



COMPENDIUM



THE NCQA INNOVATION AWARDS 2021

Featuring Quality Accelerators in Health Care



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ABOUT THE NCQA INNOVATION AWARDS

The NCQA Innovation Awards recognize accredited health plans and recognized practices for implementing leading-edge strategies that improve both quality and value. They also recognize organizations that support delivery system redesign and patient engagement initiatives (including digital engagement strategies) that help drive better integration across the delivery system and support person-centered care. Visit www.ncqa.org/innovationawards for more information.

› Topics

1. Integration of Care
2. Use of Technology
3. Customer Experience
4. Behavioral Health Care
5. COVID-19 Interventions
6. Delivery System Design
7. Patient and Family Engagement

› Selection Criteria

Winners were selected based on the following criteria.

- Innovation and creativity
- Sustainability
- Scalability
- Impact on intended audience
- Solution is distinct from existing approaches
- Quantitative data show results/impact
- Potential for cost impact
- Potential for quality impact
- Added value for payer/provider/patient

*Winners are listed in alphabetical order.

WINNERS



PROJECT TITLE: Integration of Care to Address Social Determinants of Health

Organization: Alliance Medical Ministry

Topic: Integration of Care

Project Contact: Selina Witherspoon, Clinic Intern, switherspoon@alliancemedicalministry.org

Project Overview: Alliance Medical Ministry (AMM) is dedicated offers holistic primary medical care for working uninsured adults in Wake County. The patient population is predominantly historically marginalized people. In 2020, AMM provided 2,100 social work and behavioral health counselling appointments and more than 250 wellness activities, complementing its 6,600 primary care visits. SDOH screenings revealed transportation needs, food insecurity, financial problems, legal issues and many other practical living challenges that make it difficult to lead a healthy life. The AMM social worker helps patients find community resources to meet these needs and collaborates with providers to address barriers that keep patients from following treatment plans.

More than 1,000 active AMM patients suffer from at least one chronic illness, including diabetes, hypertension and cardiovascular disease. AMM partners with these patients to manage and control chronic illness. Its chronic disease management program is an essential part of the community's health initiative to reduce racial disparities in health outcomes.

Innovation: AMM knows that social, financial, emotional, and environmental conditions have a huge impact on a person's overall well-being, creating barriers to health—especially for those with chronic illnesses. The AMM social worker assesses the whole person and identifies those barriers, then connects patients with helpful resources. The social worker consults with providers to create practical, everyday goals that will help improve their health.

AMM began collecting SDOH data on patients' social environment, social history, emotional needs and financial needs. The most common issues were access to food and financial assistance. Based on the trends indicated by the results, the social worker dedicated efforts to find community resources that could provide assistance in those areas.

The social worker also provides individual case management for patients with uncontrolled diabetes. He conducts home visits as needed basis, to ensure that patients have the necessary blood sugar monitoring supplies. Many AMM patients email their blood sugar results to the social worker, who can then assist the provider in care. The social worker also helps patients develop written care plans, discuss weekly glucose logs and nutritional information.

More than 73% of all vaccinations given by AMM were for people in historically marginalized communities. AMM has leveraged the staff social worker to establish relationships with university Social Work programs; as a result, it has attracted interns from Shaw University, St. Augustine's University and NC State University, who have helped expand social work outreach, create patient education materials and provide counseling services to patients.

Outcome: AMM has significantly reduced blood pressure and blood sugar levels for patients with hypertension and diabetes. During the past 15 months, 26% of diabetic patients with an A1c >7 were able to bring it under control. During the same period, 42% of patients with blood pressure >140/90 brought it under control. Maintaining weekly logs that tracked social conditions, access to medications and supplies, compliance with treatment plans and follow-up gave caregivers confidence that their patients were on the right track.

A main barrier to health has been access to food. AMM responded by passing out more than \$3,000 in Food Lion gift cards to patients during the pandemic—a time when food insecurity was a critical issue. AMM also collaborated with other agencies to provide access to food and fresh produce, job training and access to basic life necessities.

AMM's network of social services has expanded to include the Wake County's Housing Affordability and Community Revitalization Program, the Center of Volunteer Caregiving, Southeastern HealthCare, Oak City Cares (resources for those facing homelessness), the Capital Care Collaborative (health care referrals) and referrals into clinics that participate in the State's Behavioral Health system. All of this happened because AMM realized the importance of integrating our medical care with social work.

PROJECT TITLE: It Takes All of Us: A Community/Member/Provider Approach to Achieving Health Equity

Organization: Centene Corporation

Topic: Health Equity

Project Contact: April Canetto, Director, Accreditation & Pop Health Equity, april.canetto@centene.com

Project Overview: Health Equity is the anchor of Centene's Population Health Management Framework, through which it identifies, addresses and mitigates racial and ethnic health disparities. Centene's four-step, data-driven Health Equity Improvement Model uses a public health framework that integrates quantitative and qualitative data to identify barriers and design initiatives across community, member and provider levels. This model was successfully implemented in multiple markets, with demonstrated reductions in disparities. The enterprise goal is 20% market adoption of the model by 2023.

Centene's initiative goal was to reduce the HbA1c testing disparity between Native American/Alaska Native and Black members of the Arizona Complete Care Medicaid health plan by 2%, compared to White members. Centene's model is rooted in community engagement and leverages community coalitions to align strategies across the model's four steps.

