), which provides opportunity to meet an Olympic gold medalist and great role model for children. The public schools engaged in the initiative during the first year of program launch have continued to participate in the initiative in the 2015-16 school year. Health plan members may be identified for weight management.

**Clinician Outcomes:** Clinician outcomes not yet calculated for this initiative.

**Community Impact:** The four public schools engaged in the initiative have continued with the program in school year 2015-16, and they are highly satisfied with program activities implemented for both students and parents. The program has maintained strong partnerships forged with community partners for program implementation (i.e., FQHC, SBHCs, NYRR, NYCDOH). The program has increased awareness for program participants and linkage to community resources (i.e., farmers' markets; Food Box Program; Shape Up NYC; NYRR).

**Cost Savings:** Cost savings not yet calculated for this initiative.

**Quality Improvement Efforts:** Quality improvement efforts not yet calculated for this initiative.

## Lessons Learned

**Challenges:** Engagement of target public school schools requires approval of school principal. The health plan held provided on-site overviews in meetings with principal, school nurse and other administrators to gain approval for program implementation at the school. Empire BCBS needed staffing resources to sustain a five-week healthy eating workshop series that met all language needs. Additionally, all program components have to be coordinated with community partners; to handle that, a health educator lead is assigned to intervention with schools. Budget needs for some program activities had to be met, including an exercise class for parents and adults, space for exercise class, snacks for participants, and incentives for participants. It can be difficult to gain access to BMI info for students in target group.

**Successes:** Measures of success include the number of target schools engaged in program, and ongoing participation in the next school year. Additionally, schools were engaged in all program components and involved in the timely implementation of the program. The program increased awareness of community resources and provided linkage to these resources, including Farmer's Markets, NYRR, and Shape Up NYC. The participants in the program are seeing success with improvement in healthy behaviors and improved outcomes for HEDIS measures: BMI, well-child visits, adherence to asthma medications.

Elements for success with this program include how the health plan forged and maintained strong partnerships with key community partners in target intervention area: FHQC, school-based health centers, public school administrators, NYCDOH, and NYRR. The health plan coordinated introductory meetings with leads at the SBHCs and FQHC to share initiative and discuss opportunities for joint interventions. The health plan facilitated various on-site education sessions for SBHC's clinical staff on HEDIS guidelines for BMI, well-visits, and asthma medication management. The program's health promotion team provided oversight of initiative ensuring cultural sensitivity of program components and sustaining strong partnerships with community partners.

**Advice:** Forging strong partnerships with community partners is key to the success of this type of initiative, and introducing the initiative as an opportunity for joint interventions between health plan and community. It is important to maintain communication with FQHCs and SBHCs to learn more about initiatives they are working on that target same population. This will provide opportunities for the health plan to collaborate. For example, the health plan will collaborate with NYU Lutheran FHC, affiliated with the health plan's childhood obesity prevention program, in an innovative childhood obesity weight management pilot program launched in the first quarter of 2016. This program targets children in South Brooklyn, the same community targeted by the plan.

### Key Partners

NYU Lutheran School Health Program  
NYC Department of Education  
New York Road Runners (NYRR)  
NYSDOH  
NYCDOHMH  
NYU Lutheran Family Health Centers (FHC)



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# NH Healthy Families; Louisiana Healthcare Connections (Centene Corporation)

## KEEP IT MOVING – FUN FITNESS PROGRAM

Childhood obesity is a risk factor for cardiovascular disease, pre-diabetes, and social and psychological problems. It has been recently reported that one-third of adults and 17 percent of children have obesity. More strikingly, the prevalence of adult obesity has nearly tripled from 13 percent since 1960. Thus, it is essential to establish mechanisms to promote healthier lifestyle habits. The Keep It Moving-Kid Fitness Program (K.I.M.) pilot program was designed to improve healthy eating and physical activity in children to lower their risk for obesity and other comorbid conditions.

