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Welcome Letter

A Message from MHPA President & CEO Thomas L. Johnson and
MHPA Center for Best Practices Director Michelle M. Martin

Dear Colleagues:

On behalf of Medicaid Health Plans of America and the MHPA Center for Best Practices, we are pleased to bring you the Treatment Adherence Best Practices Compendium. This publication examines an issue at the heart of treatment effectiveness: adherence. Without patient adherence to medications and healthy behaviors, health care interventions will never reach their full potential to improve outcomes.

Good health care depends on access to services and on physicians and other providers delivering evidence-based treatments. It also relies on engaged patients taking action to stay healthy and manage their health conditions. The Medicaid program is one of the largest payers of health care services in the U.S. By providing insurance coverage to millions of low-income and disabled Americans, Medicaid is making enormous strides in opening access to services that improve overall health of beneficiaries.

Over half of Medicaid beneficiaries in 36 states are enrolled in Medicaid health plans. Essential partners with states, providers and beneficiaries, Medicaid health plans play an important role in encouraging treatment adherence by promoting improved access, evidence-based care and member engagement. Medicaid health plans help patients get the best possible care and are persistent when it comes to getting patients needed treatment while removing barriers that are prevalent among Medicaid recipients. They offer patient education, classes and individualized care coordination, all designed to help patients make the most of services needed to stay healthy.

We are proud of the programs described in this compendium. They range from UPMC for You’s program to help members with schizophrenia access services needed to function successfully, the Amerigroup Corporation’s text messaging program to increase use of healthcare visits and HealthPartners’ use of care management to improve adherence to comprehensive diabetes and asthma care.

The MHPA Center for Best Practices is very pleased to highlight the best practice examples in this publication. We believe that health plans have an invaluable role in collaborating with patients, providers and communities to move towards better health. We thank Merck & Co, Inc. for supporting development of this publication.

Sincerely,

Thomas L. Johnson  
President & CEO, Medicaid Health Plans of America  
President, MHPA Center for Best Practices

Michelle M. Martin  
Director,  
MHPA Center for Best Practices

About MHPA Center for Best Practices

The Medicaid Health Plans of America (MHPA) Center for Best Practices (CBP) is a 501(c)(3) affiliate organization created to support MHPA’s mission: to provide efficient health care services and improve quality and access to care for Medicaid beneficiaries. The CBP serves as a convener of Medicaid health plans on research, quality improvement and dissemination of health plan best practices in both clinical and operational domains. With guidance from the leadership of premier health plans serving Medicaid populations and expert stakeholders, the CBP uses data, information and knowledge transfer to disseminate innovative solutions to caring for underserved populations.
Introduction

Adherence is a challenging problem across all sectors of the health care system — Medicaid, Medicare and commercial health insurance. Experts say that 20 percent of patients don’t ever fill prescriptions they get from doctors for needed medications, and 50 percent of people taking medications for chronic diseases don’t refill them as prescribed.1 There are many reasons behind non-adherence. These include lack of understanding about the purpose or importance of treatments, difficulty picking up medications, financial barriers, or patient beliefs about treatment effectiveness. The net result, though, is that non-adherence is a major problem in managing chronic diseases and promoting good health. Lack of treatment adherence can be a factor explaining why many patients with chronic diseases get sicker over time. It can also be a factor in higher costs if patients end up needing more emergency care or hospitalizations.

What then, does treatment adherence mean to Medicaid? The Medicaid program covers over 51 million people located in every state.2 People in the Medicaid program tend to be sicker or have more health care needs than people with other types of insurance. Good health depends on people adopting healthy behaviors such as a nutritious diet and regular exercise. It also means adhering to treatments needed to control diseases — including taking essential medications as prescribed. Treatment adherence in the Medicaid program leads to healthier beneficiaries and better outcomes across a range of conditions, including healthier babies, fewer complications from diabetes, and decreased risk of heart attack or stroke.

In this Best Practices Compendium we discuss the scope of the problem of non-adherence and some of the reasons behind it. Then, we highlight some programs being used by Medicaid health plans to educate beneficiaries and improve adherence to behavioral and clinical treatments that improve health outcomes. Note that treatment adherence is broader than just sticking with medications. Adherence also encompasses other treatment recommendations such as eating a healthy diet, exercising, and stopping smoking. Many of the health plan best practices included in this compendium help to educate and motivate patients around an array of behaviors that promote health, including and extending beyond medications.

The Problem of Non-Adherence

Most studies about the effect of non-adherence look at adherence in specific populations and for specific health conditions. Some condition-specific examples that illustrate the scope of the problem include:

- **Asthma:** In Medicaid programs in Florida and Texas, researchers found that compliance with asthma treatments was 20% for children treated with inhaled corticosteroids and 28% for children treated with leukotriene inhibitors.3 These are both preventive medicines that doctors say are important to keep children from having asthma emergencies.
- **High Blood Pressure (also called hypertension):** Up to half of patients with high blood pressure don’t take their medications as prescribed. Almost 90,000 lives could be saved annually if people were adherent to hypertension medications.4 On the flip side, over 80,000 lives per year are being saved now because people do control their hypertension.5
- **Diabetes:** In a recent study of Medicaid beneficiaries newly starting medication for diabetes, the adherence rate was 56% in the year following the diagnosis of diabetes. During the year, almost 37% of these patients were hospitalized and 40% had emergency department visits, with an average annual health care cost of $10,000. The researchers estimated that an increase of 10% could reduce likelihood of hospitalization by 7% and decrease likelihood of emergency care by 5%.6
The conditions identified above are not unusual. For virtually every health condition, people have difficulty adhering to treatment, and there are both health consequences and costs associated with non-adherence. Stakeholders across the health care system have adopted the goal of improving adherence as a strategy to improve both efficiency and effectiveness of health care services.

Improving Adherence

If health suffers as a result of non-adherence, why do people not take their medications and adopt healthier behaviors? For medications, many reasons have been identified including presence of financial barriers, difficulty understanding medication instructions, not grasping the importance of treatments, lack of trust in the system and even lack of trust in the medication. The challenge here is that it simply is very difficult to change behavior. As anyone who has tried to lose weight, stop smoking, or eat healthier knows, changing behavior is hard to initiate and even harder to continue over the long run. The challenge for health care providers and health plans is to offer education on the importance of adherence, support members in making changes and help break down barriers to successful adherence.

Many different types of interventions to improve adherence have been studied. There is no magic bullet to solve the problem of non-adherence—the most effective approaches use multiple strategies that include a number of features and include information, convenient care and follow up. Long-term adherence for disorders such as diabetes, schizophrenia and heart disease is particularly challenging. Some techniques that can be applied include:

- **Improving patient health literacy:** Health literacy refers specifically to the capacity of a patient to understand information about health and carry out actions recommended by the treatment team. People with low health literacy may not understand instructions or may not understand the relationship between the health problem and the treatment. For example, some patients with low health literacy may stop taking chronic disease medications because they ‘feel better,’ when feeling better actually is a sign that the medications are working and should be continued.

- **Reminders:** Physician offices, pharmacies and health plans now commonly offer reminders to patients when it is time to refill medications or see their health care providers. These can be in the form of phone calls, emails or postcards. Some providers also offer practical tools such as text messaging or pill boxes to help patients remember to take their medications on a day-to-day basis.

- **Care Coordination:** Many health plans and some provider offices now employ nurse or social work care coordinators who interact with patients to improve adherence to medications and behavior change treatments such as smoking cessation. Care coordinators commonly communicate with patients by phone to educate and motivate them about healthy behaviors.

- **Delivery System Improvements:** Recent delivery system changes to adopt “medical homes” are partly designed to improve interactions with patients that can improve treatment adherence components. One goal of medical home arrangements is to promote the personalized relationship between the health care provider and the patient. This builds trust and helps patient and provider adopt a shared treatment plan that increases adherence. Even connecting people with primary care providers outside of a medical home can improve adherence.

- **Identifying At-Risk Patients:** Risk of non-adherence can be identified through a simple risk assessment questionnaire or through complex algorithms that rely on health care data. Health plans and pharmacy benefit managers have access to claims data that show when the patient uses the health care system or obtains prescription medication. Plans use data systems to identify patients who have not refilled essential medications and then can send a reminder or refer them to a care coordinator who can help to address reasons for non-adherence.

- **Culturally Competent Services:** Some patients simply mistrust the health care delivery system and question the value of some medications. Strategies to enhance culturally competent care and build trust include identifying same-language resources, using peers or care coordinators from the community and designing health information to address concerns about medications.

- **Incentives:** Incentives have been shown to influence health behaviors, although their effect may be relatively short term. Providers and plans may use incentives in prenatal care programs and for other relatively short-term interactions such as smoking cessation in which it is critical for the patient to be motivated. Incentives can include small gift cards, “points” towards a prize or child care items, to name just a few.

- **Peer Support:** Particularly for behavior changes, teaming up with friends or a group can improve engagement and persistence (incorporating the change into their behavior patterns). Prenatal care classes and group exercise classes are two common examples of group-based strategies to engage people in healthy activities.

- **Culturally Competent Services:** Some patients simply mistrust the health care delivery system and question the value of some medications. Strategies to enhance culturally competent care and build trust include identifying same-language resources, using peers or care coordinators from the community and designing health information to address concerns about medications.

**HEALTH LITERACY**

The Center for Health Care Strategies (CHCS) defines health literacy as the ability to read, understand and act on health information. CHCS has a series of nine fact sheets created for those who are designing patient education materials for consumers with low health literacy skills. The sheets define health literacy, describe its impact on health outcomes, provide strategies to prepare appropriate educational materials to assist low-literate consumers, and identify resources.

CHCS Fact Sheets are:

- What is Health Literacy?
- Who Has Health Literacy Problems?
- Impact of Low Literacy Skills on Annual Health Care Expenditures
- Health Literacy and Understanding Medical Information
- Strategies to Assist Low-Literate Health Care Consumers
- Preparing Patient Education Materials
- Tools to Evaluate Patient Education Materials
- Health Communication and Cultural Diversity
- Resources for Health Literacy Information and Publications

The Role of Health Plans in Medicaid

Medicaid health plans are accountable for both the cost and quality of health care services delivered to beneficiaries. With passage of the Affordable Care Act, more people will be covered under Medicaid. States are turning to managed care with the goal of better coordinating care, improving access and managing costs. Medicaid populations currently in the fee-for-service system, particularly Medicare and Medicaid “dual eligible” populations, are being moved into managed care arrangements.

Health plans are taking actions to improve adherence because it affects both outcomes for patients and the cost of services. Health plan programs may have a broad goal such as improving healthy living, or have a condition-specific focus like improving diabetes care. Care management programs often include coaching their members to improve adherence to diet, exercise and medication prescriptions. Health plans typically also have prevention and wellness programs designed to keep healthy people healthy. The net result of effective programs is both to improve the health of the Medicaid member and to keep health care costs under control.

MHPA believes that health plans offer a higher level of accountability for quality than the fee-for-service Medicaid programs designed to keep healthy people healthy. The net result of effective programs is both to improve the health of the Medicaid member and to keep health care costs under control.

Health plans report on their performance to state Medicaid agencies using standardized and customized performance metrics. Medicaid health plans may also be accredited by external accountability organizations. Accredited health plans report performance measures using a standardized protocol developed by the National Committee for Quality Assurance (NCQA) called HEDIS – the Healthcare Effectiveness Data and Information Set.

The HEDIS measurement set includes many metrics related to adherence. For example, HEDIS measures capture information on control of high blood pressure, diabetes and cholesterol management. Control is more clinically specific than simply measuring whether medications are prescribed for people with these conditions. Control is a sign that the member is receiving necessary treatments and is adhering to treatment. The success of health plan adherence improvement initiatives can be measured through many of the performance metrics reported through HEDIS.

Examples of standardized HEDIS measures reported by Medicaid health plans and related to adherence include:

- Controlling High Blood Pressure
- Prenatal and Postpartum Care Rates
- Use of Appropriate Medication for Asthma
- Antidepressant Medication Management
- Follow-Up Care for Children Prescribed ADHD Medication

- Annual Monitoring for Patients on Persistent Medications
- Comprehensive Diabetes Care (eye exam, LDL-C screening and control, hemoglobin a1c testing and control, kidney screening)

Many states produce report cards or online search tools that enable policy makers and consumers to assess performance of health plans.

Health Plan Approaches to Adherence

Part 2 of this report features best practice examples from Medicaid health plans seeking to improve their performance and improve member outcomes through innovative programs. Health plans apply multiple resources and diverse strategies to increase adherence. Adherence interventions may focus on a particular disease condition, or may broadly seek to increase connections with the health care system. Some strategies to engage members in adherence include:

- Connecting Data to Create Coordinated Systems: Health plans use claims, enrollment and pharmacy data to look for patterns of non-adherence or identify at-risk members. These members can then be helped either through personalized care coordination or through simpler systems of reminders and educational materials. Health plan data can also be used to identify gaps in care for other important treatment indicators, such as blood glucose testing for people with diabetes.

  **Best Practice Example:** In the ConnectedCare™ Program, UPMC for You implemented a monthly process to notify the prescribing provider and primary care physician of gaps in filling antipsychotic medications or other medication used to treat chronic conditions. The program also informed providers whether recommended laboratory tests for monitoring patients with schizophrenia were being carried out, including annual glucose screening for members on antipsychotics. (See page 19)

- Using Care Coordinators to Identify and Fill Gaps: The Best Practice examples featured here often draw upon trained care coordinators to work with Medicaid members. These personnel provide a variety of services, including assessing treatment adherence, coordinating with providers about patients’ treatment needs, ensuring members have transportation, language translation and other support services needed to access care, and providing health education. Many of the best practices featured in this publication deploy care coordinators to assist members who have been hospitalized or who have visited the emergency department.