Centene stratified HEDIS data using race, ethnicity and language, overlaying these analyses with additional data such as geography, disability, gender and SDOH. It used these analytic processes to develop its Health Equity Dashboard to identify disparity reduction opportunities and track year-over-year related performance.

Innovation: Interventions to reduce the HbA1c testing disparity focused on training, outreach and SDOH integration interventions at the community, member and provider level. SDOH interventions are integral to the success of the model because it treats the whole person and removes barriers inhibiting members from focusing on their health.

AZ Complete Care mailed members information about wellness, the importance of HbA1c testing and other Comprehensive Diabetes Care measures. Members were also provided with in-home HbA1c test kits with multiple delivery modalities and service alignment, and offered incentives for Comprehensive Diabetes Care measure compliance. AZ Complete Care also provided telehealth and telemonitoring for members with diabetes.

Outcome: Implementation of Centene's Health Equity Improvement model successfully reduced health disparities in HbA1c testing for AZ Complete Health Native American/Alaska Native and Black Medicaid populations. From 2019–2020, the HbA1c testing disparity for the Native American/Alaska Native population dropped from 12.78% (compared to White members) to 9.89%. The HbA1c testing disparity dropped from 4.21% (compared to White members) to 3.01% for Black members during the same time.

Given the success of the model and benefit to our membership, Centene continues to work toward its enterprise goal of 20% market adoption by 2023.

Partner: Health plan.

PROJECT TITLE: “Know More: HPV”—Improving Vaccination Uptake and Closing Health Disparities With A Digital Patient Intervention

Organization: CenCal Health

Topic: Patient and Family Engagement

Project Contact: Rachel Ponce, Supervisor Population Health, rponce@cencalhealth.org

Project Overview: CenCal Health identified a marked health disparity in adolescent vaccination uptake between North and South Santa Barbara County: North Santa Barbara County’s HPV vaccination rate was 48.72%; South Santa Barbara County’s rate was 31.03%.

After searching unsuccessfully for an existing intervention, CenCal Health decided to develop one “from scratch.” It collaborated with the American Cancer Society to create a multimedia, interactive, tablet-based educational program, “Know More: HPV,” to educate parents on the importance of the vaccination at a critical moment: when the child is already at the provider’s office. During the COVID-19 pandemic, this delivery mechanism was adapted to accommodate contactless visits.

CenCal partnered with a local Federally Qualified Health Center to implement this innovative patient education, which resulted in a significant increase in adolescent HPV immunization compliance and closed the health disparity for adolescents ages 11–12 in Santa Barbara County in just 9 months. Since launching the program in 2019, its HPV vaccination rates have continued to increase. CenCal reported a 59.12% HPV vaccination rate for HEDIS 2020 and a rate of 64.62% for HEDIS 2021 in Santa Barbara County—both rates surpassed NCQA’s established 95th percentile benchmark for those years.

Innovation: Human papillomavirus (HPV) annually infects 14 million people and causes more than 33,000 men and women in the U.S. to develop HPV-related cancers each year. The HPV vaccine prevents the infections that can lead to six common types of cancer later in life, yet the rate of HPV vaccination remains low. Some reasons include the prevalence of antivaccination messaging, misconceptions about the vaccine’s correlation to sexual activity and a general lack of awareness that the vaccine is recommended for adolescents.

Healthy People 2020 and the American Cancer Society set a goal to reach 80% HPV vaccination for both males and females by 2030 and 2026, respectively. Medicaid plans nationwide are far from meeting this goal—even the top 10% achieve a vaccination rate of 50.85% in 2016. CenCal Health, the Medicaid health plan serving Santa Barbara and San Luis Obispo Counties, had only a 38.36% HPV vaccination rate for adolescents living in Santa Barbara County in 2016. With NCQA’s addition of the HPV antigen to the Immunizations for Adolescents HEDIS measure in 2017, CenCal Health began monitoring HPV vaccination compliance and identified a significant geographic health disparity. There were no potential existing programs to adopt that could close this disparity. The program needed to meet health literacy and threshold language requirements, be low cost, easily implemented and provide accurate outcome data.

Outcome: Success of the “Know More: HPV” program is measured in several ways, including HPV vaccination rate data, parent/guardian satisfaction data and anecdotal provider satisfaction feedback. An in-house dashboard that calculates measure rates through HEDIS-certified software captures vaccination rate data and monitors program impact. As of June 30, 2021, the HPV vaccination rate at SBNC was 52.8%, a 33.8% increase from the provider’s original rate of 19.05%. Patient satisfaction with and knowledge gained from “Know More: HPV” is measured through a survey at the end of the program. Survey results report that patient satisfaction is very high. 82.9% of survey respondents said they agreed/strongly agreed that the content was enjoyable; 95.6% said they learned something new about the HPV vaccine; 92.4% said “my child will get the HPV vaccine today.”

CenCal Health received the 2019 California Department of Healthcare Services’ Innovation award, which highlighted the importance of HPV vaccination to the community, as well as CenCal Health’s commitment to providing creative interventions that improve member care. The program implementation is also cost-effective:

CenCal Health offers it at no cost to providers and other health plans and it can be accessed on any type of smart device—a cell phone, computer or tablet. The program’s accessibility makes it especially useful during the current COVID-19 crisis.

Partner: Non-profit, primary care practice(s).