Centene Corporation's K.I.M. program is a novel intervention designed to encourage children and adolescents to take part in regular physical activity and provide education on healthy lifestyle habits. K.I.M. promotes music, learning, dancing, and staying active through an exclusive partnership with H3TV. Knowledge and physical endurance scores improved after a five-week program piloted in Louisiana and New Hampshire. This program serves as a potential model to address this significant public health concern.

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### Key Priorities

- Encourage children and adolescents to take part in regular physical activity.
- Provide education on healthy lifestyle habits, including healthy eating, physical activity, anti-bullying, and self-esteem.
- Collaborate with community schools to promote supportive environments with activities and practices that support healthy behaviors.

## Population

The population targeted for both pilot populations included male and female children from two Centene health plans of all races. The New Hampshire Healthy Families' participants (n=42) targeted elementary-age children and the Louisiana Healthcare Connections (n=22) targeted third-grade children. There were 91 beneficiaries.

## Intervention and Methods

The K.I.M pilot was a 25-day program (five days per week for five weeks). Each week, the program used a different children's workbook component, warm up, fitness exercise or dance, and physical activity. The first day of each week was dedicated to completing assignments in the workbook. Topics in the workbook included: Focus and Organization, Healthy Eating, The Importance of Physical Activity, Anti-Bullying, and Discover the Magic in You.

Next, facilitators used the H3TV DVD to complete warm-up exercises. Then the children worked on learning the fitness exercise or dance for that week. One physical activity was selected to complete with the children from the Play Works website (<http://www.playworks.org/>). Lastly, the children played the Eat to Win Board game, which teaches nutrition and physical activity for children ages 6 years and older.

School staff were trained on the curriculum before the start of the program in-person or through conference call with the health plan and H3TV. Upon completion of the program, there was a live performance by H3TV to congratulate the kids on all their hard work and get them excited about healthy behaviors. The performance included a live fitness exercise or dance from the DVD, a Magic Show, and a ceremony to hand out certificates. Each student who completed the program received items to take home for further engagement and impact:

1. A live performance by H3TBV with Rappin' Roy and Reggie Regg.
2. Children's Keep It Moving – Fitness Workbook.
3. Free Listen and Learn Volume 1 music CD, which includes songs about healthy eating, physical activity, anti-bullying, school is cool, and more.
4. Certificate of completion.
5. T-shirt and water bottle.
6. Centene book: The Adventures of Bolngg & Sprockette – Adventures Through Fitropolis and Parents Guide.

The K.I.M. program used geo-mapping to identify communities with a heavy concentration of membership that met the targeted age ranges. From this information, schools within that community, preferably schools that Centene's health plans have already adopted, were selected. Boys & Girls Clubs were also utilized as optional venue choices.

The program is designed to capture audiences by using everyday music. The concert, magic show, and learning sessions engage kids on their level. Facilitators are required to maintain a level of excitement and energy throughout the program. H3TV staff complete cultural competence and disability sensitivity training.

## Outcomes

**Patient/Family Outcomes:** A pre-/post-knowledge test was administered and showed an improvement in the understanding for lifestyle domain (e.g., when to go to bed or when to set out clothes) and in healthy eating choices (e.g., choice of a protein snack or reading a nutrition label). A pre-/post-physical endurance test was also completed. Jumping jacks, sit-ups, push-ups, and square jumps all demonstrated a statistically significant difference ( $p=0.001$ ) before and after the Louisiana pilot program. In New Hampshire, push-ups showed a statistically significant difference ( $p=0.012$ ).

**Clinician Outcomes:** Clinician outcomes were not measured for this initiative.

**Community Impact:** One of the program goals was to collaborate with local community schools and community centers to promote supportive environments with activities and practices that support healthy behaviors. Centene partnered with a local school and the local Boys & Girls Club, which were both excellent locations. This community impact was also uniquely fostered through an exclusive relationship with H3TV. Through this unique relationship, members within their communities were linked to healthier lifestyles.