  **Best Practice Example:** Centene Corporation uses member data to identify members who have sickle cell disease and then to determine usage gaps and compliance with hydroxyurea. Centene analyzes a member’s claims for emergency care, inpatient admissions, outpatient visits, preventive care gaps, and narcotics usage with the goal of prioritizing those with frequent vaso-occlusive crises who do not have evidence of regular use of hydroxyurea. The plan arranges home visits by care coordinators help identify social, literacy and other barriers that may be impeding that member’s care. Centene also contacts providers with a letter or call to let them know about the care management program and inform them of the member's claims and pharmacy history, which may indicate that there is a problem with hydroxyurea adherence. (See page 49)

- Offering Multiple Modes of Patient Education and Communication: Patient education is core to the mission of Medicaid health plans. Plans use diverse approaches ranging from web-based, searchable information, to mailed materials in a variety of languages, to personalized interactions with professionals or trained peer educators. Key to these services are providing the education at the health literacy/reading literacy level as well as the appropriate language for the patient.
Best Practice Example: UnitedHealthcare Community & State “Baby Blocks” is an interactive, mobile-optimized incentive program to encourage members to make and keep doctor appointments throughout pregnancy and into the first 18 months of a baby’s life. Once a member is identified as pregnant, Baby Blocks contacts them through member mailings, outreach calls and high volume OB/family medicine practices and community health centers. A member enrolled in Baby Blocks is reminded about her prenatal, post-partum and well-baby appointments and is provided health tips at appropriate points in her pregnancy and her baby’s life. (See page 17)

Connecting Members to Physicians: Many plans have initiatives to connect Medicaid members with a primary care physician. Adherence to preventive and follow-up visits helps to ensure that members have recommended treatments and screenings. Health plans also monitor use of emergency care since frequent use is often a signal that members need help accessing primary care or intensified treatments from their providers. Plans also help to ensure primary care follow up after patients have visited the emergency room or have been admitted to the hospital. The health plan may be the first to find out about urgent visits, either through a bill for services or a call from the hospital and can alert the primary physician of the need to follow up.

Best Practice Example: Amerigroup Corporation developed a reminder program called TXT2Care, which supports patients and helps them gain access to needed services. The TXT2Care pilot program implemented by Amerigroup’s Maryland and Texas (Houston area) health plans explored the use of two-way text messaging as a tool to improve utilization of preventive services, such as annual physician visits and well-child care, for plan members identified as having gaps in their care. The program resulted in approximately 71% of members who responded ‘yes’ to the text from Amerigroup getting their care access needs met. Furthermore, the program made the care management process more productive and more efficient. (See page 52)

Expanding the Care Team: Providing culturally competent care is one of many ways health plans can help build trust in the health care system and improve adherence. In addition to offering information through varied channels (web, text messages, written materials) and in several languages, many plans augment their staff with community health workers or members of the community.

Best Practice Example: DC Chartered Health Plan, Inc. developed Positive Pathways as an evidence-based structural intervention which addresses barriers to HIV medical care for African-American women and very high-risk heterosexual men. Through a network of trained peer Community Health Workers (CHWs) placed in community settings, Positive Pathways identifies out-of-care DC Chartered Health Plan members, builds peer-based trust informs them about living with HIV, provides personalized assistance to help them enter and navigate service systems, and supports them throughout the early part of their medical care until they become fully engaged in treatment. (See page 47)

Accountability for Prevention: Health plans recognize that preventive care is critical to improving health in the long term. Efforts to increase adherence to lifestyle improvements that control weight and promote exercise are expected to have long-term health value. In addition, plans are taking the initiative to increase adherence to recommended clinical screenings, well-child checks and smoking cessation treatments.

Best Practice Example: Breast cancer is the second most common cause of cancer death among African-American women. With an 87% African-American membership, OmniCare Health Plan has engaged women on multiple levels to improve adherence to regular screenings. OmniCare uses multiple campaigns to engage women in our African-American population and educate them about the benefits of regular mammograms and Pap screenings. Strategies include: targeted mailings and follow-up calls; a mobile mammography van at events across the community; partnering with providers to have monthly mammography days; sponsoring events and screenings; direct messaging campaign (mail and calls) identifying women missing both their mammogram and Pap screenings; partnering with OB and PCP sites for scheduled Pap and mammography appointments at each site on the same day; providing PCPs with real time electronic listings of non-compliant members that they can access at their office 24 hours a day, seven days a week. (See page 41)

Community Partnerships: Health plans are connected to the communities they serve. Many plans are partnering with community organizations and schools to develop early interventions focused on adopting healthy behaviors.

Best Practice Example: The Diamond Plan (Coventry Health Care of Delaware) created a three-part program to educate members on exercise, nutrition and fitness. With partners in public agencies, the plan offers youth and adult nutrition education workshops to help limited income, culturally diverse families learn to make nutritious food choices. The plan is also partnering with local fitness instructors and centers to provide classes on rhythm moving, such as Zumba and hip hop, and uses Wii “Dance Dance Revolution” to catch the attention of members and potential members. Programs are offered to schools, Head Start Programs, community centers and public events. Diamond Plan also partners with community agencies and the Baltimore County Parks and Recreation to provide childhood obesity-focused events for members and their families, inviting the entire community to participate. (See page 33)

Conclusion

Improving adherence to clinical treatment and behavior change is an ongoing process. Medicaid health plans are bringing to bear diverse and innovative resources to make a difference: data, staff, educational materials, outreach capability and collaboration with patients, providers and communities. The best practices in the next sections illustrate some of the innovative approaches used by plans to reach members and break down the barriers to adherence. Success of these efforts is rewarded by improved health for members and more efficient use of resources for all of the partners in the Medicaid program. As the Medicaid program continues to grow, health plan innovations are an increasingly important part of their stewardship of the public’s health and health care resources.
Comprehensive Medicaid Managed Care Models: MCOs and PCCMs Operating in the States, 2010*

Several states have modified their approaches to delivering Medicaid managed care services since 2010. Please contact MHPA for the latest information.

SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

PART 2: Adherence Best Practice Submissions

UnitedHealthcare Community Plan

Attention Deficit Hyperactivity Disorder in Children Intervention

DESCRIPTION: In October 2010, UnitedHealthcare Community Plan launched a collaborative (medical/behavioral) intervention for ADHD in children. The objective of the intervention is to promote adherence to ADHD best practices through education and treatment referral for identified UHC Community Plan members between six and 12 years of age. We have a two-prong approach: (1) Member Focused – Telephonic outreach to the parent/guardian to educate about the importance of taking medication as prescribed and having regular follow-up appointments with their Primary Care and/or behavioral provider. We then provide education and assistance based on the conversation; and (2) Provider Focused – mailing to the member’s prescribing provider a UnitedHealthcare ADHD toolkit to provide education of the clinical guidelines and resource assistance (Primary Care Provider/Behavioral Health provider). Our current measurement is the HEDIS measures of adherence to clinical guidelines of the best care for children with ADHD.

RATIONALE: ADHD is the most prevalent behavioral health condition among school-age children. The prevalence of ADHD is generally estimated to be between 3%-5% (APA, 2000) although studies have found prevalence rates spanning 2% to 18% (Hinshaw, Klein, and Abicoff, 1998). This variability is due to a range of factors including gender, race/ethnicity, age, socioeconomic status (Rowland, Lesesne, and Abramowitz, 2002), as well as the parent’s level of education and the family’s state of residence (Centers for Disease Control and Prevention, 2005).

KEY OBJECTIVES:
- Improve the health of the population
- Enhance the patient experience of care (including quality, access and reliability)
- Control or reduce the per capita cost of care or increase efficiency
- Improve delivery of benefits
- Reduce disparities in care of racial and ethnic minorities
- Demonstrate accountability of Medicaid health plans, including fraud and abuse
- Promote adherence to ADHD best practices through education and treatment referral for identified members between six and 12 years of age.

ACTIONS TAKEN: A weekly claims based report detailing the demographics of members who have filled prescriptions for ADHD medications. Quality Improvement staff attempt to identify “new” starts on ADHD medication through a manual review process and direct intervention efforts towards those members. Based on the NCQA HEDIS specifications for Follow-Up Care for Children Prescribed ADHD Medication “new starts” are defined as children with a negative medication history of 120 days (four months) during which time the member had no ADHD medications dispensed for either new or refill prescriptions. Once identified, the parent/guardian will be contacted via phone by Quality staff. During the outreach call, the staff member will confirm with parent/guardian that the member in question is on the identified medication for the purposes of ADHD treatment. The staff will educate the parent/guardian on the following key objectives and rationale.

- The importance of medication adherence — the importance of taking medications as prescribed, the importance of not stopping medications without consulting the prescribing physician including in circumstances when the member is feeling or performing better in school or at home, and the importance of discussing side effects with the prescriber.
- The importance of attending one follow up visit within 30 days with the prescribing physician — staff will attempt to obtain information on whether a follow up appointment has been scheduled and provide assistance in scheduling appointment if needed.
- The importance of adjunctive behavioral health therapy in the treatment of ADHD. Staff will assist in providing referrals for therapy if needed.
- The importance of medication adherence — the importance of taking medications as prescribed, the importance of not stopping medications without consulting the prescribing physician including in circumstances when the member is feeling or performing better in school or at home, and the importance of discussing side effects with the prescriber.
- Promote awareness of national and local ADHD resources and support groups (i.e. www.chadd.org) Children and Adults with ADHD, www.brightfutures.org (Bright Futures), and www.nimh.nih.gov/HealthInformation/adhdmenus.cfm (National Institute on Mental Health).

*Several states have modified their approaches to delivering Medicaid managed care services since 2010. Please contact MHPA for the latest information.

SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.
In an effort to educate providers on the ADHD best practice guidelines staff will send a letter containing those guidelines with additional resources on ADHD to the prescribing physician who treated the identified member.

**OUTCOMES:** The National Committee for Quality Assurance (NCQA) has established a set of measures to monitor treatment adequacy for patients with ADHD.

- The percent of children prescribed an ADHD medication that had at least one follow-up visit with a prescribing practitioner within 30 days (Initiation Phase)
- After the initiation phase, the percent of children that remained on their medications for at least six months and were seen at least twice in the next nine months by a prescribing clinician and/or a non-prescribing behavioral health clinician (Continuation and Maintenance Phase).

These measures are consistent with clinical guidelines of the best care for children with ADHD. The health plan will review quarterly data regarding the rate of successful outreach attempts. Data in the first year of implementation will be used to establish a benchmark for future goals. Additionally any barriers will be identified and discussed. Annual ADHD HEDIS rates will be a guide to determining whether the intervention has had a potential positive impact on HEDIS performance of this metric.

In 2011, a total of 432 members were identified as “new starts on ADHD prescription. Additionally, 328 ADHD toolkits were sent to the member’s prescriber which includes PCPs and psychiatrists. HEDIS measurement will be completed June 2012.

**GEOPGRAPHIC LOCATION OF PROGRAM:** Iowa

**CONTACT:** Nancy Lind  
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**UnitedHealthcare Community & State Baby Blocks**

**DESCRIPTION:** Baby Blocks is an interactive, mobile-optimized incentive program to encourage members to make and keep doctor’s appointments throughout their pregnancy and into the first 15 months of their baby’s life. The goal of the program is to increase prenatal, post-partum, lead testing and well-child HEDIS scores.

**RATIONALE:** Baby Blocks was designed with the following insights about our members:

- Average age of our members giving birth is 21
- 82% of members have cell phones; 70-80% have regular online access and/or smartphones
- Appointment compliance is an ongoing issue
- Members often fail to re-certify for themselves after they give birth and for their babies as they pass through the first year of life

**KEY OBJECTIVES:**

- Identifying and intervening with members at risk for non-adherence
- Identifying and reaching out to members with gaps in adherence
- Identifying and reaching out to providers whose patients have gaps in adherence or omissions of essential therapies
- Implementing reminder programs, incentive programs or other strategies to support patients

**INTERVENTIONS:** Once a member is identified as pregnant, Baby Blocks reaches them through member mailings, outreach calls and high volume OB/family medicine practices and community health centers. Once engaged, members that are enrolled in Baby Blocks are reminded about their prenatal, post-partum and well-baby appointments and are provided health tips at the respective point in their pregnancy/baby’s life.

**OUTCOMES:** Baby Blocks launched in November 2011. The primary outcome metrics for Baby Blocks are improvements in prenatal, post-partum and well-baby visits, which will be measured about nine months into the program. Also, we are tracking enrollment data. In January 2012 (the most recent full month of data), 32% of members identified as pregnant in the pilot markets signed up for Baby Blocks.

**GEOPGRAPHIC LOCATION OF PROGRAM:** Maryland, Ohio, Pennsylvania and Rhode Island

**CONTACT:** Brett Edelson  
Vice President, Children’s Health, UnitedHealthcare Community & State  
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**CareNet (Southern Health Services, Inc.)**

**CareNet Postpartum Care**

**DESCRIPTION:** CareNet has provided a perinatal program for over 10 years. In 2008, we enhanced our program to better identify at-risk mothers. We developed more comprehensive initiatives to improve our outreach to these members, and in 2010, we added a NICU component and increased case management and social worker face-to-face visits to members.

We incorporate aspects of the following perinatal program goals:
- CareNet (healthy moms deliver healthy full-term babies)
- March of Dimes (preterm birth rate and low birth weight)
- Healthy People 2020 (preterm births and low birth weights)

**RATIONAL:** Since the majority of our pregnant moms fall into the high-risk category and our HEDIS® rates for this measure reflated room for improvement, increasing the rate of healthy birth outcomes was identified as important for our members.

**KEY OBJECTIVES:**
- Identifying and intervening with members at risk for non-adherence
- Identifying and reaching out to providers whose patients have gaps in adherence or omissions of essential therapies
- Implementing reminder programs, incentive programs or other strategies to support patients

**INTERVENTIONS:** The elements of our postpartum program include:
- Educational mailings to members
- Communications to providers
- Transportation services (when eligible)
- Home visits
- Member incentive for making and keeping the postpartum appointment
- High-risk OB Case Management
- Postpartum phone calls
- Postpartum depression information/assessments
- Wrap-around mental health services

**Additional Outreach Initiatives** we have implemented include:
- **text4Baby** - A partner in this program since its inception in 2010, we include information on the program in our prenatal and postpartum member materials. We discuss it during home visits, and we have information on the program on our website.
- **Member newsletter** - We include information on healthy pregnancies and follow-up care each year.
- **Provider newsletter** - We remind providers about our maternity incentive program and include information on HEDIS® measures and our rates.

**OUTCOMES:** Our Postpartum Care rate has improved annually over the last three years: 62.6%, 67.29% and 70.63%, respectively, and we have moved from the 10th percentile (HEDIS® 2007) to the 75th percentile (HEDIS® 2011) — which we attribute to the positive effects of our Comprehensive Perinatal Program.