SUBMISSIONS ON BEHAVIORAL HEALTH



PROJECT TITLE: Behavioral Health Point of Care Program

Organization: Anthem

Topic: Behavioral Health

Project Contact: Kathryn Kranitzky, Quality Growth Director, kathryn.kranitzky@amerigroup.com

Project Overview: As part of Amerigroup/Anthem’s efforts to reduce health care disparities, it works with providers to assist in the purchase of testing equipment to use for diabetes and cholesterol screening in practices. Having point-of-care equipment on site reduces the added barrier of a second appointment for patients and ensures that members get the care they need. Providers that agree to participate in the program agree to meet specific quality improvement goals. Anthem/Amerigroup staff work with providers on a monthly basis to identify members who need testing and assist with outreach to members, if requested, to support provider with meeting the goals of increasing their rates for the HEDIS measures Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) and Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM).

Innovation: People with serious mental health illness die 10–25 years earlier than the general population, due in part to co-occurring chronic conditions that are not well managed. Anthem/Amerigroup identified a disparity and a need to target this population for the SSD and APM measures.

Anthem/Amerigroup provides a one-time payment to support behavioral health providers in purchasing point-of-care testing equipment, and provides educational tools on coding, billing and HEDIS.

Having point-of-care equipment on site ensures members get the care they need. Providers can use the point of care equipment on all members, not specific to any managed care organization or insurance company, to help improve outcomes for people with behavioral health diagnoses in their community and in pursuit of health equity goals.

Outcome: The program was launched in May 2021 and all participating providers have improved their month-over-month HEDIS rates for SSD and APM. Anthem/Amerigroup anticipates continued improvement in rates and a significant year-over-year improvement.

Partner: Other.

PROJECT TITLE: Creation of Slide Fee for Behavioral Health Patients

Organization: Healing Hands Ministries

Topic: Behavioral Health

Project Contact: Princess Murchison, QI on Behavioral Health Services, princessmurchison@hhmtx.org

Project Overview: In 2021, Healing Hands Ministries performed an internal review of all its service lines to determine ways to improve accessibility to the community and patients served. The audit identified several areas. Services offered by the Behavioral Health team were highlighted as an area that could have an immediate impact on the patients served by Healing Hands. It was further determined that cost was the primary reason for patients not utilizing services. Therefore, a slide fee discount was created for services offered by Behavioral Health to increase their utilization.

Innovation: The new slide fee discount was board approved and implemented. Posters and flyers were hung in each exam room to notify patients of the new price structure, and staff were encouraged to inform patients and their families to utilize the services under the new discount fee.

Outcome: In February 2021, 28 patients were diagnosed with behavioral health related conditions and referred for services. Under the old fee schedule, those referrals yielded 39 behavioral health visits. After the new slide fee discount pricing was implemented in March 2021, 28 patients were referred and increased the number of visits approximately three times, for a total of 96 visits.

This trend has continued since the new pricing plan was implemented. Since implementing the new pricing for behavioral health services, there has been an exponential increase in behavioral health visits for initial or new patients and for patients seen for multiple visits. The Behavioral Health team increased outreach to all service lines offered at Healing Hands Ministries. Utilization has improved because behavioral health services are no longer viewed as cost prohibitive by patients.

Partner: Primary care practice(s).

PROJECT TITLE: Integrating Behavioral Health Into Primary Care in a Rural Community

Organization: Flagstaff Family Care

Topic: Behavioral Health

Project Contact: Cindy Wade, Practice Administrator, cindy.wade@flagfamilycare.com

Project Overview: In fall 2008, Flagstaff Family Care Clinic began a partnership with evolvedMD to leverage the Psychiatric Collaborative Care Model to integrate behavioral health services into primary care. In this partnership, evolvedMD provides patients in Coconino County with behavioral health services and interventions via therapists embedded in practices. A licensed clinical social worker sees patients who exhibit behavioral health needs, as identified by screenings, and collaborates with the primary care physician, behavioral health provider and psychiatric consultant to provide interventions and ongoing support.

The team also helps combat SDOH for patients, in addition to providing high-level patient navigation. For patients experiencing housing or food insecurity, transportation issues, or anything that prevents them from receiving care, there is a dedicated team to help find and connect them with resources, yielding better patient outcomes and a more impactful experience. The innovative part of this model is the true collaboration between primary care and behavioral health to focus on whole-patient and whole-body care.

Innovation: To help patients, Flagstaff Family Medical Clinic partners with evolvedMD to identify patients experiencing symptoms and recommend their participation in the program. Once identified, patients are scheduled with an onsite therapist who works collaboratively to create a care plan, and then delivers on that

plan to ultimately see progress on the path to a better life. Intervention includes a dedicated team to support growth, evidence-based treatment, a personalized care plan and tools to enable continued success. This can be done in person and on site or virtually to reach patients in remote areas who need care.

Outcome: As a direct result of evolvedMD's interventions, Flagstaff Family Medical Clinic was able to develop a robust, comprehensive screening protocol that allowed it to screen over 4,000 patients in 2020. evolvedMD's data show that even its least advanced partners still see an increase of 22% in mental health/substance abuse diagnoses because of behavioral health integration. This project and partnership create a mechanism to better identify and serve patients for their behavior health needs.

A moment of impact can be illustrated by an onsite behavioral health provider working with a patient who is a frontline health care worker in the Navajo Nation. The patient struggled with PTSD and loss, and worked with the therapist to deal with the multiple deaths and ongoing trauma. The patient told the behavioral health provider they were shutting down and pulling away instead of feeling and healing. With help from the behavioral health provider, the patient's sleep improved, they worked on a nutritional plan and the patient was able to feel less anxious and more connected. Simple but powerful, and it happens daily in this partnership.