**Cost Savings:** Cost savings were not measured for this initiative.

**Quality Improvement Efforts:** The K.I.M. program outcomes showed that, by using engaging content, children can increase their knowledge about healthy food choices and improve their endurance in the short term. Longer studies will be required to determine if body-mass-index (BMI) and other longer lasting physiological outcomes for childhood obesity can be affected.

## Lessons Learned

**Challenges:** Fostering change and accountability is a challenge with children in this age range. To overcome this obstacle, the K.I.M. pilots implemented two practices. First, the students were split into multiple groups for the activities. Students learn best in smaller groups, and it also helps them practice accountability. Moreover, a discipline zone was also established to help control problematic situations.

**Successes:** The primary manner through which K.I.M. program attempted to measure success was to look for a favorable change in behavior and attitudes toward physical activity in participants as well as increased knowledge regarding healthy lifestyle habits, school preparation, and life skills. A pre/post-endurance test was also planned to determine if there would be any short-term improvement in physical ability after the program was completed.

The K.I.M. program established multiple community partnerships that contributed to the success of the program. For example, the Derry Boys & Girls club created a photo collage documenting the experience they have had with New Hampshire Healthy Families, and H3TV demonstrated the impact of the rewarding work of this program on the lives of the affected children. Support from Centene Corporation, particularly from the Office of Member Connections, contributed to the success of the program.

**Advice:** In setting up such a program, it is important to engage with community schools and centers in the earlier part of the school year to determine when the program can best fit within the school year. This program can be implemented in local community centers; however, it was difficult to restrict and control the age range of the students who participated. It is recommended that the program be implemented in a school setting where the kids are already grouped by grade level, and interactions can be applicable to a specific age range. At the community center, the program was publicized, leading to high levels of interest. As a result, Centene was flexible and opened enrollment up to all elementary grade levels.

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## Key Partners

Department of Member Connections  
H3TV  
New Hampshire Healthy Families  
Louisiana Healthcare Connections



## *Kudos to the Team*

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## Cardinal Innovations Healthcare

### THE BOULEVARD PILOT

Homelessness is a key issue for the Medicaid population in the Chicago area. According to the Chicago Coalition for the Homeless, the city of Chicago had approximately 125,848 homeless persons last year. According to research, homelessness is a major contributor to increased mental and physical health issues, including substance abuse. Additionally, the Illinicare staff encountered many members who were using the hospital as a source of housing. In response, the organization hypothesized that providing housing to members could help alleviate many of their challenges.

In 2015, Illinicare partnered with the Boulevard, a medical respite facility, to address homelessness within Illinicare membership. Homelessness is often associated with mental illness, substance abuse, and poor health that increases the utilization of inpatient and emergency department (ED) services. Illinicare reimburses the Boulevard for eight beds to be used solely for its members. The Boulevard provides these members with safe and stable short-term housing and medical, social and mental health support, including transition to permanent housing. The program has already seen many successful transitions with significant cost savings.

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#### Key Priorities

- Safe and stable housing.
- Reduction in unnecessary inpatient and emergency room utilization.
- Better health outcomes.
- Cost savings.

## Population

The Boulevard Program is open to all Illinicare members over 18 years of age who are homeless. The Boulevard serves men and women (as well as the transgendered community) of any race or ethnicity in the Chicago area. Twenty-two beneficiaries were enrolled in this program. This program was designed to serve members who are homeless, with medical or mental health issues, that are exacerbated due to their lack of housing.

## Intervention and Methods

Since identifying homelessness as a major barrier to care for its members, Illinicare has actively engaged community partners to address the issue. Research shows that the homeless have mortality rates three to six times higher than their housed counterparts and have elevated rates of mental illness, substance abuse, and co-morbidities that increase their need for health services. Currently Medicaid dollars in Illinois cannot be used for housing, and there is a severe housing shortage for low-income residents in Illinois, especially in the city of Chicago. This made it even more challenging to assist health plan members who are homeless. The Boulevard approached Illinicare regarding a collaboration.