**GEOGRAPHIC LOCATION OF PROGRAM:** Virginia

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**UPMC for You**

**Connected Care™**

**DESCRIPTION:** Connected Care™ is an initiative to improve the connection and coordination of care for those with serious mental illness (SMI) among health plans, personal care physicians (PCP), and behavioral health providers in outpatient, inpatient and emergency department (ED) care settings. Behavioral health is a carve-out for the mandatory Medicaid managed care program in Pennsylvania, thus members would have a different managed care plan for behavioral health (BH) and physical health (PH) care. There were several goals of Connected Care™:

- Decrease PH and BH admission/1000
- Decrease PH and BH readmission/1000
- Increase average number of community days between each PH or BH admission
- Decrease average length of stay
- Decrease ED visits/1000
- Increase the percent of members with at least 3 atypical antipsychotics filled with glucose screen
- Increase the percent of members with at least 3 atypical antipsychotics filled with an annual glucose screen or HbA1c

**RATIONAL:** UPMC for You’s population has a high rate of BH and PH admissions and readmission and emergency room utilization. Historically, there is a coordination gap between physical health (PH) and behavioral health (BH) providers, similar to gaps between other specialists and PCPs. This occurs regardless of financing mechanism. Coordination is a challenge posed by confidentiality provisions.

Increased morbidity and mortality associated with SMI result in high rates of premature death. Those with SMI die 25 to 32 years younger than the general population. This trend has accelerated in recent decades. Most deaths (60% to 70%) result from physical conditions with treatable risk factors, such as metabolic disorders, cardiovascular disease, diabetes and modifiable risk factors such as obesity and smoking.

Their odds of dying from the following causes, compared to the general population are:

<table>
<thead>
<tr>
<th>Cause</th>
<th>Times more likely to die</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td>3.4</td>
</tr>
<tr>
<td>Diabetes</td>
<td>3.4</td>
</tr>
<tr>
<td>Accidents</td>
<td>3.8</td>
</tr>
<tr>
<td>Respiratory conditions</td>
<td>5.0</td>
</tr>
<tr>
<td>Pneumonia, influenza</td>
<td>6.6</td>
</tr>
</tbody>
</table>

Additionally, the introduction of the atypical antipsychotics has resulted in significant clinical advances for individuals with severe mental illness but several of these agents have a variety of significant metabolic health risks associated with them such as weight gain and its related risks for adverse changes in glucose and lipid metabolism. According to literature, patients with mental illnesses such as schizophrenia and bipolar disorder have an increased prevalence of metabolic syndrome and its components, risk factors for cardiovascular disease and type 2 diabetes1. (Newcomer et al.)


**KEY OBJECTIVES:**
- Identifying and reaching out to members with gaps in adherence
- Using care coordination programs to address treatment adherence
- Evaluating the impact of improved adherence on other measures, including hospitalization, ER use, costs and selected health outcome measures
INTERVENTIONS: New processes were implemented to facilitate care coordination among the physical health and behavioral health care management staff and the identification of members who had an inpatient admission or emergency room visit. The care managers were jointly trained on the program and to help the staff from each organization understand the differences in their approach to care management. An integrated care plan was developed that was viewable by staff from both organizations. Data from the two discrete care management systems was merged to create a common view. This helped staff to identify who the member was seeing, the care managers involved with the member, key barriers and a text field for case notes. Members were identified for the program, the care managers discussed the case and determined, based on the member’s existing relationships, the staff member that would take the lead in managing the member. Weekly integrated care team meetings were implemented for the most complex members were discussed. The meeting included medical directors from both organizations, care managers and pharmacists. Information that had been obtained from the member or their providers was discussed along with the review of the member use of services and medication profile. A care plan was developed based on the team’s input. The responsible care manager then facilitated the implementation of the care plan with the member and applicable providers.

To help the member and their providers manage acute episodes of care, daily process were implemented to identify when a Connected Care member was admitted to a physical or behavioral health inpatient facility or had an emergency room visit. This information was shared with the care managers from both organizations and faxed to the member’s behavioral health provider and primary care provider. The care managers would assist with discharge planning and contact the member upon discharge or after the emergency room visit to provide education and care coordination.

A monthly process was implemented to notify the prescribing provider and primary care physician of gaps in filling antipsychotic medications or other medication that are used to treat chronic conditions. In addition to this information, the providers were informed if recommended laboratory tests that help to monitor specific conditions were not done. This includes an annual glucose screening for members on antipsychotics.

Other activities that were implemented to support the program are provided below:
- Consumer group meetings to obtain input on program design and materials
- Using BH providers to help obtain consents
- In 2009 provided $25 gift card incentive to 4,400 members who had a visit with their PCP. In 2010 the incentive was changed to $25 gift card for completing the consent form and enrolling in the program
- 24 hour/day phone line managed by Community Care to answer member questions

The following summarizes activities done to promote provider engagement:
- Mailing sent to PCP’s and BH providers explaining the Connected care program
- UPMC Health Plan and Community Care clinical leadership conducted joint on site visits to high volume PCP offices and BH providers to explain Connected Care and shared materials consumers would be receiving.
- In the first quarter 2010 Community Care met with the BH providers and shared the list of their members so that they could assist in informing them of the program and help in obtaining consents resulting in increased consents.

OUTCOMES:

Baseline: 7/1/08-6/30/09 n = 4,953
First Year: 7/1/09-6/30/10 n = 6,743
Second Year: 7/1/10-6/30/11 n = 8,257

* = statistically significant to baseline
** = statistically significant to first year
*** = statistically significant to both baseline and first year

<table>
<thead>
<tr>
<th>Year</th>
<th># unique members with PH admission</th>
<th>PH Admissions /1000</th>
<th># unique members with BH admission</th>
<th>BH Admissions /1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>692 (12.8%)</td>
<td>273.6</td>
<td>950 (19.2%)</td>
<td>391.0</td>
</tr>
<tr>
<td>1st Year</td>
<td>1,045 (18.8%)</td>
<td>302.7</td>
<td>885 (12.8%)**</td>
<td>240.1</td>
</tr>
<tr>
<td>2nd Year</td>
<td>1,305 (11.0%)**</td>
<td>359.4</td>
<td>918 (11.1%)***</td>
<td>193.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th># unique members with PH and BH admission</th>
<th>% of unique members with PH or BH admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>208</td>
<td>4.2%</td>
</tr>
<tr>
<td>1st Year</td>
<td>196*</td>
<td>2.90%</td>
</tr>
<tr>
<td>2nd Year**</td>
<td>207*</td>
<td>2.50%</td>
</tr>
</tbody>
</table>

- Average Number of Community Days Between each Admission
- Average Length of Stay

Baseline: 52.09 Days 17.47 Days
First Year: 53.18 Days 15.04 Days
2nd Year: 48.54 Days 13.93 Days*

<table>
<thead>
<tr>
<th>Year</th>
<th>ED visits /1000</th>
<th>% unique members with ED visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>1,963.1</td>
<td>2.708 (54.6%)</td>
</tr>
<tr>
<td>1st Year</td>
<td>1,963.8</td>
<td>3.620 (53.7%)</td>
</tr>
<tr>
<td>2nd Year</td>
<td>1,842.4</td>
<td>4.266 (51.7)***</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th># unique members with PH and BH admission</th>
<th># unique members with 3 atypical antipsychotics drug fills with glucose screen</th>
<th>% of unique members with 3 atypical antipsychotics drug fills with glucose screen or HLA**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>1,267**</td>
<td>64.5%</td>
<td>1,285</td>
</tr>
<tr>
<td>1st Year</td>
<td>1,622*</td>
<td>67.47%</td>
<td>1,656*</td>
</tr>
<tr>
<td>2nd Year</td>
<td>1,784*</td>
<td>68.01%</td>
<td>1,817*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th># unique members with PH and BH admission</th>
<th># unique members with 3 atypical antipsychotics drug fills with glucose screen or HLA**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>146 (7.0%)</td>
<td>47.1</td>
</tr>
<tr>
<td>1st Year</td>
<td>288 (2.8%)</td>
<td>877 (5.4%)</td>
</tr>
<tr>
<td>2nd Year</td>
<td>202 (3.4%)</td>
<td>197 (2.5%)</td>
</tr>
</tbody>
</table>

GEORGIC LOCATION OF PROGRAM: Allegheny County, Pennsylvania

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(412) 454-7755, hornd2@upmc.edu
Coventry Health Care of Florida
Coventry Better Health for Kids Program

**DESCRIPTION:** The Coventry Better Health for Kids Program is a community outreach initiative designed to positively impact the health behaviors of children.

The program focuses on the physical and emotional wellness of children to reduce their obesity rates through two components:

- **Physical activity (Play for Better Health)** — getting children moving by promoting the importance of outdoor play
- **Education (Learn for Better Health)** — providing educational programs through local schools and nonprofit organizations focusing on all aspects of healthy lifestyles, including eating right, staying active and abstaining from unhealthy behaviors such as smoking.

**RATIONALE:** In the last two decades, obesity has developed into an epidemic for children in the United States; with the growing popularity of computers, television and video games, children are moving less and weighing more.

**KEY OBJECTIVES:**

- Identifying and intervening with members at risk for non-adherence
- Identifying and reaching out to members with gaps in adherence
- Using and measuring the effect of appropriate patient education

**INTERVENTIONS:**

Play for Better Health

Play for Better Health provides safe play spaces for children in underserved areas. We fund the installation of outdoor play areas for nonprofit organizations that offer on-site programs and services for underserved or financially disadvantaged children.

- **Play for Better Health was developed to fight childhood obesity by promoting outdoor play.** Outdoor play has several fitness benefits including building muscle, burning calories and increasing activity levels. It also helps release stress and promotes sensory learning.
- **According to a 2010 report by the National Wildlife Federation, children spend only four to seven minutes a day in unstructured outdoor play.** In contrast, the Kaiser Family Foundation reported that individuals ages eight to 18 years old are connected to some type of electronic media anywhere from eight to 12 hours a day. Through Play for Better Health, Coventry encourages children to put down the electronics and step away from computers and televisions.
- **Launched in 2011, the first recipient of the Play for Better Health program was the Miami Seventh Day Baptist Church.** Deeply rooted in the community and located in an impoverished area, the church provides crisis and support services for families and children.
- **In addition to a monetary contribution, the Play for Better Health program has a volunteer component, in which Coventry employees help with the play space installation by performing basic tasks such as cleaning away debris, organizing materials and mixing concrete.** The volunteer component provides an opportunity for employees to make a positive difference in the community and helps Coventry forge compassionate partnerships that extend beyond a single financial contribution.
- **Nonprofit agencies can apply for the Play for Better Health program through an application process.** The program is open to 501(c)(3) classified organizations that provide onsite programs and/or services for children ages three to 12 years old. Applications are available online at chcflorida.com.

Learn for Better Health

The Learn for Better Health initiative creates partnerships with local schools and nonprofit organizations to provide educational programs that focus on all aspects of healthy lifestyles. Through the programs, children learn the importance of eating right, staying active and abstaining from unhealthy behaviors such as smoking.

In 2011, as part of the Learn for Better Health program, Coventry in partnership with Young At Art Children’s Museum, launched Alice’s Wonderscapes — an early childhood outreach program for Broward County Public Schools. Based on the popular children’s fantasy *Alice in Wonderland,* Alice’s Wonderscapes promotes health education through literacy, physical movement and art-based learning activities that teach children about nutrition and the importance of being physically active.

Alice’s Wonderscapes targets children in pre-K through second grade and is comprised of four one hour sessions:

- **Down the Rabbit Hole: Children use motor skills to crawl through a magic tunnel and learn colors and shapes**
- **Alice’s Outdoor Maze and Garden: Kids get moving as they skip through a maze and explore the beauty of the outdoors, learning about food that can be grown in a garden and creating nature rubbings**
- **Mad Hatter Kitchen & Tea Party: Students learn about healthy food choices by creating a healthy mixed media soup collage**
- **Alice’s Queen of Hearts: Discovering numbers and shapes while being active, children create and play with their own croquet sets**

**OUTCOMES:** When schools face a budget crisis, art and physical education programs are usually the first to be eliminated. Through Alice’s Wonderscapes, Coventry Health Care of Florida is helping to bring the arts back to schools, while also integrating health education and physical activity. Alice’s Wonderscapes is available to all Broward County Public Schools throughout the academic year.

**GEOGRAPHIC LOCATION OF PROGRAM:** Florida

**CONTACT:** Cathy Moffitt, MD
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(954) 858-3329; cmoffitt@cvty.com

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For more information, contact Cathy Moffitt, MD at (954) 858-3329; cmoffitt@cvty.com.
OmniCare Health Plan

Doc Bear Shuffle: Addressing Obesity Amongst Youth

DESCRIPTION: OmniCare Health Plan has taken action to address the lack of movement and unhealthy eating habits of our youth. The Doc Bear Shuffle has been designed to encourage physical activity and healthy eating among children and adults. Our goal is for schools and communities to incorporate the Doc Bear Shuffle into their curriculum — education is the key to reducing obesity in our communities and the Doc Bear Shuffle is a fun way to convey this very important message.

RATIONALE: With our State, ranking 10th in the nation for obesity and 33% of our population in Wayne County reported as being obese or overweight, it’s imperative that we create some solutions for this growing epidemic. We developed the Doc Bear Shuffle to address the sedentary lifestyle of our youth.

Children in the United States today are less physically active than they were a generation ago, and as a result, many are developing preventable diseases such as type 2 diabetes and high blood pressure, etc, that are related to obesity. The incidence of obesity only increases when children and adults do not “move,” eating the wrong foods and sitting in front of a TV or video game for hours.

Studies have shown, obese children and adolescents are more likely to have risk factors associated with cardiovascular disease (such as high blood pressure, high cholesterol, and Type 2 diabetes) than other children and adolescents. Eighteen percent of children enrolled in Head Start Programs have body mass index (BMI) levels at or above the 95th percentile, indicating that they are obese.

The Task Force on Childhood Obesity recently reported to President Obama that one of every three children in the United States is overweight or obese (May 2010). According to the Centers for Disease Control and Prevention (2010), 1 of 7 low-income, preschool-aged children in the United States are obese. Obese children are at risk for health problems during their youth and as adults. In fact, 40% of obese children and 70% of obese adolescents will become obese adults.