Partner: For-profit.

PROJECT TITLE: Medication Adherence

Organization: Sunrise Medical PC

Topic: Behavioral Health

Project Contact: Lucy Osorio, Program Administrator, losorio59@sunrisemedicalpc.com

Project Overview: Sunrise Medical identified high-risk patients who did not follow through with office appointments, went months without taking their medication and used the ER and hospitalization more often. With the goal of improving these patients' conditions, decreasing hospital admissions and ER visits and controlling costs, Sunrise developed a questionnaire for high-risk patients to identify those not in compliance with their treatment plan.

Innovation: Sunrise Medical developed treatment plans to educate patients about medication adherence as a way to improve and control their conditions. Its providers also adopted strategies to address patients' economic and physical barriers in order to improve medication adherence. Staff call high-risk patients every month to make sure they have picked up their medications after seeing the doctor and to discuss the importance of medication adherence and barriers to compliance—socioeconomic or physical. If patients have not picked up their medication after a doctor visit, Sunrise calls the pharmacy and coordinates medication delivery. Sunrise found that patients' SDOH reveals insights about their health behavior, and used the monthly conversations to discuss physical activity and healthy eating. Since adopting this strategy, Sunrise has seen significant improvement in patient health outcomes and treatment plan compliance, in addition to health cost reductions.

Outcome: To make this project possible, Sunrise works with health care plans/groups and pharmacists to improve high-risk patients' medication adherence and health outcomes and reduce hospital and ER admissions. The main goal is to patients in good health and minimize costs.

Patients say they are more adherent with medication since they can get it delivered to their home, that they have fewer problems taking medication regularly, feel healthier and do not visit hospitals or the ER as often as before the project. Because Sunrise coordinates medication adherence with health plans and pharmacies, it has seen a major difference in high-risk patients and costs.

Partner: Hospital pharmacy and rheumatology

PROJECT TITLE: Minds Matter Program: A Preventative Care Approach to Pediatric Behavioral Health

Organization: Rainbow Pediatric Center

Topic: Behavioral Health

Project Contact: Prasanthi Reddy, MD, Medical Director, CEO, reddy.rainbow@gmail.com

Project Overview: The behavioral health needs of children continue to surpass the availability of services. Rainbow Pediatric Center developed the Minds Matter program to address this severe gap in care. Pediatricians are often the first to see children with behavioral health issues and often have the opportunity to implement interventions at the early stages of behavioral health issues. Traditionally, these patients are referred to behavioral health therapists and can wait at least 4–6 months before being seen by one. In the meantime, behavioral issues can escalate to a point of needing ER visits, psychiatric interventions or hospitalizations. The local pediatric ER reported a 300% increase in behavioral health visits in 2020.

Rainbow developed the Minds Matter program to take a preventive approach to behavioral health. Pediatricians already have an established, trusted relationship with patients and families and can start interventions at the early stages for better outcomes. This program allows interventions while waiting to see the therapist and decreases the need for future specialist and ER visits and hospitalizations.

Innovation: A subset of physicians and nurse practitioners have training in diagnosing and managing behavioral issues such as depression, anxiety, oppositional defiant disorder, eating disorders, ADHD and LGBTQ issues. Training included collaborating with a local university's pediatric psychiatry department and online training. Rainbow also developed resources, educational materials and behavioral health intervention tools that it shares with patients' families. Providers see patients in the practice to help families navigate their child's condition. Extra time is allocated in the provider's schedule. The Minds Matter team meets once a month with a local pediatric psychiatrist to review cases as a group.

Outcome: The Minds Matter program was created in 2019, prior to the COVID pandemic. Provider training occurred from November 2019–April 2020, when the program was implemented. Since it began there has been a 77% increase in office behavioral health visits. Prior to the program, the referral rate to psychiatry was 13%; it has decreased to 8%. Providers feel more confident that they can guide families dealing with children with behavioral health issues within the medical home. Families have voiced appreciation for the program and the guidance offered. This program can be easily implemented in any primary care medical home, provide cost savings to the health care system, improve patient care and address a needed gap in care.

SUBMISSIONS ON COVID-19 SOLUTIONS



PROJECT TITLE: A Community Based Comprehensive Plan for Battling COVID-19

Organization: Wayne Memorial Community Health Centers

Topic: COVID-19 Solutions

Project Contact: Wynter Newman, Administrative Director, newmanw@wmh.org

Project Overview: Wayne Memorial Health Centers cover a four-county rural area in North Eastern Pennsylvania. Access to health care can already be limited, but the constraints of the pandemic added a barrier. Wayne Memorial wanted to ensure that its patient base was educated on all the aspects of COVID-19, and wanted to be a resource for school districts in the community to plan for a safe return to school. The affiliated hospital is small and might reach critical capacity quickly, so the next step was to look at testing and to create a plan that would allow patients to be tested at any Wayne Memorial clinic or at a mobile testing facility. Another focus was reaching patients who were uncomfortable leaving their homes or who were too sick to leave their homes, which led to creation of a telehealth platform. The last step was leading the vaccine movement in Wayne Memorial's communities.

Innovation: In the early stages of the pandemic, the main issue was educating patients and clinicians about the virus. As the pandemic progressed, the need for a telehealth platform and vaccine education became more important.