The Boulevard, a 64-bed medical respite facility, is the only provider of its kind in Illinois. The Boulevard offers case management, substance abuse counseling, housing advocacy, and 24-hour staffing. Funding is primarily through the U.S. Department of Housing and Urban Development (HUD); however, funding has been less than adequate to meet the needs of the residents. Through partnership with Illinicare, the Boulevard has been able to house eight homeless Illinicare members per month. On average, members typically reside at the Boulevard for approximately 90 days; however, Illinicare will pay for members to stay as long as needed and appropriate. Illinicare members were shown to better manage chronic and acute medical and behavioral health conditions, resulting in overall better health, fewer hospitalizations, and reduction in health care costs to the plan.

Illinicare is using the Impact Pro predictive modeling program to determine member appropriateness for the program as well as to assist in determining future risk and cost. All program participants undergo comparative utilization measurements before and after program completion.

Understanding the culture of homelessness is key to resolving the issue. Illinicare staff work closely with the Boulevard staff to better understand the needs of this population. This collaboration is further supported by the presence of Illinicare's care coordinators who meet on site with members in the pilot.

## Outcomes

**Patient/Family Outcomes:** Preliminary analyses show that 22 members were served for a total of 1,442 bed days. In the 12 months prior to residing at Boulevard, members experience 201 inpatient admissions; after residing at Boulevard, this number dropped to 14. Similarly, members had a total of 352 emergency department visits in the 12 months prior to residing at Boulevard, decreasing to 15 visits after residing at Boulevard. Total inpatient and emergency department admissions following 90-days post-discharge were 53 and 62, respectively.

**Clinician Outcomes:** Clinician outcomes were not measured for this initiative.

**Community Impact:** Community impact outcomes not yet calculated for this initiative. Once final data is collected, the importance of housing to overall health will be demonstrated and may encourage other stakeholders in Illinois to help support initiatives that allow Medicaid funding to be used for housing.

**Cost Savings:** Cost savings not yet calculated for this initiative. However, Illinicare has seen significant cost savings for high-utilizing members who complete the program and transition to permanent housing.

**Quality Improvement Efforts:** Illinicare is still working to determine the full impact of the program on quality metrics. However, the program is designed to help close Healthcare Effectiveness Data and Information Set (HEDIS) care gaps, through regular communications with Boulevard staff to ensure members receive appropriate follow-up with care providers.

## Lessons Learned

**Challenges:** A significant challenge was identifying and locating homeless members. Due to the inherent transience of homelessness, communicating with members can be difficult. Also, many members who meet the HUD definition of homeless do not identify as such. To overcome these challenges, Illinicare has educated its staff on how to communicate with members about homelessness and what it means. The health plan also developed a method of tracking and reporting members who are homeless in its clinical documentation system. Finally, when the member is reached, he or she is provided a phone either through the government Safelink or Illinicare's Connections Plus program.

**Successes:** Measures of program success include completion of the program, transition to permanent housing, medication adherence, reduction in inpatient hospitalizations, and emergency department visits. Additionally, Illinicare is looking to close HEDIS gaps and a reduce overall cost of the members.

The key element to the success of this program was the willingness of Illinicare to fund non-billable, non-encounterable services and the support and engagement of a community partner, The Boulevard.

**Advice:** Before beginning a similar pilot, an organization should ensure that a solid plan is in place to identify appropriate members, have the ability to communicate with those members in the community, and have the ability to determine members who are willing and ready to engage in the program prior to admission.

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### Key Partners

The Boulevard (formerly Interfaith House)

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## Anthem, Inc.