OmniCare has taken action to address the unhealthy activity and eating habits of our youth. Research shows obesity can be reduced with continued practice of three simple elements:

- Constant movement
- Reducing the fat and sugar intake
- Laughter to reduce the stress

We wanted to provide an alternative, the Doc Bear Shuffle—a simple dance routine that encourages physical activity, proper nutrition, and laughter.

KEY OBJECTIVES:

- Identifying and intervening with members at risk for non-adherence
- Identifying and reaching out to providers whose patients have gaps in adherence or omissions of essential therapies
- Using and measuring the effect of appropriate patient education

INTERVENTIONS: The Doc Bear Shuffle song and dance routine were created in 2010 and debuted in Detroit at the Winter Festival for 500 disabled youth.

- OmniCare distributed the DVD to local schools, Head Start programs, and community centers.
- The Doc Bear Shuffle song and dance routine were created in 2010 and debuted in Detroit at the Winter Festival for 500 disabled youth.
- Several community centers were asked to participate, and children and adults performed the dance.
- Matrix Human Services provided the studio for the children to practice and to film.
- The YMCA opened their gym for filming.
- Numerous landmarks around the State of Michigan allowed us to film on location.
- OmniCare distributed the DVD to local schools, Head Start programs, and community centers.

OUTCOMES: Helping the community understand that good nutrition and exercise improves their health, impacting the lives of children and resulting in healthier communities.

- Since its release, schools and community centers have included the Doc Bear Shuffle video in their curriculum to encourage their students and participants to exercise frequently.
- To date, more than 1,500 DVDs of the Doc Bear Shuffle video have been distributed to families, children, community groups, and schools in the State of Michigan.

GEOGRAPHIC LOCATION OF PROGRAM: Michigan

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Manager, Community Development, OmniCare Health Plan
(313) 465-1590; dbyrdrd@cvty.com
**UPMC for You**

**Doula Care**

**DESCRIPTION:** In August 2006, UPMC for You and the Birth Circle implemented Doula services for the UPMC for You pregnant women who resided in the Braddock area of Allegheny County. This intervention was designed to address the disparities in birth outcomes between Caucasian and African American members in that area. The Doulas were recruited from the community, received training, and became certified Doulas. They assist members in making and keeping prenatal and postpartum appointments and well appointments for newborns, answer questions to reduce anxiety and fears regarding pregnancy and delivery, and help members understand the changes in their life as a result of having a child.

This program has evolved since it was implemented. In 2011 the focus of the Doula program was modified. The program now allows for any member to be referred for Doula services. The woman must reside in Allegheny County and deliver at one of hospitals where the Doulas have approval to attend deliveries (UPMC Mercy, Magee Women’s Hospital of UPMC, West Penn Hospital, Forbes Regional Hospital or Midwife Center for Birth and Women’s Health). A member may be referred to the Doula program from a UPMC for You maternity case manager, a provider, a community agency, by the member, or be identified by a Doula. There are currently eight Doulas from this agency providing services to UPMC for You members in Allegheny County.

The specific aims of the Doula program are as follows:
- Provide additional support to women throughout their pregnancy, at delivery and during the postpartum period while in the hospital.
- Help the mothers establish pediatric care for their infants.
- Link members to UPMC for You Case Managers during their pregnancy or postpartum period for additional clinical or social support and care coordination for the mother and her newborn.
- Improve birth outcomes such as decreasing the number of low birth weight babies, decreasing NICU admissions, decreasing premature deliveries.

**RATIONALE:** After detailed analysis of birth outcomes in Allegheny County, it was noted that there was a disparities gap for birth outcomes between African Americans and Caucasians. This intervention was designed to address the disparities in the Braddock community, part of the Pittsburgh metro area, which is a poor community with a high African American population. Later this program was introduced to the entire county.

**KEY OBJECTIVES:**
- Identifying and reaching out to members with gaps in adherence.
- Using care coordination programs to address treatment adherence.
- Addressing cultural and ethnic disparities as factors in non-adherence.

**INTERVENTIONS:** The Doula contacts the member, informs her of the details of the program, and enrolls the member in the program. The Doula meets with the member during her prenatal period to provide education on what to expect during the pregnancy, labor and delivery, and to help the woman prepare a birth plan. The Doula reinforces provider prenatal instructions such as tobacco cessation. The Doula can be present with the woman during her delivery to offer support and encouragement. The Doula will also see the mother in the hospital prior to discharge to reinforce postpartum care for the mother and well child care for their newborn.

In addition to providing delivery support for enrolled women, a Doula may respond to a provider’s request for a Doula to be present to support other members during their delivery. These are occasions when the maternity provider determines that the woman’s experience in the delivery room may be enhanced by the presence of a Doula. The request must come from one of the four (4) hospitals that the Doula has been approved to attend a delivery.

**OUTCOMES:** During the six-month period of 7-1-10 to 12-31-10, 306 women were referred to the Doula Program, 100 women enrolled into the program with 113 declining and 93 Unable to Reach (UTR). The enrollment rate for women referred to a Doula during this time period was 32.68%. Below are some of the outcomes from the 7-1-10 to 12-31-10 analysis.

<table>
<thead>
<tr>
<th>Post-Partum Visits by Doula for Enrolled Women from 4-1-2009 to 6-30-2010</th>
<th>Post-Partum Visits byDoula for Enrolled Women from 7-1-2010 to 12-31-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliveries</td>
<td>327</td>
</tr>
<tr>
<td>Post-Partum Visits</td>
<td>152</td>
</tr>
<tr>
<td>% of Total Deliveries</td>
<td>46.48%</td>
</tr>
<tr>
<td>Doula At Delivery</td>
<td>149</td>
</tr>
<tr>
<td>% of Total Deliveries</td>
<td>45.57%</td>
</tr>
</tbody>
</table>

In both periods, mothers who had a Doula saw a 10 percentage points higher rate for post-partum visits then mothers not enrolled in the Doula program.
### Birth Outcomes Enrolled Women from 4-1-2009 to 6-30-2010

<table>
<thead>
<tr>
<th>Birth Outcomes</th>
<th>Doula Referred / Enrolled but not Full Service</th>
<th>Full Service*: Referred and Enrolled in Doula Program</th>
<th>Doula Referred / Enrolled but not Full Service</th>
<th>Full Service*: Referred and Enrolled in Doula Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # of Babies Born</td>
<td>245</td>
<td>90</td>
<td>70</td>
<td>26</td>
</tr>
<tr>
<td>Low Birth Weight Babies (&lt;2500 grams)</td>
<td>30</td>
<td>12.24%</td>
<td>9</td>
<td>10.00%</td>
</tr>
<tr>
<td>Premature Births (&lt;34 weeks gestation)</td>
<td>16</td>
<td>6.53%</td>
<td>8</td>
<td>8.89%</td>
</tr>
<tr>
<td>Newborn Visit with PCP within 30 days</td>
<td>198</td>
<td>80.82%</td>
<td>76</td>
<td>84.44%</td>
</tr>
<tr>
<td>Babies with NICU Admissions</td>
<td>40</td>
<td>16.33%</td>
<td>14</td>
<td>15.56%</td>
</tr>
<tr>
<td>NICU/Neonatal Average LOS</td>
<td>12.76</td>
<td>12.53</td>
<td>15.16</td>
<td>14.00</td>
</tr>
</tbody>
</table>

Compared to mothers who enrolled but did not have a doula, those who used the full service Doula program saw improved outcomes for:
- Babies who were low birth weight
- PCP visits within 30 days of birth
- NICU Admissions
- Decrease NICU average length of stay

### Geographic Location of Program
Allegheny County, Pennsylvania

### Contact Information
Debra Smyers
Senior Director, Program Development, UPMC for You
(412) 454-7755; hornd2@upmc.edu

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### UPMC for You Emergency Room Diversion Grant

**Description**: UPMC for You, in collaboration with the PA Department of Public Welfare and UPMC McKeesport hospital was awarded a $1.67 million grant by the Centers for Medicare and Medicaid Services (CMS) to reduce the cost of emergency room (ER) care in McKeesport, Pennsylvania. The grant’s objectives are to reduce the overall cost of ER care, primarily by decreasing the incidence of non-emergent patient care visits to the UPMC McKeesport Emergency Department, that could otherwise be provided in a more appropriate and supportive patient care setting.

**Rationale**: Medicaid recipients use the ER for nonurgent health care for a variety of reasons such as easy access and not being connected to a primary care physician. This results in expensive and inappropriate use of health care services. The McKeesport community is part of the Pittsburgh metro area which suffered significant economic decline with the downturn in the Steel Industry in the 1980’s and the subsequent closure of the National Tube Works which once employed 10,000 individuals. UPMC McKeesport provides patient care for the underserved population within the McKeesport community. An assessment of the use of the ER at UPMC McKeesport indicated that approximately 37% of visits were non-emergent in nature.

**Key Objectives**:
- Evaluating the impact of improved adherence on other measures, including hospitalization, ER use, costs and selected health outcome measures
- Using and measuring the effect of appropriate patient education

**Interventions**: Interventions for the ER Diversion Grant include:
- Providing resource-sensitive care that will assist in reducing the cost of care by implementing a more focused, protocol-driven care model in the ER.
- Identifying patients at triage and during treatment for referral to and intervention by a Patient Navigator. The Patient Navigator position was implemented in May 2009. This position works closely with the mid-level providers in the ER Fast Track Area and in the acute section of the ER. The Patient Navigator helps to schedule appointments with primary care practitioners (PCPs) and conducts follow-up with both the patients and practices. In addition, the Patient Navigator provides patients with direct one-on-one education and supplemental educational materials aimed at helping them to find alternatives to ER care, providing resource support based on individualized needs, and following-up to determine if the patient did obtain that care.
- Establishing alternative service providers (PCP locations) to accommodate same-day and walk-in appointments with the use of mid-level providers, including Certified Registered Nurse Practitioners or Physician Assistants. The initiative included three PCP practices to partner in this program.
- Collaborating to provide better coordination of care for patients with both medical and behavioral health care needs.
- Conducting a focused media and communications campaign aimed at educating the targeted audiences about the more appropriate use of ER services and about alternative care options.

**Outcomes**:
- **Patient Navigator**
  - Through December of 2011, the Patient Navigator has:
    - Engaged over 6,000 individuals – approximately 56% of which are Medicaid.
    - Approximately a 70% success rate in getting patients to keep follow-up appointments.

- **Mid-Level Practitioners**
  - Two of the three PCP practices received mid-level practitioner support. The third PCP practice did not receive mid-level practitioner support, which affected the overall success of the program. Through December of 2011:
    - The mid-levels have seen almost 4,600 sick office visits.
The analysis of the ER program was included five (5) distinct periods due to the introductions of different interventions. The dates of Service (DOS) for the five (5) periods were:
- Period 1 – DOS 6/01/2008 through 11/30/2008 (Pre-Program Period)
- Period 2 – DOS 6/01/2009 through 11/30/2009 (Patient Navigator Program Period)
- Period 3 – DOS 1/01/2010 through 6/30/2010 (Mid-level Practitioner Period)
- Period 4 – DOS 7/01/2010 through 12/31/2011 (Post Implementation Period)
- Period 5 – DOS 1/01/2011 through 6/30/2011

Key findings for all UPMC Health Plan products include:
- Members associated with one of the three sites saw a decrease in the level 1 & 2 ER visits per 1,000, from 105.79 in the pre-program period to 77.37 in the post-implementation period representing a 26.9% decrease.
- At the three PCP practices for all UPMC Health Plan products, the PCP sick visits per 1,000 increased in the post-implementation period compared to the pre-program period by 2.4%.
- At the three PCP sites across all lines of business, the ratio of PCP sick visits per 1,000 to non-emergent ER visits (level 1 & 2) per 1,000 increased from 7.2 in the pre-program period to 9.6 in the post-implementation period representing a 33.2% increase.
- Looking at data for UPMC Health Plan’s Special Needs Product (SNP) and Medicaid (MA) product at the two PCP practices which received the mid-level practitioner intervention, the following results were seen:

### Non-Emergent ER Visits Per 1000 (Periods = 6 mos.)*

<table>
<thead>
<tr>
<th>Product</th>
<th>Practice</th>
<th>Period 1</th>
<th>Period 2</th>
<th>Period 3</th>
<th>Period 4</th>
<th>Period 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNP</td>
<td>Practice A</td>
<td>747.72</td>
<td>862.62</td>
<td>375.59</td>
<td>455.70</td>
<td>556.89</td>
</tr>
<tr>
<td>MA</td>
<td>Practice A</td>
<td>537.98</td>
<td>602.96</td>
<td>502.98</td>
<td>443.16</td>
<td>494.30</td>
</tr>
</tbody>
</table>

### PCP Sick Visits Per 1000 (Periods = 6 mos.)

<table>
<thead>
<tr>
<th>LOB</th>
<th>Practice</th>
<th>Period 1</th>
<th>Period 2</th>
<th>Period 3</th>
<th>Period 4</th>
<th>Period 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNP</td>
<td>Practice A</td>
<td>5306.99</td>
<td>4504.79</td>
<td>4976.53</td>
<td>4911.39</td>
<td>6592.61</td>
</tr>
<tr>
<td>MA</td>
<td>Practice A</td>
<td>1921.63</td>
<td>1998.03</td>
<td>2106.12</td>
<td>1878.09</td>
<td>2186.10</td>
</tr>
</tbody>
</table>

Non-emergent ER visits per 1000 data for the third PCP practice (Practice C) who did not receive mid-level practitioner support, is represented in the table below and showed:
- An increase in non-emergent ER visits per 1000 for MA and SNP; however there was some decline over the final two periods for the MA membership.
- For the SNP population, Practice C increased in ER visits per 1000 while the other two practices who received mid-level support showed a decreased rate.
- For the Medicaid population, all three practices showed an overall decrease in non-emergent ER visits per 1000 from period 1 to periods 5 and 6.

### Non-Emergent ER Visits Per 1000 (Periods = 6 mos.)

<table>
<thead>
<tr>
<th>LOB</th>
<th>Practice</th>
<th>Period 1</th>
<th>Period 2</th>
<th>Period 3</th>
<th>Period 4</th>
<th>Period 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNP</td>
<td>Practice C</td>
<td>472.05</td>
<td>498.19</td>
<td>367.59</td>
<td>632.62</td>
<td>617.78</td>
</tr>
<tr>
<td>MA</td>
<td>Practice C</td>
<td>699.39</td>
<td>711.43</td>
<td>811.33</td>
<td>601.50</td>
<td>590.29</td>
</tr>
</tbody>
</table>

Similarly, there were offsetting trends for Practice C in terms of PCP sick visits per 1000 for SNP and MA. SNP showed a positive trend while MA showed inconsistent trends over time. The other two practices showed similar trends.