Creating protocols and securing PPE allowed Wayne Memorial to test for COVID-19 in all of its clinics. Because the state Department of Health was overwhelmed, Wayne Memorial also created/implemented its own internal contact tracing process. It was part of a core committee that hosted regular meetings to keep local school districts informed and prepared, and the medical director held first daily, then weekly, radio shows. Wayne Memorial traveled to nursing/residential homes and visited homebound patients to offer vaccinations. It hosted regular mass vaccine clinics, staffed by employees.

When CMS decided that Federally Qualified Health Centers could conduct and bill for telehealth visits, Wayne Memorial developed and implemented a telehealth platform to provide access to care throughout the pandemic. It collaborated with school districts and the community, meeting with schools weekly as a resource for schools and parents. Wayne Memorial also vaccinated patients outside its patient base and normal office locations. Mass vaccination clinics were open to the general public—over 34,000 vaccinations have been administered to 20,500 patients since December 2020. To date, 49% of the eligible patient population has been vaccinated, in addition to 3,550 patients outside the patient base.

Outcome: Wayne Memorial has tested 8,000 patients in the community and its internal contact tracing has helped lower the infection rate. Implementation of a telehealth program allowed flexibility for visits with the elderly/immunocompromised, to keep them from having to travel into the office. Regular radio shows and video interviews with medical directors educated the community and were a calming force during an uncertain time. Collaboration with local school districts resulted in a safe and robust back-to-school plan. Wayne Memorial currently offers vaccines daily in two locations, while also shifting to focus on vaccine hesitancy.

PROJECT TITLE: Achieving Speed and Scale with Monoclonal Antibody Infusions in the FQHC Setting

Organization: Refuah Health Center, Inc.

Topic: COVID-19 Solutions

Project Contact: Amanda Salzman, Medical Director of External Affairs, asalzman@refuahhealth.org

Project Overview: In early January 2021, Refuah Health Center (RefuahHealth), a Federally Qualified Health Center (FQHC) located in Rockland County, NY, launched its Monoclonal Antibody Therapy Program to make this groundbreaking COVID-19 treatment available to eligible patients. Monoclonal antibody therapy has been shown to dramatically reduce hospitalization rates for certain high-risk populations (e.g., 65+, diagnosed with diabetes, chronic kidney disease, immunosuppressive disease). The RefuahHealth treatment program involved patient pre-screening, one 2-hour visit to receive the infusion and follow-up care via telehealth. Its rapid turnaround times made it well-positioned to quickly identify patients who would benefit from monoclonal treatment and get them into treatment right away, often within hours of a positive diagnosis. The program is still active and providing treatments to area residents.

Innovation: RefuahHealth was one of the first FQHCs to offer monoclonal antibody therapy in the United States. The program rollout was identified as a National Best Practice by the Duke-Margolis Center for Health Policy, and it was featured in a national Project ECHO presentation sponsored by the US Health and Human Services Office of the Assistant Secretary for Preparedness and Response. As an FQHC, RefuahHealth is uniquely positioned to capture high-risk populations, including racial and ethnic minorities with higher rates of underlying medical conditions, high-risk uninsured and individuals with high deductible health plans and low income individuals who are less likely to be in an organized system of care. Its community health center setting ensures equitable access to monoclonal antibody treatment, which will continue to provide important benefits, particularly for patients who are unable or unwilling to be vaccinated or who do not mount an adequate immune response. RefuahHealth's delivery model for timely and routine access to monoclonal antibody treatments within a community health center setting, is vital to achieving an equitable and comprehensive short- and long-term response to the COVID-19 pandemic.

Outcome: Since January 2021, Refuah has provided monoclonal antibody infusions to nearly 500 high-risk COVID-19 positive patients. Of those, only 1 individual was admitted to the hospital.

All patients were served within 24 hours of testing positive, with the vast majority receiving an infusion immediately after positive diagnosis at Refuah Health Center. The center's rapid testing, eligibility screening and onsite infusion services ensured immediate treatment, which improved health outcomes for high-risk individuals who had contracted COVID-19. Not only did the program improve health outcomes, but it also improved quality of care.

RefuahHealth's monoclonal antibody treatment program demonstrates financial sustainability and cost savings. Antibody supplies are purchased by the federal government and distributed at no cost to infusion providers. COVID-19 antibody administration is reimbursed by Medicare at \$309 per infused patient, with no patient copays and is delivered in any setting. Refuah also lowers upfront cost by leveraging data systems to qualify and schedule patients and draws from current health center staff to facilitate treatment. Overall, the health care system benefits from cost saving that infusions generate by preventing hospitalizations.

Partner: Government agency.

PROJECT TITLE: Blue Shield of California’s Support of the State of California’s COVID-19 Vaccination Program to Help Ensure Equity and Save Lives

Organization: Blue Shield of California

Topic: COVID-19 Solutions

Project Contact: Natasha Terk, Program Manager of Citizenship & Reputation, natasha.terk@blueshieldca.com

Project Overview: Blue Shield of California is a nonprofit health plan whose goal is to help ensure all Californians have access to quality health care that is sustainably affordable. Its extensive vaccination effort reached every corner of the state, especially in communities hardest hit by the pandemic. Starting in mid-February 2021, Blue Shield stepped in as the state’s third-party administrator to manage its enhanced vaccine provider network, providing a single, California-wide system for managing allocation and administration of the vaccine. The state achieved its goal of providing 4 million vaccinations a week, which Blue Shield carried out weeks ahead of the state’s schedule. The result is that not only has California administered more vaccine doses by far than anywhere else in the country, it is one of the most vaccinated places in the world.