### *HIGH INTENSITY INTEGRATED TEAM (HIT)*

*A HEALTH CARE PROGRAM FOR YOUTH  
TRANSITIONING FROM FOSTER CARE TO ADULTHOOD*

The High Intensity Integrated Team (HIT) program goes beyond the standard case management process with additional interventions. Staff buys into an integrated team and manages physical and behavior health. Additional staff training is given on patient and behavior activation. The team identifies and vets providers for partnership and collaboration. If vendors are not available, the program hires or trains field-based case managers or nonclinical staff for feet-on-the-street approaches.

The HIT program was implemented in the Texas markets in the fourth quarter of 2014 (Q4-2014). The team provides an integrated approach with a single point of contact for physical and behavioral health services based on completed needs assessment. The team provides selected members with a higher intensity services and level-of-care options. The focus is on a member's individual needs to improve functioning and empowerment over healthcare. Members are engaged in the program through the use of motivational interviewing, recovery and resiliency work, and person-centered care planning. With these techniques, members actively manage their healthcare needs and improve their quality of life. Improving quality of care reduces admissions, readmissions, and emergency department (ED) visits, and results in decreased costs.

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#### Key Priorities

- Reduce ED visits.
- Reduce inpatient admissions.
- Realize pharmacy savings.
- Increase engagement and empowerment of members to manage their healthcare options.
- Focus on shared decision making to improve quality of care and quality of life for members.

## Population

Super-utilization and high-cost members were identified. This group included patients who have used the ED or inpatient services excessively and are predicted to have high complex case management needs.

In Texas, 123 members were identified as qualifying for the program, with no demographic, gender, or age distinctions. As of the fourth quarter of 2015(Q4-2015), 32 members were active in the program.

## Intervention and Methods

HIT core components employ a program with corporate-level oversight to act as a liaison, subject matter expert, and coordinator to the health plans. The HIT intervention's work flow is unique, with a higher intensity of case management, shared decision making, and strong patient engagement.

Stage 1: Standard care management (CM) plus care monitoring of appointment.

- Ensuring members are seeing a primary care provider (PCP) and specialists per treatment plan with verification from the physician or through claims.
- Assisting member in making appointments with member on the phone or in person.
- Following up with member after appointments for any change in physician treatment plan and if needed following up with physician.

Stage 2: Standard CM plus medical coordination and education.

- Medication reconciliation during assessment and after physician visits.
- Education/teaching on disease processes and self-management skills.
- Labs: Follow up when labs are due, discussion with member regarding lab values and lifestyle changes needed.

Stage 3: Standard CM plus enhanced care coordination.

- Assisting with care coordination between PCP/Specialist/Ancillary regarding any needed referrals and/or services (Home Health/Personal Assistance Services (PAS)/Attendant Services- Department of Aging and Disability Services (DADS)/Durable Medical Equipment (DME)).
- When appropriate: Utilization of clinical programs or setting up home health visits for home assessment to determine needs if clinical programs not available for home physicians.

Stage 4: Standard CM plus care frequency and intensity.

- Members may initially require and agree to weekly CM contact. Based on member's specific needs and willingness to receive calls, the frequency of contact could vary.
- Ongoing discussion between the member and CM of frequency of telephonic outreach as well as the reasoning for the frequency of contact is needed to meet member goals.

HIT evaluates efficiency measures with staff and provides additional resources, interventions, and tools as needed. The program conducts random audits of HIT cases, meets weekly with staff for troubleshooting, and meets monthly with stakeholders to discuss and monitor metrics, HIT use, and reporting.

## Outcomes

**Patient/Family Outcomes:** By Q4-2015, the program has retained 32 active members. No Healthcare Effectiveness Data and Information Set (HEDIS) or satisfaction scores are available at this time. The HIT program has accomplished a 6 percent reduction in ED utilization at a cost saving of 57 percent post-care management intervention.

**Clinician Outcomes:** Clinician outcomes were not measured for this for this initiative.

**Community Impact:** Community impact outcomes were not measured for this initiative.

**Cost Savings:** Savings reflect a per-member-per-month (PMPM) savings of \$1,297.92 and a total year-to-date (YTD) savings of \$256,988. Estimated yearly savings is \$385,000. This number is lower than expected because membership in the program is trending downward. The health plan will address membership to increase program participation.