### PCP Sick Visits Per 1000 (Periods = 6 mos.)

<table>
<thead>
<tr>
<th>LOB</th>
<th>Practice</th>
<th>Period 1</th>
<th>Period 2</th>
<th>Period 3</th>
<th>Period 4</th>
<th>Period 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNP</td>
<td>Practice C</td>
<td>4844.72</td>
<td>4418.47</td>
<td>3693.88</td>
<td>5950.88</td>
<td>5840.87</td>
</tr>
<tr>
<td>MA</td>
<td>Practice C</td>
<td>6257.67</td>
<td>4594.29</td>
<td>3778.49</td>
<td>4248.12</td>
<td>4473.79</td>
</tr>
</tbody>
</table>

**GEOGRAPHIC LOCATION OF PROGRAM:** McKeesport, Pennsylvania

**CONTACT:** John Lovelace  
President, UPMC for You  
(412) 454-7832 ; lovelacejg@upmc.edu

*The non-emergency ER visits were calculated for the members who selected these practices as their PCP.*
Coventry Health Care of Kansas and HealthCare USA of Missouri (formerly Family Health Partners)

Health Education Videos for the Low Health Literate

DESCRIPTION: In December 2009, CoventryCares of Kansas began uploading health education videos on our English language YouTube channel located at www.youtube.com/cmfhp1 in an effort to cost-effectively:

- Educate low health literate members on their benefits
- Provide tips on being the best patient possible
- Help members navigate the healthcare system
- Provide members with access to our disease management experts

With a unique, high-touch care management program, Coventry offers face-to-face care management using Registered Nurses for high-risk members with complex needs. Care managers can use the videos to supplement face-to-face patient education, and can also use it to address health information needs of patients at the patient’s choice of mode and timing. As of January 2012, our English YouTube channel contains over 60 videos with over 26,000 views directly from the channel. Spanish language videos are also available.

RATIONALE: The videos have been developed to cover frequently asked questions regarding specific diseases and conditions with information from our Nurse Care Managers and Health Coaches, providing easy access to low health literate members.

KEY OBJECTIVES:

- Using and measuring the effect of appropriate patient education
- Addressing cultural and ethnic disparities as factors in non-adherence
- Evaluating the impact of improved adherence on other measures, including hospitalization, ER use, costs and selected health outcome measures

INTERVENTIONS: With a unique, high-touch care management program, we offer face-to-face care management using Registered Nurses for high-risk members with complex needs. Our nurses are separated into specialty areas for care management, including:

- Pediatrics
- Adult
- Lead toxicity
- ER
- Asthma
- Diabetes
- High Risk OB

The process to develop the videos first begins with audio podcasts:

- The podcasts are interviews with the Nurse Care Managers and Health Coaches covering frequently asked questions regarding the specific disease or condition.
- The information is recorded in an interview format with the Nurse Care Managers and Health Coaches focusing on their area of expertise.

Even though our goal is to do as much face-to-face interaction as possible, we felt that the interviews would be an effective way to either remind members of their interaction with our staff or reach those our staff were not able to touch personally. The audio programs are available via:

- Streaming or downloading from our website
- A CD that can be requested
- Giveaways at community events or in some medical offices

The videos are produced using smaller portions of the audio programs. We match stock photos with the words being spoken, the pictures helping members more easily identify with the words of the medical expert. The videos are also downloaded onto DVD and provided to members and others within our territory at community outreach events, in case they do not have access to the Internet.

Since late 2010, we have also provided a Spanish-language YouTube channel with videos directed at our Spanish speaking population. These videos are on the same topics as our English videos, but simply reproduced using Spanish narrative. We encourage the use of the videos by respected blogs, websites and other entities focused on educating the low health literate.

OUTCOMES: As of January 2012, our English YouTube channel contains over 60 videos with over 26,000 views directly from the channel. The Spanish channel contains 23 videos with over 11,000 views from the channel. Our videos have also been uploaded and picked up by many other sites including:

- ICYOU.com
- The Doctor’s Videos
- VideoJug
- Yahoo videos
- Metacafe
- VideoMD

From what can be tracked, we have achieved over 120,000 world-wide views of our videos. Therefore, we feel we are reaching even more individuals than the over 200,000 members we serve in Missouri and Kansas. We look forward to the continued growth of this program into 2012 and beyond.

GEOGRAPHIC LOCATION OF PROGRAM: Kansas and Missouri

CONTACT: Chris Beurman
Community Relations Manager, CoventryCares of Kansas
(816) 559-9455; cbeurman@fhp.org

Diamond Plan (Coventry Health Care of Delaware)

Health, Nutrition and Child Obesity

DESCRIPTION: With the lack of movement and unhealthy eating habits common among our youth, the Diamond Plan created a three-part program to educate members on exercise, nutrition and fitness and encouraging them to:

- Develop healthier eating choices
- Set and achieve realistic weight loss goals

RATIONALE:

- The Task Force on Childhood Obesity recently reported that one out of three children in the United States is overweight or obese (May 2010).
- According to the Centers for Disease Control and Prevention (CDC), in 2010, 1 of 7 low-income, preschool-aged children in the United States are obese.
- 18% of children enrolled in Head Start Programs have body mass index (BMI) levels at or above the 95th percentile, indicating that they are obese.
- 40% of obese children and 70% of obese adolescents will become obese adults, resulting in increased health risk.

The videos have been developed to cover frequently asked questions regarding specific diseases and conditions with information from our Nurse Care Managers and Health Coaches, providing easy access to low health literate members.

KEY OBJECTIVES:

- Using and measuring the effect of appropriate patient education
- Addressing cultural and ethnic disparities as factors in non-adherence
- Evaluating the impact of improved adherence on other measures, including hospitalization, ER use, costs and selected health outcome measures

INTERVENTIONS: With a unique, high-touch care management program, we offer face-to-face care management using Registered Nurses for high-risk members with complex needs. Our nurses are separated into specialty areas for care management, including:

- Pediatrics
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- ER
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- 18% of children enrolled in Head Start Programs have body mass index (BMI) levels at or above the 95th percentile, indicating that they are obese.
- 40% of obese children and 70% of obese adolescents will become obese adults, resulting in increased health risk.
KEY OBJECTIVES:

- Identifying and intervening with members at risk for non-adherence
- Implementing reminder programs, incentive programs or other strategies to support patients
- Using and measuring the effect of appropriate patient education

INTERVENTIONS:

Eating Well & Staying Healthy on a Budget Program

Partnering with the Expanded Food and Nutrition Education Program (EFNEP), which provides youth and adult nutrition education workshops to help limited income, culturally diverse families learn to make nutritious food choices at the grocery store, restaurants, and at fast food places, we provide classes on shopping for and preparing healthy meals at affordable prices. In these classes participants learn:

- How to establish a plan and prepare simple, tasty, nutritious snacks and meals
- Safe food handling, preparation and storage
- How to stretch food dollars to last the whole month

The workshop consists of a series of six one-hour adult sessions or four one-hour youth sessions of fun and culturally appropriate nutrition lessons offered by nutrition assistants who work through University of Maryland’s Cooperative Extension. EFNEP provides all the food materials for the classes. Lesson topics include:

- Smart snacking
- Increasing variety of fruits and vegetables
- Increasing whole grains
- Food label reading
- Healthier fast food choices
- Decreasing fat in the diet
- Food safety

Promoting this program to our Medicaid population is critical because lower-income kids not eating the right kinds of foods can lead to obesity-related conditions such as:

- Hypertension
- Diabetes
- Heart disease

We are also providing workshops to promote healthy eating habits for families who struggle with food insecurity, which affects one out of every five children:

- We are setting up six locations at key areas of Baltimore to hold the two-hour sessions four times a week
- We provide gift cards and completion certificates to participants who attend every class

Move to the Rhythms Fitness Program

Partnering with local fitness instructors or fitness centers to provide classes on rhythm moving, these classes focus on simple exercise movement such as Zumba, a mixture of Latin America, hip hop and fitness. Wii “Dance Dance Revolution” and other movement games are added to the mix of rhythms and movements to catch the attention of members and potential members.

Combining easy-to-learn steps with fantastic rhythms for a great total body workout, this fitness program helps promote healthy quality of living with the Diamond Plan while focusing on obesity in the family unit.

We bring these activities to:

- Fitness centers
- Schools
- Head Start programs
- Community centers
- And more!

Consisting of six classes (two sessions a week for three weeks), sessions start with the participant recording weight and BMI and a realistic weight loss goal to achieve by the end of the sixth class. We then award prizes for the “Biggest Losers” in reaching their weight loss goals.

Additionally, the program:

- Brings a Wii game to well-attended events to promote healthy fitness
- Sends out monthly health tips to members via text message
- Creates a format with up-to-date, fun equipment for all ages and abilities. Sessions are designed to:
  - Improve muscle awareness
  - Promote weight loss
  - Reinforce the importance of health and well-being
  - Decrease obesity among adults and children
  - Encourage children to use their imagination and learn that exercise can be fun every day
  - Target a member’s entire family unit

Healthy Hoppity Hop “Obesity Focused”

Diamond Plan partners with community agencies and the Baltimore County Parks and Recreation to provide childhood obesity-focused events for our members and their families, inviting the entire community to participate. Attendees’ parents are treated to a healthy cooking demonstration by EFNEP and gifted with a free lunch bag. Community agencies are invited to help promote fitness, dental, heart health, housing, Head Start and much more.

The children are separated into age groups for activities such as:

- Egg hunt (find the gold egg and win a prize!)
- Sack races, jump ropes, hula hoops
- Healthy snacks and drinks

OUTCOMES: Through the program, we are helping the community understand good nutrition and exercise improves their health, which will impact the lives of children and result in healthier communities overall. With a current focus on members with high blood pressure and diabetes, the program is currently assisting approximately 489 members.

GEOPGRAPHIC LOCATION OF PROGRAM: Maryland

CONTACT: Kalena Johnson (McCrae)
Director of Medicaid Services, Diamond Plan (Coventry Health Care of Delaware)
(410) 910-7112; kpjohnson@cvty.com
Health Partners of Philadelphia, Inc.

Health Partners’ Healthier You Disease Management Programs

**DESCRIPTION:** The Health Partners’ Healthier You Disease Management Programs (asthma and diabetes) are designed using evidence-based guidelines in support of the practitioner-patient relationship. The overall goal is to improve health outcomes and empower our members to achieve self-management of their lifelong condition.

Health Partners measures the effectiveness of their programs not only by trending the HEDIS specific measures overall in the health plan, but also by trending those same measures for members in disease management programs.

To date, the HEDIS rates for members who are case managed indicate a higher level of compliance for specific measures, as the grid below demonstrates. This document will describe some of the innovative approaches used to achieve these rates.

**RATIONALE:** Year after year, Health Partners has seen an upward trend in the number of members diagnosed with either asthma or diabetes, with many members having more than one co-morbidity. In addition, an opportunity existed to educate clinical staff to align their management approach with national guidelines. Condition-specific HEDIS measures for Comprehensive Diabetes Care and Use of Appropriate Medications by People with Asthma were presenting a neutral trend line.

### Diabetes Program

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9,240</td>
<td>11,407</td>
<td>13,648</td>
</tr>
<tr>
<td>Percentage</td>
<td>5.8%</td>
<td>6.7%</td>
<td>8.4%</td>
</tr>
</tbody>
</table>

Goal: To improve the reported HEDIS rates for Comprehensive Diabetes Care by 2% points.

### Asthma Program

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10,645</td>
<td>22,548</td>
<td>24,384</td>
</tr>
<tr>
<td>Percentage</td>
<td>12.5%</td>
<td>13.3%</td>
<td>15.0%</td>
</tr>
</tbody>
</table>

Goal: To improve the reported HEDIS rates for Use of Appropriate Medications by People with Asthma by 2% points.

**KEY OBJECTIVES:**
- Identifying and intervening with members at risk for non-adherence
- Identifying and reaching out to members with gaps in adherence
- Using care coordination programs to address treatment adherence
- Evaluating the impact of improved adherence on other measures, including hospitalization, ER use, costs and selected health outcome measures
- Using and measuring the effect of appropriate patient education

**INTERVENTIONS:** In order to address these undesired trends, Health Partners implemented processes that attributed to the overall success of the programs. Some of these coordinated processes included:

- Partnering with community pharmacies that not only filled and refilled prescribed medications but coordinated all the member’s medication needs at one pharmacy, and worked with the practitioner to understand the member’s prescription needs. In addition, the community pharmacy was available to coordinate the necessary durable medical equipment needed to dispense the medication, provide education and ensure ongoing prescription refills. Many times they delivered the medication to the member’s home.
- Implementing the program at a high volume pediatric site, managed by a Practice-Based Care Manager who provides assistance to the member and office staff to ensure that the member’s health care needs are being met. They also make sure the member understands the practitioner’s instructions, educates the member about their condition, refers them to disease management for continued follow up and connects the member to a community pharmacy.
- Providing auto messaging reminders to members who were non-adherent to disease specific topics
- Partnering with a Social Economic Center to provide health education sessions in a high volume member zip code area.
- Partnering with a Social Economic Center to provide health education services in a high volume member zip code area.
- Hiring a dietician who provides nutritional case management services, and in addition to her case load, educates members in the community, including food preparation demonstrations. In addition, we hire nurses and social workers.
- Utilizing a health educator at after school programs and summer camps to promote preventive health care and disease-specific education.
- Providing auto messaging reminders to members who were non-adherent to disease specific topics
- Increasing the number of smoking cessation counselors throughout Health Partners so that more staff is available to help the members enrolled in our Healthier YOU program stop smoking.
UnitedHealthcare Heart Smart Sisters™
Heart Smart Sisters™

DESCRIPTION: UnitedHealthcare Heart Smart Sisters™ is a national bilingual signature cardiovascular risk screening, prevention education and outreach initiative with activities focused and customized to help women live healthier lives. This community-wide initiative was created to address the prevalence of heart disease and health disparities among African-American and Latino women to invoke change and raise awareness in targeted areas of our community that are most vulnerable to this health epidemic. Heart Smart Sisters™ partners with other organizations that share a common goal to advocate for women to become knowledgeable about heart disease prevention and the associated risk factors.