Innovation: As third-party administrator for California, Blue Shield was responsible for enrolling providers, lending support in the state’s vaccine allocation efforts, tracking vaccines and collecting data to measure the efficiency, effectiveness and equity of the state’s vaccination effort. Blue Shield worked with providers to get vaccines to people and communities that were unable to travel to a provider or to a mass vaccination site—it included local pop-up sites, mobile vaccination units, in-home vaccinations and bringing vaccine clinics directly to farm workers. This meant that California residents had a single point of contact for vaccine allocation and administration, improving communication; providers had greater predictability of how much vaccine they received, allowing them to minimize cancelled or delayed appointments; the state knew where vaccine doses were on their journey from shipment to shot, minimizing waste and maximizing supply; and California met its equity pledge by ensuring that the vaccine reached individuals and communities hardest hit by the pandemic.

Outcome: Blue Shield helped build and manage a statewide COVID-19 vaccine network that now includes 570 providers and 3,000 sites, with a network capacity to deliver 6.6 million vaccine doses weekly, reaching more than 99% of Californians. More than 40 million doses of COVID-19 vaccines have been administered. Nearly 73% of eligible Californians (12 and older) have received at least one dose of the vaccine, and nearly 60% are fully vaccinated. The third-party administrator-supported collaboration among state agencies, county public health officials, thousands of providers and a myriad of experts and advisors has been instrumental in enabling the state to administer an average of 477,000 vaccine doses daily. The CDC reported that California’s 7-day rate of new COVID-19 cases is lower than the national average and better than every state but Hawaii.

Partner: Government agency.

PROJECT TITLE: COVID-19 Community Response to the Pandemic

Organization: Jordan Valley Community Health Center

Topic: COVID-19 Solutions

Project Contact: Jessica Johns, Quality Manager, jessica.johns@jordanvalley.org

Project Overview: The COVID-19 pandemic presented new and complex challenges for health care providers worldwide. As a provider of comprehensive medical, dental and behavioral health services, Jordan Valley Community Health Center (Jordan Valley) found new and innovative ways to ensure safe access to primary care and actively participate in the community pandemic response. To ensure continuity of regular clinical operations while also aggressively supporting community testing and vaccination efforts, Jordan Valley established a COVID Response Team composed of RNs, LPNs and MAs, including new hires and staff reassigned from other Jordan Valley teams. A dedicated mobile vaccination unit was also purchased, and a mobile vaccine unit coordinator was hired to lead Jordan Valley's community vaccination efforts.

Innovation: From clinical locations and community-based mobile testing sites, Jordan Valley has administered over 19,124 COVID-19 tests. Test results were typically available within 3–5 days via email, and all positive patients received a phone call from Jordan Valley nursing staff. In December 2020 Jordan Valley opened an outpatient infusion center to provide treatment to COVID-positive patients. In July 2021 this infusion center was expanded and relocated to a newly acquired building, where Jordan Valley serves as an outpatient referral site to relieve pressure on the two major health systems in the area.

Jordan Valley was also contracted by the state of Missouri to serve as a regional vaccination coordinator, working with the Missouri National Guard and SEMA to help bridge vaccine access gaps for South Central Missouri. Jordan Valley's remote clinics also worked with local health departments to schedule vaccine events. Jordan Valley has adapted its approach throughout the pandemic, shifting from mass vaccination events to smaller sites at various locations (e.g., churches, schools) throughout the community. It continues to offer testing and vaccinations at all of its clinics, and offers infusion treatments at its outpatient referral site.

Outcome: As of August 1, 2021, Jordan Valley had:

- Administered 19,124 COVID-19 tests.
 - Administered 98,542 COVID vaccinations.
 - Administered 86 infusions to treat COVID-positive patients.
 - Completed 67 school based/community vaccination events.
 - Held 34 mass vaccination clinics, distributing a total of 28,864 vaccines.
-

Partner: Government agency.

PROJECT TITLE: COVID-19 Outreach Calls

Organization: Elaine Ellis Center of Health

Topic: COVID-19 Solutions

Project Contact: Kate Milone, Director of Quality and Compliance, kmilone@eechealth.com

Project Overview: In addition to testing patients for COVID-19 and providing them with results, Elaine Ellis Center of Health developed a follow-up process for patients who test positive. Many are residents of public housing, lack access to critical information and needed answers about symptoms to look out for and what to do if symptoms worsen. The center has become a resource for the community, focusing on assessing and monitoring patients who test positive.

Innovation: The Elaine Ellis Center of Health established a process to call patients COVID-positive patients every other day, including weekends and holidays, to answer questions and provide medical direction, if needed, until they were symptom free. Clinical staff were provided with cell phones and laptops for home use and the center expanded its language interpretation services to remove language barriers. Staff used test results available in the EMR to determine which patients to call, and documented the calls and outcomes of the conversations so the next provider would know the patient's status.

Outcome: The center tested its first patient on March 17, 2020. By December 31 it had tested 1,281 patients. All positive patients received at least one phone call to assess their status, and about half had more than one follow-up phone call. The average number of calls made to patients was 4–5 over a 2-week period. Patients were reminded to stay hydrated, monitor their status and temperatures, self-quarantine and seek help should their condition change. Less than 1% required referral to a higher level of care at the local ER.

The impact on patients who tested positive was immeasurable. The center used this outreach as a way to monitor patients and answer their questions.