**Quality Improvement Efforts:** At the center, HIT is designed to improve outcomes and reduce the total cost of care. The health plan is seeing a reduction in cost of inappropriate ED use and reductions in avoidable hospitalizations. As a result of better coordinated care, Anthem will be monitoring and measuring increased adherence to individualized care plans and the initiation of substance use disorder (SUD) services.

## Lessons Learned

**Challenges:** Getting stakeholders to buy in to something different with a known population is a challenge. It is hard to identify field-based vendors, providers, and staff that can adapt to finding members that are hard or difficult to engage. Members themselves are often reluctant to engage in the program. The HIT program goes beyond standard case management with additional interventions. To engage staff, additional staff training was provided and ensures potential gaps are identified and resolved. Field-based vendors were not available or trained to manage the population.

**Successes:** A key component of success has been identifying internal staff—on both behavioral health and physical health sides—that are willing to be the initial single point of contact regardless of training, license, and experience. In past programs, when staff did not have the specialized knowledge to manage a member, they would transfer the case rather than consult or co-manage the case. Moving cases back and forth placed additional burden on the smaller behavioral team. It has been very



important to engage staff to understand the population, give them useful tools, and train them to help members manage behaviors that are driving medical costs. Most important is engaging members in recovery and behavior activation.

**Advice:** Plans should maintain appropriate staffing ratios, a 1:5 ratio of behavior health clinicians to registered nurses, based on memberships similar to super-utilizer populations. It is important to ensure that utilization review staff are participating in the rounds and discharge planning and that both medical and psychiatric doctors attend the rounds for medical guidance. Partnership with provider relations and contracting is needed to build field base support services. Buy-in is important from the top down as well as the bottom up. Remember that case managers for the HIT maintain a low case load, which at times can be seen as less productive than traditional case management. Health plans should screen and select staff passionate about helping a difficult-to-engage population. Keep data up to date and check it often. Utilize provider relationships and networking to identify vendors for inclusion. If vendors not available, hire field-based case managers or nonclinical staff for feet-on-the-street.

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## Anthem California (Anthem, Inc.)

### END STAGE RENAL DISEASE (ESRD) PILOT PROGRAM

The management of end stage renal failure (ESRD) and hemodialysis is a complicated and ongoing process requiring close adherence to a medical program. To maintain a relatively healthy lifestyle, ESRD patients must take multiple medications, adhere to a careful diet, and attend not only frequent hemodialysis sessions, but also see a variety of healthcare professionals regularly.

Few interventions have been rigorously tested, but patient education and/or individualized attention, supervision, encouragement, and support are widely advocated strategies to improve patient compliance.

Through a collaborative partnership with an Anthem partner, Anthem California initiated a pilot program in 2015 focusing on intensive case management for members with ESRD in the San Francisco area. Intensive case management includes face-to-face interaction and care coordination with the member and local dialysis centers and providers. Initial findings demonstrate improved adherence to diet and medication recommendations, increased time per dialysis session, and 96 percent engagement with health plan case management.

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#### Key Priorities

- Improve quality of care through effective utilization management (UM), care coordination, and case management.
- Decrease avoidable inpatient admissions.
- Decrease avoidable emergency department (ED) visits.
- Improved adherence to dialysis visits, diet, and medications.

## Population

Anthem members in the San Francisco area traditionally are high cost and have multiple co-morbidities and complications. Due to the dense population in this small space, members with ESRD in the San Francisco were targeted for this pilot program to maximize impact and health improvement opportunities. The health plan identified 69 members through claims and case management referral in the San Francisco area for this pilot.