The goal is to educate women about the risk factors for developing heart disease and empowers them to make the necessary lifestyle changes to improve their individual health status and reduce the overall incidence of heart disease in their community, to affect behavioral change through information, education and linkages to physicians and a medical home and to “know their numbers.”

The initiative has resulted in reaching out to more than 1,000 women and families impacting behavioral patterns by targeting outreach to several churches and community-based organizations through educational events, town hall forums and health screenings.

RATIONAL: Heart disease is the number one killer of women in America. More women die of cardiovascular disease than breast cancer, stroke and lung cancer combined. Each year, heart disease kills approximately 450,000 women in the U.S., which is about one every minute. Sixty-four percent of women who die suddenly of coronary heart disease have no previous symptoms. According to the American Heart Association, more than 41 million American women are living with one or more types of cardiovascular disease. Research indicates that there is an alarmingly high rate of heart disease, obesity, diabetes and generally poor health among how African American and Latino women and heart disease affects women of color disproportionately.

Targeting education and outreach to women who generally make the health and nutrition decisions for the family and improving their health status will keep the “entire” family healthy.

KEY OBJECTIVES:
- Identifying and intervening with members at risk for non-adherence
- Identifying and reaching out to members with gaps in adherence
- Increasing provider involvement in treatment adherence through use of medical homes or payment incentives
- Using care coordination programs to address treatment adherence
- Evaluating the impact of improved adherence on other measures, including hospitalization, ER use, costs and selected health outcomes measures
- Addressing cultural and ethnic disparities as factors in non-adherence
- Using and measuring the effect of appropriate patient education

INTERVENTIONS:
Building of Collaborative Teams
The purpose of the teams is to ensure key stakeholder commitment, and create an environment for building community, networking and leveraging best practices. The teams consist of faith-based and community-based organizations, providers and local grassroots organizations that serve targeted populations. Train and integrate health plan outreach staff with community based providers and local grassroots organizations. The collaborative team model is designed to ensure key stakeholder commitment and credibility with community participants.

<table>
<thead>
<tr>
<th>HEDIS 2011 Measure</th>
<th>Data Collection Method</th>
<th>HEDIS 2011 Eligible Population</th>
<th>HEDIS 2011 Members in CCMS DM That Are HEDIS Compliant (%)</th>
<th>HEDIS 2011 Reported Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate Medications for Asthma (Ages 5-50)</td>
<td>Admin</td>
<td>5,049</td>
<td>93.33%</td>
<td>89.29%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - BP Control &lt;140/80</td>
<td>Admin</td>
<td>8,456</td>
<td>0.00%</td>
<td>0.04%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - BP Control &lt;140/90</td>
<td>Admin</td>
<td>8,456</td>
<td>0.00%</td>
<td>0.05%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Eye Exam</td>
<td>Admin</td>
<td>8,456</td>
<td>63.11%</td>
<td>53.61%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - HbA1c &lt; 8</td>
<td>Admin</td>
<td>8,456</td>
<td>42.46%</td>
<td>51.31%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - HbA1c Poor Control</td>
<td>Admin</td>
<td>8,456</td>
<td>56.61%</td>
<td>35.41%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - HbA1c Test</td>
<td>Admin</td>
<td>8,456</td>
<td>90.26%</td>
<td>80.37%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - LDL-C &lt;100</td>
<td>Admin</td>
<td>8,456</td>
<td>43.16%</td>
<td>40.10%</td>
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<tr>
<td>Comprehensive Diabetes Care - LDL-C Screening</td>
<td>Admin</td>
<td>8,456</td>
<td>82.83%</td>
<td>77.70%</td>
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<tr>
<td>Comprehensive Diabetes Care - Monitor Nephropathy</td>
<td>Admin</td>
<td>8,456</td>
<td>93.27%</td>
<td>84.52%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - BP Control &lt;140/80</td>
<td>Hybrid</td>
<td>548</td>
<td>44.44%</td>
<td>31.57%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - BP Control &lt;140/90</td>
<td>Hybrid</td>
<td>548</td>
<td>59.26%</td>
<td>51.28%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Eye Exam</td>
<td>Hybrid</td>
<td>548</td>
<td>70.37%</td>
<td>64.05%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - HbA1c &lt; 8</td>
<td>Hybrid</td>
<td>548</td>
<td>37.04%</td>
<td>52.37%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - HbA1c Poor Control</td>
<td>Hybrid</td>
<td>548</td>
<td>48.15%</td>
<td>36.32%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - HbA1c Test</td>
<td>Hybrid</td>
<td>548</td>
<td>88.89%</td>
<td>83.03%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - LDL-C &lt;100</td>
<td>Hybrid</td>
<td>548</td>
<td>40.74%</td>
<td>42.88%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - LDL-C Screening</td>
<td>Hybrid</td>
<td>548</td>
<td>77.76%</td>
<td>79.93%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Monitor Nephropathy</td>
<td>Hybrid</td>
<td>548</td>
<td>96.30%</td>
<td>86.86%</td>
</tr>
</tbody>
</table>

OUTCOMES: The grid below demonstrates the effectiveness of the program based on selected HEDIS measures. In addition, members who have been intensively case managed by HP staff demonstrate an even higher rate of compliance.

GEOGRAPHIC LOCATION OF PROGRAM: Philadelphia, Pennsylvania

CONTACT: Dr. Mary C. Stom, MD
CMO & Senior Vice President of Healthcare Management, Health Partners of Philadelphia, Inc. (215) 991-4102; mcstom@healthpart.com

Data Collection Method
Philadelphia, Pennsylvania

HEDIS 2011

Appropriate Medications for Asthma (Ages 5-50) Admin 5,049 93.33% 89.29%
Comprehensive Diabetes Care - BP Control <140/80 Admin 8,456 0.00% 0.04%
Comprehensive Diabetes Care - BP Control <140/90 Admin 8,456 0.00% 0.05%
Comprehensive Diabetes Care - Eye Exam Admin 8,456 63.11% 53.61%
Comprehensive Diabetes Care - HbA1c < 8 Admin 8,456 42.46% 51.31%
Comprehensive Diabetes Care - HbA1c Poor Control Admin 8,456 56.61% 35.41%
Comprehensive Diabetes Care - HbA1c Test Admin 8,456 90.26% 80.37%
Comprehensive Diabetes Care - LDL-C <100 Admin 8,456 43.16% 40.10%
Comprehensive Diabetes Care - LDL-C Screening Admin 8,456 82.83% 77.70%
Comprehensive Diabetes Care - Monitor Nephropathy Admin 8,456 93.27% 84.52%
Comprehensive Diabetes Care - BP Control <140/80 Hybrid 548 44.44% 31.57%
Comprehensive Diabetes Care - BP Control <140/90 Hybrid 548 59.26% 51.28%
Comprehensive Diabetes Care - Eye Exam Hybrid 548 70.37% 64.05%
Comprehensive Diabetes Care - HbA1c < 8 Hybrid 548 37.04% 52.37%
Comprehensive Diabetes Care - HbA1c Poor Control Hybrid 548 48.15% 36.32%
Comprehensive Diabetes Care - HbA1c Test Hybrid 548 88.89% 83.03%
Comprehensive Diabetes Care - LDL-C <100 Hybrid 548 40.74% 42.88%
Comprehensive Diabetes Care - LDL-C Screening Hybrid 548 77.76% 79.93%
Comprehensive Diabetes Care - Monitor Nephropathy Hybrid 548 96.30% 86.86%
OmniCare Health Plan
Improving Women’s Health through Screenings

DESCRIPTION: OmniCare uses multiple campaigns to engage women in our African-American population and educate them about the benefits of regular mammograms and Pap screenings.

- Our goals for 2011 were a Breast Cancer Screening rate of 60% and a Cervical Cancer Screening rate of 77%.
- With screening rates increasing significantly since 2008, our 2010 results of a Breast Cancer Screening rate of 52.5% and a Cervical Cancer Screening rate of 73.5% are strong indicators of our success toward our 2011 goals.

RATIONALE: Breast cancer is the second most common cause of cancer death among African-American women.

- Although there has been a decrease in the death rate since 1992, the average rate for African-American women is lower than for white women, and they continue to have a 37% higher death rate than white women.
- African-American women are more likely to be diagnosed with and die from cervical cancer than white women—primarily due to a lack of screening and unequal access.

There is no guarantee to prevent breast and cervical cancer.

- However, regular screenings are an important step in early detection.
- A woman’s best overall preventive strategy is to reduce her known risk factors such as:
  - Avoiding weight gain
  - Engaging in regular physical activity
  - Minimizing alcohol intake

With 87% of our membership African American, OmniCare Health Plan has engaged women on multiple levels to get them in for regular screenings.

KEY OBJECTIVES:

- Implementing reminder programs, incentive programs or other strategies to support patients
- Identifying and reaching out to members with gaps in adherence
- Addressing cultural and ethnic disparities as factors in non-adherence

INTERVENTIONS: OmniCare has created target goals for both measures above the HEDIS® 75th percentile and has established workgroups to work towards continuous improvement in each measure.

OmniCare uses multiple campaigns to engage women in our large African-American population and educate them about the benefits of regular mammographies and Pap screenings.

- Targeted mailings and follow-up calls to chronically non-compliant members.
- A mobile mammography van at events across the community.
- Partnering with providers to have monthly mammography days throughout 2010 and 2011.
- Sponsoring a community walking event and screening called “Sista Strut” with Clear Channel radio for the past three years during Breast Cancer Awareness month.
- Direct messaging campaign (mail and calls) started in June 2010 identifying women who were missing both their mammogram and Pap screenings.
- Partnering with University Physician’s Group and Northland Radiology (mammograms) and an OB and PCP site (Pap screenings) for scheduled appointments at each site on the same day.
  - Transportation was arranged and we helped shuttle members between the two sites.
  - This event ran ten times since its inception and over 43 women have had both screenings and additionally 89 women have had a mammogram.
- Providing PCPs with real-time electronic listings of non-compliant members that they can access at their office 24 hours a day, 7 days a week.
- Providing our Customer Service department with pop-up indicators showing if a member who has called is non-compliant so the customer service representative can discuss getting a screening with the member.

Community Education & Outreach
Screen, educate and motivate women who are known to be disproportionately suffering from cardiovascular disease and its risk factors (obesity, hypertension, diabetes, and smoking).

Medical Literacy Training
Conduct presentations for providers and staff to facilitate patient self-management awareness and education which is critical to all risk/disease management and wellness programs, ongoing practitioner training in evidence based practice guidelines to facilitate patient self-management awareness and education.

Capacity Building/Evaluation
Promote the development of a market specific collaborative to include researchers, physicians, safety net health centers and other provider-related organizations focused on reducing health disparities and health inequities. These strategic partnerships will provide for:

- Research & Evaluation
- Development and assessment of performance measures and key clinical outcomes based upon predefined metrics.

Leverage UHC’s Brand in Cardiovascular Outreach
Assist to communicate initiative to members, providers and community at large through direct contact, special events & mass media.

OUTCOMES: We have tracked community attendee numbers reached, brand awareness and visibility which have lead to promoting member acquisition and retention. The program can be tailored to meet the specific needs of the health plan and their market whether building community and/or measuring health outcomes and reduction of ER visits.

The program provides the opportunity to partner with local organizations and build community relationships in potential geographic location of program.

CONTACT: Charlisa Watson
Vice President Community Development, UnitedHealthcare Heart Smart Sisters®
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OmniCare has created target goals for both measures above the HEDIS® 75th percentile and has established workgroups to work towards continuous improvement in each measure.

OmniCare uses multiple campaigns to engage women in our large African-American population and educate them about the benefits of regular mammographies and Pap screenings.
OUTCOMES: Both Breast and Cervical Cancer screenings are measured annually as part of HEDIS®.

OmniCare has shown continuous improvement in both measures over the past three years, and statistically significant* improvement in the Breast Cancer Screening rate from 2008 to 2010.

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<thead>
<tr>
<th></th>
<th>2008</th>
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<th>NCQA 75th% 2009</th>
<th>2011 Target Goal</th>
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<tr>
<td>BCS*</td>
<td>49.4%*</td>
<td>49.8%</td>
<td>52.5%*</td>
<td>57.4%</td>
<td>60%</td>
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<td>CCS</td>
<td>67.5%</td>
<td>69.8%</td>
<td>73.5%</td>
<td>73.2%</td>
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We are encouraged by our improved rates, and continue to seek opportunities to engage, educate, and provide easy access for our members.

GEOPGRAPHIC LOCATION OF PROGRAM: Michigan

CONTACT: Pat Beard
Manager, Member Outreach, OmniCare Health Plan
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Select Health of South Carolina
In Control Diabetes Care Management

DESCRIPTION: South Carolina ranks eighth highest in the nation for percentage of population with diabetes, according to the most recent Diabetes Fact Sheet by the South Carolina Department of Health and Environment Control.

ACTIONS TAKEN: First Choice members with diabetes were stratified into low-risk and high-risk groups, based on resource utilization rates (ER visits, medications, inpatient stays) and predictive modeling scores. Both the low-risk and high-risk members received educational mailings throughout the year. These mailings included a welcome packet of comprehensive diabetic information for newly diagnosed plan members, quarterly printed material informing members about necessary health management topics and periodic member newsletter articles relating to seasonal diabetic topics of interest.

High-risk members were further screened by a nurse case manager to determine the candidates most appropriate for case management intervention. The nurse collaborated with the member or caregiver and the primary care provider, specialist or other providers to develop an appropriate individualized plan of care to match the member’s needs. High-risk members engaged in disease case management received focused educational mailings when appropriate based on the diabetic care plan. Mailings focused on healthier eating habits, promoting physical activity, smoking cessation, medication compliance, screening tests, home monitoring glucose testing and managing stress.

In 2010, a supplemental mailing was sent to all members with diabetes to educate about the need for cholesterol screening, what the results indicate and ways to improve their LDL results if elevated. For members with diabetes, lowering the LDL is essential to lower the risk of a heart attack or stroke.