Partner: Government agency.

PROJECT TITLE: Delivering Medical Care for Low-Income and Uninsured Children During a Pandemic

Organization: VHC Pediatrics

Topic: COVID-19 Solutions

Project Contact: Tatiana Zenzano, Medical Director, tzenzano@virginiahospitalcenter.com

Project Overview: VHC Pediatrics provides preventive/well-child, acute illness and chronic medical condition health care for Arlington County, Virginia's, most vulnerable infants and children. These children live at or below 200% of the Federal Poverty Level and are uninsured or have Medicaid or FAMIS. They are at greater risk for health problems that can become emergencies without proper care. Most live in areas hardest hit by the pandemic. Hispanic residents make up less than 16% of the Arlington population, but represent more than 28% of COVID-19 cases. The majority of VHC Pediatrics' patients are Hispanic. VHC Pediatrics' commitment to remaining open and continuing to care for patients has been unwavering. Staff worked together to develop innovative, flexible, creative solutions and sustainable systems. At the onset of the pandemic, VHC Pediatrics realigned resources, reallocated staff, launched telehealth and monitored patient and appointment data. At the same time, staff worked with families to ensure they were safe and had medical care, behavioral healthcare, medications, food, housing and other resources.

Innovation: VHC Pediatrics quickly changed its medical care model and remained open with expanded services during the pandemic. It realigned resources to enhance patient care, offering telehealth appointments to keep children and families home and safe and reorganizing appointments to see healthy children in mornings and sick children in afternoons. Its space and workflow were redesigned to ensure that families remained distanced and there were designated rooms for patients and/or parents with COVID-19. VHC Pediatrics communicated with patients via text messaging and increased phone triage staffing.

VHC Pediatrics reallocated staff to ensure it could meet the needs of its high-risk population. Because fewer registered nurses were in office, care coordinators assumed their responsibilities. Physicians answered triage calls previously handled by nurses. Many of patients' families became unemployed, and VHC Pediatrics helped families connect to food bank, housing and other community resources—it ultimately hired a case manager to fill these needs. Everyone assisted with daily cleaning and sanitizing.

VHC Pediatrics collected patient data regarding COVID-19 testing, treatment and outcomes, and began offering free drive-through testing. It also set up Saturday clinics to vaccinate patients and their parents.

Outcome: To ensure it could remain open and serve the community, VHC Pediatrics quickly implemented trainings and protocols that ensured a successful transition to caring for patients during a pandemic. It added new telehealth technology, trained staff and educated patients on how to participate. It developed new operating procedures and systems to ensure that patients could be screened and safely seen in office. Local community groups donated PPE, and grants and donations from the community funded technology, equipment and PPE expenses.

Patient education was critical. VHC Pediatrics educated patients and families in Spanish and English about COVID-19, how to wear a mask and the importance of getting the vaccine. Staff connected patients' families with food banks, housing programs and other community resources and became a food distribution site for families in need.

Partner: Health system (ACO, hospital).

PROJECT TITLE: Innovative Telehealth Response to COVID-19 Pandemic Will Set a New Industry Standard for Safe, Convenient, High-Quality Care

Organization: Kaiser Permanente

Topic: COVID-19 Solutions

Project Contact: Jennifer De Laura, Comms Manager, Enterprise Communications, jennifer.delaura@kp.org

Project Overview: Telehealth options have been available to Kaiser Permanente members since the 1990s. Telehealth capabilities currently include video visits, telephone visits, E-visits, secure email exchanges between clinicians and members, chat with a clinician, online physical therapy, remote patient monitoring and TeleCritical Care, in which specialized teams of nurses and physicians monitor patients hospitalized in ICUs.

Telehealth services are integrated with Kaiser Permanente's EHR and clinicians using telehealth have immediate and secure access to members' health information. This enables consistent and highly coordinated care during and after a visit. In response to the pandemic, Kaiser Permanente has rapidly scaled its proven and innovative telehealth infrastructure to expand options for care and meet demand. Integrated telehealth capabilities have made it easy for most members to receive care from the safety of their own homes.

Innovation: Kaiser Permanente's telehealth team instituted a daily monitoring regimen for all facets of its telehealth platform—including infrastructure, application utilization and conferencing activity—to keep pace with demand. The support team's model (providing real-time, clinician- and member-facing technical support) was critical to successfully managing the increase in video utilization, expanding its member and provider

“Tech Check” program, performing audio and video tests prior to visits. The telehealth team accelerated national release of a solution to provide video visits in settings such as skilled nursing facilities and developed a virtual urgent care video visit capability. Remote monitoring options for diabetes and hypertension were expanded and Kaiser Permanente launched a platform addition to monitor patients with chronic heart failure and low-risk prenatal patients.

As part of its response to the pandemic, Kaiser Permanente created a National Command Center (NCC) composed of medical and administrative leaders across the organization. To keep the NCC informed, the telehealth support team instituted and continues to refine metric reporting through a dedicated COVID-19 site, providing daily updates for national activity and infrastructure capacity. The site includes access to metrics and reports, applicable training, resources, as well as intake requests and forms. A 5-Star rating survey was implemented to capture patient and provider feedback on all video visits, immediately after the visit.