## Intervention and Methods

The availability of life-saving dialysis therapy has been one of the great successes of modern medicine. Despite treatment of hundreds of thousands, there has not been significant improvement in patient quality of life. Anthem California developed a pilot program focusing on the more complex intermediate clinical and social needs of the Medicaid member—consistent dialysis therapy, service coordination, health literacy, and medication management. Successfully addressing these needs may drive improvements in the primary outcomes, improve survival rates, fewer hospitalizations, better patient experience with treatment, and ultimately, lead to improved quality of life.

Dialysis utilization for patients with ESRD has many factors. Patients with ESRD often lack adequate disease and healthcare navigation knowledge, have inadequate self-efficacy skills, and a combination of forgetfulness, transportation, financial constraints. Any one of these may present as a barrier toward better compliance to fluid, dietary, medication, and dialysis, respectively.

Anthem California case managers worked hard to engage members with ESRD to improve their health literacy and understanding of their condition. Case management interventions emphasized building relationships and establishing trust with members through face-to-face contact, feet-on-the-street, and consistent presence. Service coordination, including facilitating transportation, navigating and maximizing health plan benefits, and connecting members to additional services available such as meal services, were included in case management. Additionally, case managers collaborate with local dialysis centers to expedite authorizations, coordinate care, and promote adherence with diet, medications, and visits.

The health plan's members with ESRD represented a diverse sampling of the health plan's population. Using Language Line, care coordinators worked with members to meet their cultural needs, beliefs, and values.

## Outcomes

**Patient/Family Outcomes:** In the initiative, 96 percent of targeted members were actively engaged with case management. The health plan found improved adherence to diet and medications. This population showed a decrease in inpatient and emergency room admission, along with an increase in use of professional services and the pharmacy. Anthem expects positive outcomes associated with members' compliance with dialysis treatments.

**Clinician Outcomes:** Clinician outcomes were not measured for this initiative.

**Community Impact:** Community impact outcomes were not measured for this initiative.

**Cost Savings:** Pilot participants decreased average per-member-per-month (PMPM) expenses by \$718 (10 percent). Additionally, pharmacy PMPM expenses increased by 33 percent, demonstrating improved medication adherence, and scripts per 1,000 members increased by 2 percent. Inpatient admissions per 1,000 decreased by 44 percent and inpatient PMPM costs dropped by approximately 43 percent. Outpatient admissions per 1,000 decreased by 3 percent.

**Quality Improvement Efforts:** Quality improvement outcomes were not measured for this initiative.

## Lessons Learned

**Challenges:** Members with ESRD use the ED as an alternative to dialysis. Anthem California partnered with area hospitals to redirect members from the ED to the dialysis clinic. Dialysis sessions were often short. Anthem California case managers developed a relationship with the member to encourage the member to stay for the full session. Reaching members by telephone is limited because of various challenges. Anthem California coordinated face-to-face interaction with the members to foster program compliance.

**Successes:** Anthem California compared outcomes of the pilot with a control group, focusing on inpatient, outpatient, pharmacy, and professional PMPM expenses. Overall PMPM was found to have decreased, specifically:

- Inpatient PMPM costs decreased by 50 percent, roughly \$782.
- Outpatient PMPM costs decreased by 12 percent, or \$365.
- Pharmacy PMPM costs increased by 28 percent.
- Professional PMPM costs increased by 1 percent.

The key elements of success included stratifying members to align with the intensity of services, reducing staff member ratios, and performing intensive case management of

high-utilizers. The health plan also employed fast-track prior authorizations and an integrated team of physical health, behavioral health, and support services. Biweekly rounds with medical director support was an element as well. Anthem is actively engaged with members and providers through personal interaction sustaining long-term engagement.

**Advice:** In the right geography, with trained resources, the intensive case management program will be successful. The health plan's care model uses a nurse and social worker in the field engaging members and providers for improved access to care through referrals and connections with community resources, along with in-house care extender support. We also worked with another Anthem partner to provide additional services such as vascular procedures, wound care, and fistula maintenance.

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