The plan’s members with diabetes in all risk categories were additionally mailed a Vision Care Directory with a listing of all participating vision care providers by county in 2010. Members were encouraged to select a provider and schedule a yearly retinal eye exam as recommended by the American Diabetes Association.

In 2011, the first in a series of three supplemental mailings was titled, “Knowledge is Power.” It encouraged members to know their “numbers” and emphasized the importance of knowing their blood pressure, weight, A1C, LDL, glucose and urine for micro albumin. Members also were encouraged to get a yearly foot exam.

The next mailing included a diabetes checklist for members to take with them each time they visited their doctor. The checklist covered the important test members should have to keep diabetes under control.

“Power Over Diabetes” was the final mailing in the series. It shared helpful information about common problems related to diabetes and ways to prevent or reduce them.

In addition, a video on “Type 1 Diabetes in Children and Teens” was placed on the plan’s website to provide additional member education and support. To see the video and other resources and support related to First Choice’s In Control Diabetes Care Management, visit us on the web at: http://www.selecthealthofsc.com/firstchoice/member/eng/health/diabetes/index.aspx

OUTCOMES: Select Health achieved significant improvement in 2011 Healthcare Effectiveness Data and Information Set (HEDIS®) results (measurement year 2010) for the following diabetes measurements from the previous measurement year:

- Members receiving HbA1c testing increased from 80.8% to 83.3%.
- Members with poor HbA1c control (>9) decreased to 47.13% from 57.65% (decrease denotes better performance).
- Members with an LDL C screening (<100) increased to 28.16% from 20.71%.
- Retinal eye exams increased to 61.69% from 55.2%.

CONTACT: Janis Power
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WellPoint State Sponsored Business  
Member Health Education Program  

DESCRIPTION: In our experience, we have found that some members don’t know who their doctor is. Others don’t like their primary care physician (PCP) and aren’t aware that they can change their doctor. And then there are others who think that the emergency room is their only option for medical care. One internal study showed that almost 20% of ER visits involved avoidable medical services across WellPoint-affiliated health plans. The WellPoint State Sponsored Business (SSB) Health Management and Education team was established to give members correct information about these issues, about ER use and about common health conditions like asthma, diabetes, heart disease and prenatal care/maternity.

The Health Management and Education (HME) Programs are dedicated to providing comprehensive health education programs and enhancing the health status of its members through culturally appropriate customer-focused and customer-driven services. Operating under the direction of a Medical Director and Operations Vice President, a staff of trained Patient Education Coordinators assists members. “I am getting the sense that a lot of our members are lost and intimidated by the health system,” said one SSB patient education coordinator. “They don’t understand how the health system works. I’ve seen cases where a member isn’t happy with their primary care provider and not getting any results when seeking treatment.”

KEY OBJECTIVES: (1) To educate members on appropriate access and utilization of care; (2) To educate members on the importance of establishing a medical home in a primary care setting; and (3) To support continuity of care by reinforcing the importance of a follow-up visit with a PCP after an ER visit, regardless of the non-emergent nature of the ER visit.

The program addresses the following MHPA Best Practice priorities:

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

INTERVENTIONS: The SSB Patient Education Coordinators provide information to members, assist them in resolving issues with their providers and benefits and refer them to appropriate programs to help them achieve their health goals. Members are stratified by condition severity through an analysis of medical and claims records, missed services and other factors. HME programs include:

- Condition Care
- Emergency Room Program
- Healthy Habits Count for You and Your Baby
- Health Education Classes

OUTCOMES: All programs help educate members who in turn are better equipped to get the right health care in the right setting at the right time. For instance, the Emergency Room (ER) Program helps members understand appropriate emergency department use and provides information on ER alternatives. Members who have an established relationship with a trusted primary care provider are much less likely to use the emergency department for conditions that don’t require expensive emergency treatment. Members are identified for the program through a variety of methods — from claims, physician and self-referrals, ER census data and referrals from other WellPoint SSB care management programs. Depending on the severity of their condition, they may receive educational mailings, outreach calls or referrals to Case Management. For all of these programs, the team updates health care providers on current clinical practice guidelines for health conditions and provides them information on their patients who have been enrolled in the Member Education programs.

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Centene Corporation  
Nurtur’s Diabetes Program  

DESCRIPTION: Health Coaches who are Certified Diabetes Educators teach participants and/or their parent or caregiver how to control blood glucose levels, comply with recommended screenings, promote healthy eating habits, and encourage regular physical activity. Our diabetes program provides health coaching and support delivered through telephonic coaching and educational materials. We address life barriers, improve self-management skills, and promote adherence to prescribed treatment guidelines in order to minimize the development and/or progression of diabetic complications.

ACTIONS TAKEN: Members are identified for enrollment based on medical and pharmacy claims data. Members may also be referred to the program by a health plan physician, case manager or self-referral. An introductory mailing is sent to targeted members and health plan physicians announcing the program and informing members or caregivers they will receive a phone call. Telephonic outreach begins seven days after the introductory mailing is sent and several attempts to contact a member by telephone are made. Members who do not respond to telephonic outreach are sent a postcard encouraging enrollment. Once contact is made, the program is explained to members, eligibility is confirmed and a health assessment is initiated to identify clinical risk, education needs, and assign the member to a Certified Diabetes Educator. The Health Coach will complete an assessment and develop an individualized care plan based on the member’s or caregiver’s knowledge of their condition, lifestyle behaviors and readiness to change. Internal clinical guidelines are developed from nationally-recognized, evidence-based guidelines published by the American Diabetes Association.

The Health Coach uses a variety of creative tools to ensure the members are getting the educational materials in a format that fits them best. The program uses MP3 players for those with literacy issues. For members without safe, reliable phone access, a pre-programmed cell phone is given to them loaded with our Diabetes Management book (which received the Merit Award for the 2011 Web Health Awards) as well as other podcasts on wellness and managing their disease. The phones also include videos on diabetes and insulin as well as a link to the American Diabetes Association. A trial of members with smart phones is currently underway in one of our health plans. These phones contain application materials in general categories: calorie counting, meditation music, medicine reminder and sugar tracking.

OUTCOMES: Our review consisted of 6256 members from six health plans enrolled in our diabetes health coaching program as compared to a matched control group. The average time in health coaching was 244 days. Participants in the program had a 26% decrease in diabetes-related admissions per 1000 claimant years (p<.001) as compared to the matched control group. Diabetic complication-related admissions per 1000 claimant years decreased by 23.4% (p<.001). HbA1c testing increased by 11% as compared to the control group (p<.001).

CONTACT: Dan Cave  
President and Chief Executive Officer, Nurtur  
(860) 676-3601; dcave@nurturehealth.com

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<thead>
<tr>
<th>Control Group</th>
<th>Participant Group</th>
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<tr>
<td>Diabetes-Related Admissions per 1000 claimant-years</td>
<td>510</td>
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<tr>
<td>410</td>
<td>340</td>
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<td>310</td>
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Value is statistically significant
UnitedHealthcare Community & State
Pediatric Asthma – Pilot Initiative

DESCRIPTION: UnitedHealthcare Community & State launched the Pediatric Asthma – Pilot Initiative to improve engagement of children and families in self-management activities for asthma. The two primary components of the program include dissemination of the child-specific “A is for Asthma” materials (http://www.sesamestreet.org/parents/topicsandactivities/toolkits/asthma) created with Sesame Workshop, the nonprofit organization behind Sesame Street, and a customized asthma outreach program. The program has been launched in three pilot markets.

RATIONAL: Our data shows that children less than five years of age have the highest asthma related utilization including emergency department visits per 1,000, hospitalizations per 1,000 and medical spend. There were limited interventions or outreach aimed specifically at this population.

KEY OBJECTIVES:

- Identifying and intervening with members at risk for non-adherence
- Identifying and reaching out to members with gaps in adherence
- Identifying and reaching out to providers whose patients have gaps in adherence or omissions of essential therapies
- Evaluating the impact of improved adherence on other measures, including hospitalization, ER use, costs and selected health outcome measures
- Using and measuring the effect of appropriate patient education

INTERVENTIONS: There are two primary components of the program:

- “A is for Asthma” materials (http://www.sesamestreet.org/parents/topicsandactivities/toolkits/asthma) were created with Sesame Workshop, the nonprofit organization behind Sesame Street, to educate children and families about asthma in an engaging, child-focused medium. These materials are available online to the public and we send them directly to members under the age of five who have been identified as asthmatic.
- We have launched customized asthma outreach approaches designed to align the health plan with our members, providers and the local community. Members and their families are educated about the importance of early identification, treatment and follow up support for asthma. Following the use of the ER, children and their families receive direct outreach from the health plan to follow up with their primary care and/or specialist providers for maintenance care. Information on utilization of services is also provided to physicians to aid them in supporting the child with asthma.

Among our efforts to support providers and members in Pennsylvania, we deliver objective four-to-six-month medication reconciliations, based on real-time pharmacy claims information, identifying the medications filled and how often they are filled. These reports help providers assess medication compliance/adherence, any inaccurately filled medications, identify other prescribers to coordinate care with and can be discussed with the member to provide further education and reinforcement, if necessary.

OUTCOMES: To date, in our three pilot markets we have mailed 7,630 “A is for Asthma” newsletters and Asthma Action Plans to children under the age of five. In Rhode Island, our team contacted children/families under the age of 12 who had been seen in the ER for an asthma-related visit and they successfully reached 60% of those identified and directed them to a local asthma education program as well as encouraged a follow-up visit with their primary care provider. As the program develops, we are looking to see improved outcomes in asthma-related emergencies visits and hospitalizations, and increasing the number of children with a primary care provider visit after an emergency visit or hospitalization. We are also looking to collaborate with high-volume providers to tailor their member outreach efforts and to meet the local needs of the community.

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DC Chartered Health Plan, Inc.
Positive Pathways

DESCRIPTION: Positive Pathways is an evidence-based structural intervention which addresses barriers to HIV medical care for African-American women and very high-risk heterosexual men in the same social and sexual networks as the primary target population to protect and improve the health of both men and women at a population level. These persons live in the poorest neighborhoods of Washington, DC (Wards 4-8) and are often difficult to reach. Through a network of trained peer Community Health Workers (CHWs) placed in community settings, Positive Pathways will identify out-of-care DC Chartered Health Plan, Inc. (Chartered) members, build peer-based trust and inform them about living with HIV, provide personalized assistance to help them enter and navigate service systems, and support them throughout the early part of their medical care until they become fully engaged.

RATIONAL: With one-in-20 residents estimated to be living with HIV/AIDS, the District of Columbia has the worst local HIV/AIDS epidemic in the country, an epidemic that is highly generalized into the heterosexual population in poor areas of the city. In addition, spatial analysis of viral load data at a population level show a correlation between poverty and HIV as well as poverty and ineffective engagement in HIV care and treatment, particularly for African-Americans, women, heterosexuals and injection drug users (IDUs). Overall, at least 7,040 individuals in DC had unmet HIV care in 2009 — 46% based on available case data. Through the model, Positive Pathways will effectively engage at least 700 people in HIV care per year, of which at least 75% will be women.

KEY OBJECTIVES:

- Identifying and reaching out to members with gaps in adherence
- Implementing reminder programs, incentive programs or other strategies to support patients
- Evaluating the impact of improved adherence on other measures, including hospitalization, ER use, costs and selected health outcome measures

INTERVENTIONS: Two CHWs are co-located with the Chartered case and disease management team. A seamless workflow has been created where cases are referred to the CHWs and care coordination occurs between the Chartered and Positive Pathways teams. Twice a week, the CHWs go out into the community to meet face-to-face with members. Support is provided to the members to include going to appointments with them, appointment reminders and connecting them to necessary services to address varied psychosocial needs.

OUTCOMES:

RESULTS:

- 18 members enrolled in Positive Pathways.
- 168 attempts (phone and door-to-door) and 18 face-to-face home visits.
- The Team has tasked members to Substance Abuse programs, and to PCP appointments.
- Two members are now in an outpatient drug program that would not have been in a drug program if not encouraged by our CHW. She discussed with them her experience with drugs and the importance of getting off of drugs and getting the needed support to be able to do that. One of the two members lives in Berry Farms and wants to move out because of the heavy drug use and selling, so she has been referred to Social Work for housing.
- Another one of our members has been HIV+ and dating his girlfriend for 5 years and had not told her of his status. He was able to tell her with the CHW’s encouragement and the girlfriend remains negative and they practice safe sex. Both of them call every now and then to speak with the CHW.
- There are other members who are now engaged in care and going to their PCP and Infectious Disease appointments.

Clinical outcomes are being tracked and will be reported in another 90 days (stable or reduced viral load, appointments kept for primary care, infectious disease and age appropriate preventive screening.)
Evaluation
Chartered is a participant in the evaluation process with the Washington AIDS Partnership and Institute for Public Health Innovation. During the Formative Phase, the senior technical advisor for evaluation will provide leadership for a community-based participatory research (CBPR) process in which the lead partner, coordinating and collaborating partners, and representatives from the CHWs and consumer groups refine the evaluation plans. It is anticipated that a one-group, longitudinal design will be used for the CHW training and its effects of the CHW strategy on clients’ engagement in medical care, adherence to treatment, and access of other community resources. The CHWs and clients will serve as their own “comparison” group, with pre-/post-tests of knowledge, skills and professionalism for the CHWs and changes in quality of life, attitudes toward the healthcare system, goal setting, and health outcomes for the clients. The evaluation will also track baseline and follow-up measures annually at the system level (e.g., community viral load by population group and ward, and new cases of HIV infection and AIDS cases). In both the Formative and Implementation Phases, mixed-methods approaches will be used with quantitative data (secondary analyses and project-specific measures) and qualitative data (document review, observations, and individual and group discussions). The DC Department of Health has committed to assist with evaluation, including gathering and analyzing data on viral loads, CD4 counts, and service utilization for Positive Pathways clients and at a population level.

Prelimarily, it is expected that the review will address these key questions, among others with the program sponsors:

- Training process and outcomes: What are the characteristics of CHW training and support? Is there evidence of increased knowledge, skills, and professionalism?
- Service process documentation: How do CHWs interact with clients? What is the place of service, type of service, duration of interaction with participants, and length of engagement between CHWs and clients?
- Intermediate outcomes: What is the impact of CHWs on utilization of healthcare services and community resources and client goal setting?
- Short- and long-term health outcomes: What is the impact of CHWs on access to care, treatment adherence and health outcomes? What is the impact on total and mean viral load at population levels? Have new AIDS cases decreased among heterosexuals in Wards 5-8? Have new HIV infections decreased?
- Systems-level outcomes: Has viral load mapping become institutionalized as a planning tool? How have the connectedness and interactions among CBOs and medical providers changed? Has a network of CHWs developed? Have training systems been developed and institutionalized?

GEOPGRAPHIC LOCATION OF PROGRAM: Washington, DC

CONTACT: Karen M. Dale Executive Vice President, DC Chartered Health Plan, Inc. (202) 326-8741; kdale@chartered-health.com

Centene Corporation
Sickle Cell Program - Hydroxyurea Utilization and Compliance in a Medicaid Population

DESCRIPTION: Our goal was to develop a comprehensive program to identify and engage our sickle cell Medicaid members and increase the use of hydroxyurea in this population. The program has resulted in almost five times more members being enrolled in care management (from 6.3% to 29.1% over the past four years) and we have seen the percentage of sickle cell members taking hydroxyurea more than double during this same time period (from 7.9% to 19.8%).

RATIONALE: It has been demonstrated that the use of hydroxyurea in certain subsets of sickle cell patients has resulted in significantly fewer episodes of acute chest syndrome, vaso-occlusive painful crises, blood transfusions, as well as fewer ED and inpatient visits. There is also evidence that it may increase survival. This translates into health care savings as well as improved wellness and quality of life for our members. In 2008, we had 6.3% of our 775 sickle cell members in care management and 7.9% of them were taking hydroxyurea. As more and more research and evidence came out regarding the importance of hydroxyurea in both adult and childhood sickle cell patients, we determined we needed to take a proactive approach at educating and promoting appropriate use of this medication. We felt we could make an impact on this patient population through a comprehensive program including case management and care coordination specifically aimed at improving adherence to treatment with this important medication.

KEY OBJECTIVES:

- Identifying and reaching out to members with gaps in adherence
- Using care coordination programs to address treatment adherence
- Identifying and reaching out to providers whose patients have gaps in adherence or omissions of essential therapies
- Identifying and intervening with members at risk for non-adherence
- Increasing provider involvement in treatment adherence through use of medical homes or payment incentives
- Implementing reminder programs, incentive programs or other strategies to support patients
- Evaluating the impact of improved adherence on other measures, including hospitalization, ED use, costs and selected health outcome measures
- Addressing cultural and ethnic disparities as factors in non-adherence
- Using and measuring the effect of appropriate patient education

INTERVENTIONS: Through the use of proprietary business solutions we have been able to identify the members who have sickle cell disease. We then identify usage and compliance with hydroxyurea. Additionally, we analyze a member’s claims for ED, inpatient admissions, outpatient visits, preventative care gaps and narcotics usage. We aggressively try to locate each member and engage them in care management when appropriate. Over the last 12 to 18 months, we have attempted to place a larger focus on hydroxyurea adherence. We’ve educated our case managers on the medication and its uses. We also have paid particular attention to members with frequent vaso-occlusive crises who do not have evidence of regular use of hydroxyurea. Home visits by our MemberConnections® representatives help identify social, literacy and other barriers that may be impeding that member’s care. Outreach to providers with a letter or call has been done to let them know about the care management program and inform them of the members claim and pharmacy history which may indicate that there is a problem with hydroxyurea adherence. We provide members with education on their condition through multiple channels including hand delivered health literate items; our book “Living Well with Sickle Cell”, MP3 players; and, for those needing a phone, the ConnectionsPlus® Sickle Cell Phone with podcasts, an audio version of our book and links to helpful websites.

OUTCOMES: As shown in the graphs on following pages, currently we have 19.8% of our sickle cell members on hydroxyurea and 29.1% are in care management. Our Mississippi Health Plan is leading the way with 32.8% of their sickle cell members on hydroxyurea and 70.9% in care management. Our goal is to see this degree of intervention in this high dollar population throughout Centene health plans.
From 2008 to 2011, the prevalence of sickle cell disease in our membership has stayed relatively stable between 0.6% and 0.8% of our population. During that time, we have experienced a 11.9% increase in hydroxyurea use throughout all of our health plans. Half of that increase (6.4%) has occurred in the most recent year and is attributed to our recent focus on hydroxyurea adherence.

We have also experienced an increase in care management which follows a similar pattern. From 2008 to 2011, we have seen the percentage of sickle cell members in case management increase by 22.8%, with well over half of that increase (16.9%) occurring during the most recent year.

Our health plans care for a large population of members with sickle cell anemia. With care coordination, steerage to centers of excellence, preventive care, the use of hydroxyurea and education, we believe we can have a significant impact on the quality of life for our members. By targeting a specific intervention — improving hydroxyurea treatment percentage and adherence, and using an aggressive program to identify the members and reach them and their providers in a personalized, effective way, we expect to see less ED visits, less admissions and better control of this disease in our members.

GEOGRAPHIC LOCATION OF PROGRAM: St. Louis, Missouri

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Amerigroup
TXT2Care

DESCRIPTION: In order to identify and assist members at risk for non-adherence and with demonstrated gaps in adherence to their care, Amerigroup Corporation developed a reminder program called TXT2Care, which supports patients and helps them gain access to needed services. The TXT2Care pilot program implemented by Amerigroup’s Maryland and Texas (Houston area) health plans explored the use of two-way text messaging as a tool to improve utilization of preventive services, such as annual physician visits and well-child care, for plan members identified as having gaps in their care. The program resulted in approximately 71% of members who responded ‘yes’ to the text from Amerigroup getting their care access needs met. Furthermore, the program made the care management process more productive and more efficient.

RATIONALE: Amerigroup developed a method to improve communication and care coordination on behalf of members with gaps in the treatment adherence. A survey of plan members indicated that two-way texting was a preferred communication channel.

KEY OBJECTIVES:
- Identifying and intervening with members at risk for non-adherence
- Identifying and reaching out to members with gaps in adherence
- Implementing reminder programs, incentive programs or other strategies to support patients

INTERVENTIONS: As a way to improve communication with members and target better adherence among members with specific gaps in care, Amerigroup piloted a new initiative in its Maryland and Texas (Houston area) markets that utilized two-way text messaging-based communication. Amerigroup determined the feasibility of implementing such a program by first surveying its members on preferred approaches and then obtaining member opt-in for enrollment in a texting pilot. As a result of this groundwork, Amerigroup, in conjunction with vendor partners, developed a messaging process that avoided the use of protected health information in the text message and allowed for member opt-out/out to the TXT2Care program. Any member who chose to participate in the program received a message reminding the member of the need to schedule their annual appointments, and was offered help in scheduling such appointments. If a member responded ‘yes’ to the text message he or she received, Amerigroup would immediately contact that member and provide assistance in making appointments or otherwise meeting their care access needs.

OUTCOMES: The TXT2Care pilot program had positive results in two key areas. First, members were very responsive to the new method of text communication. As a result, members who otherwise would have experienced gaps in their care and treatment were able to receive reminders of upcoming appointments and receive assistance setting up appointments as needed. Based on initial findings, approximately 71% of members who responded ‘yes’ to the text from Amerigroup had their care access needs met. Second, the use of text messaging proved to be a more efficient and effective way to help manage the care of members. This approach was more direct and timely than other labor- and time-intensive methods of member engagement. Both Amerigroup plans in Maryland and Texas observed that members frequently commented on the speed of the response to their requesting help. In addition, Amerigroup staff noted that members who had asked for assistance via text, and were then contacted by Amerigroup, were typically very positive about our offers of assistance. This was a significant improvement in the experience Amerigroup representatives have when, working from a gap in care list, generate outbound calls in an attempt to assist patients in obtaining necessary care. In effect, the member’s positive response to the Amerigroup text served as a ‘priming response’ and created a situation in which the subsequent Amerigroup call occurred in a context tilted toward a positive response.

Key success factors included: addressing member opt-in issues, HIPAA compliance, work flow and processes that allowed for immediate Amerigroup responsiveness to member text, and close work with network providers allowing for appointment access. Project Team Members were Charles Gross, Catherine Mitchell, Jack Young and Steve Whitehead.

GEOPGRAPHIC LOCATION OF PROGRAM: Maryland and Texas (Houston area) health plans

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UnitedHealthcare Community Plan of Wisconsin
Universal Tracking Database (UTD)

DESCRIPTION: UnitedHealthcare Community Plan of Wisconsin tracks ED utilization through UnitedHealthcare’s Universal Tracking Database (UTD). Within UTD, ED utilization can be tracked at the household (family) and individual level. Households with high ED utilization were identified for outreach. That outreach consisted of live calls to assure that all members of the household were aware of their assigned Primary Care Providers and were aware of the availability of our 24-hour Nurseline. In addition, these households received refrigerator magnets with the phone number for Nurseline and other educational materials regarding appropriate ED use. Year over year ED utilization decreased by 6.8 percent during the five-month period at the end of 2011 subsequent to the initiation of the household based outreach.

RATIONALE: Research indicates that many ED visits are associated with diagnoses that are treatable within a Primary Care setting. UnitedHealthcare Community Plan developed an intervention that would target ED utilization while achieving the greatest possible return on investment (ROI). Based on research that suggested that ED utilization is similar among family members, UnitedHealthcare identified households with high ED use. These households were targeted for telephonic outreach and educational mailings.

KEY OBJECTIVES:
- Identifying and intervening with members at risk for non-adherence
- Identifying and reaching out to members with gaps in adherence
- Evaluating the impact of improved adherence on other measures, including hospitalization, ER use, costs and selected health outcome measures
- Using and measuring the effect of appropriate patient education

INTERVENTIONS:
- Identified families/households with high ED utilization (>5 visits in a 12-month period)
- Live outreach calls to:
  - Assure all members of household have Primary Care Physicians
  - Education on appropriate ED utilization
  - Information on availability of 24/7 Nurseline
- Households received information packets regarding appropriate ED utilization, information about Nurseline and refrigerator magnets with Nurseline information.

OUTCOMES: Outreach calls to high ED utilizing households were placed each month starting in mid-July of 2011. From August 2011 through December 2011, the overall ED utilization rate per 1,000 members decreased by 6.8% year over year in the regions where the household based intervention was implemented.

GEOPGRAPHIC LOCATION OF PROGRAM: Southeast Wisconsin

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PART 3: Resources for Plans, Patients, Providers and Policymakers

The following resources may offer ideas to health plans, policymakers and others on the types of resources available to promote adherence. These resources can help patients understand and begin to adopt all of the elements of treatment — behavior and medication-related — that can help promote better health. Resources are available in many different languages and for various patient populations and conditions. This is not an exhaustive list. We encourage readers to use this as a starting point to develop more targeted adherence initiatives.

Data and Information

KAISER FAMILY FOUNDATION
www.kff.org/medicaid/index.cfm

The Kaiser Family Foundation is currently one of the most comprehensive sources of information about the Medicaid program. The site includes a search function and lists a number of publications and data reports on both fee-for-service and managed care Medicaid. For an overview of managed care arrangements in Medicaid, see Medicaid and Managed Care: Key Data, Trends, and Issues (September, 2010). http://www.kff.org/medicaid/upload/8046.pdf

CVS/CAREMARK RX ADHERENCE WEBSITE
www.cvscaremarkfri.com/category/improving-your-health/rx-adherence

This website features research findings on medication adherence. It includes state maps showing medication adherence rates by state for a variety of conditions. It also offers two free, downloadable reports, State of the States: Adherence Report, and Advancing Adherence and the Science of Pharmacy Care Volume 2

Medication Adherence for Consumers

AHRO: YOUR MEDICINE. BE SMART. BE SAFE
www.ahrq.gov/consumer/safemeds/yourmeds.htm

This website helps patients understand medications and the strategies they can use to take medications safely and effectively.

MEDICATION ADHERENCE & SAFETY RESOURCE CENTER
www.ncahc.org/med_adherence/

This resource center, designed for the healthcare provider and consumer, provides helpful information on ways to improve medication adherence and address safety concerns.

NATIONAL CONSUMERS LEAGUE MEDICATION ADHERENCE CAMPAIGN
www.chnet.org/health/150-prescription-drugs/234-ncls-medication-adherence-campaign

The National Consumers League (NCL), with planning funds from the Agency for Healthcare Research and Quality (AHRQ), is organizing a national multi-media campaign to improve public health by raising consumer awareness of the importance of good medication adherence.

NATIONAL COUNCIL ON PATIENT INFORMATION AND EDUCATION (NCPIE)
www.talkaboutrx.org/index.jsp

NCPIE plays a leadership role in stimulating and improving communication of information on safe and appropriate medicine use to consumers and healthcare professionals. NCPIE also hosts a medication adherence segment of its website.

Condition-Specific Links Addressing Adherence

AMERICAN HEART ASSOCIATION (AHA)
www.heart.org/HEARTORG/GettingHealthy/GettingHealthy_UCM_001078_SubHomePage.jsp

AHA offers heart disease-related clinical information and support for patients. It includes information to support adherence and behavior change related to diet, exercise, smoking and stress reduction, along with medication information.

ASTHMA AND ALLERGY FOUNDATION OF AMERICA
www.aafa.org

AAFA is dedicated to improving the quality of life for people with asthma and allergic diseases through education, advocacy and research.

NATIONAL DIABETES EDUCATION PROGRAM (NDEP)

NDEP includes over 200 partners at the federal, state and local levels, working together to improve the treatment and outcomes for people with diabetes, promote early diagnosis and prevent or delay the onset of type 2 diabetes.

THE NATIONAL RESOURCE CENTER ON ADHD (NRC)
www.help4adhd.org/index.cfm?varLang=en

The NRC is a program of CHADD (Children and Adults with Attention-Deficit / Hyperactivity Disorder). It is a national clearinghouse for the latest evidence-based information on ADHD and provides information and support to individuals with ADHD, their families and friends, and health professionals.

Sponsored Link

MERCK ENGAGE
www.merckengage.com/

This site includes information and resources including information about treatments and healthy lifestyles, for both patients and providers, on multiple disease conditions. It includes an adherence estimator and tools for tracking health activities.
Notes & References

15. See for example Michigan’s HEDIS report on Medicaid Health Plan performance at: http://www.michigan.gov/mdch/0,4612,7-132-2943_4860-130530--00.html
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Scan for more on CBP
Best Practices compendia