Outcome: In 2020 Kaiser Permanente conducted 26 times more video visits and 1.3 times more phone visits than in all of 2019. In 2019 video and phone visits accounted for approximately 15% of ambulatory care visits. In 2020 Kaiser Permanente provided approximately 31 million scheduled phone and video visits, conducted nearly 4.6 million e-visits (guided algorithms) and had nearly 60 million secure email encounters between patients and their clinical teams. A 2020 survey showed that most members who used telehealth during the COVID-19 pandemic said it solved their health concerns. It is anticipated that telehealth usage will remain high as members embrace a blend of telehealth and in-person care based on their needs.

Partner: Other.

PROJECT TITLE: Mobile COVID-19 Vaccination Units Reaching Minnesota’s Underserved Populations

Organization: Blue Cross and Blue Shield of Minnesota

Topic: COVID-19 Solutions

Project Contact: Jessica Titus, Accreditation Program Manager, Jessica.titus@bluecrossman.com

Project Overview: Access to the COVID-19 vaccine is one of the greatest barriers to equitable rates of vaccination in Minnesota. Data demonstrate that Minnesotans who live in an area with a high Social Vulnerability Index score have been disproportionately affected by COVID-19, and COVID-19 vaccinations are lagging in many of these areas. Mobile vaccination units are an important tool to reach people from every focus community, including people who might not otherwise have access to vaccination opportunities.

Blue Cross and Blue Shield of Minnesota launched six mobile units providing COVID-19 vaccinations to communities throughout Minnesota. The units are a key tool to ensure equitable distribution of vaccines, prioritize vulnerable and underserved communities and reduce barriers to vaccination by going directly to communities. The mobile vaccination units are a partnership between the Minnesota Department of Health(MDH), Blue Cross and Blue Shield of Minnesota and Metro Transit. Underutilized transit buses were transformed into mobile vaccination units by removing seating and installing equipment. Blue Cross and Blue Shield provides staffing.

Focus communities for the mobile units include, Black, Latinx, Asian Pacific Islander and Native American communities; LGBTQI+; people with disabilities and unique health needs; people experiencing homelessness; people more comfortable getting vaccinated in a trusted community space vs. a clinic or similar space; and people without access to vehicles. Other target populations include large employers such as factories, food processing and employers of seasonal and migrant workers.

Innovation: MDH identifies community locations through state demographic data, vaccination data and testing data, as well as input from trusted community partners, local public health and MDH equity leadership. Blue Cross and Blue Shield of Minnesota then assigns a Community Outreach Lead who works with each location

and ensures delivery of a holistic and customized approach for each site. Translators and community services appropriate for each location (e.g., food, direct connections to shelter/transportation, job opportunities) are provided and local leaders are asked to participate, when possible, to build trust (mayors, pastors, community leaders).

More than 700 associates have signed up to work the mobile vaccination sites. All are vaccinated and trained, which includes racial and health equity modules, community-specific awareness and education, operational and clinical protocols and more. Pre-registered individuals and walk-up registrations are included. The goal is for each site to be barrier-free; no ID or insurance are required. Translators are provided during all steps of the process, and in most cases, additional community services available. Information can be printed for any individual seeking additional help or services from the community. The sites operate Monday–Saturday, and each vaccinates up to 200 people per day.

Outcome:

- Vaccinated 1,000+ individuals per week
 - Served people who are homeless, undocumented immigrants, non-English speaking people, seasonal workers, people with low-income, people with disabilities, people without transportation and more.
 - Provided translators in 7 languages.
-

Partner: Government agency/nonprofit.

PROJECT TITLE: Mobile Vaccine Clinic

Organization: Tufts Health

Topic: COVID-19 Solutions

Project Contact: Christie Fluery, Director of Quality & Accreditation, christie_fluery@tufts-health.com

Project Overview: The goal of the project was to augment the Massachusetts state vaccination program by administering vaccines in a mobile clinic/van in underserved populations and in a culturally competent way. To address vaccine hesitancy in socially vulnerable areas in the state, Tufts Health partnered with minority-owned firms, health centers and other community partners to deploy digital and boots on-the-ground, culturally competent community outreach encouraging vaccination, and mobile vaccination clinics (Vax Vans) that brought the clinic to communities.

During the 2 months of this program, Tufts Health reached out to 10,000 individuals, contacted 4,300, administered vaccines to more than 3,000 and confirmed that at least 1,400 were fully vaccinated. Tufts Health learned that vaccine hesitancy is deep-rooted and based on access issues, information gaps/misinformation about vaccines and fear of vaccination, and worked to overcome those through improved outreach and education.

Innovation: Tufts Health targeted communities with high COVID rates and low vaccination rates, based on local community health center resources and capabilities, as well as physical and public spaces for the Vax Vans. The ASG team provided advance outreach, sign up and information in multiple languages, supported by social media, printed fliers and other advertising.

Sites were recommended by local officials, public health departments and other local stakeholders and supported by data such as zip-code level vaccination rates. Clinic sites included schools, public parks, areas frequented by public transit and town centers, and accommodated weekend and off-hour clinics.

Community engagement encouraged vaccinations and promoted the mobile clinic through social media, print, TV and telephone. Onsite reps helped address concerns about vaccine efficacy and vaccination dangers. Tufts

Health partnered with a marketing strategies firm specializing in culturally-competent communication to reach priority audiences in their language of preference and with a tailored message to incite action, including for follow-up appointments.

Outcome: The impact has been significant: More than 3,000 individuals have had at least one dose. Successful sites included schools, churches and public spaces. Public spaces were particularly successful because they could be highly visible, attract passers-by and leverage music and a “festival” atmosphere to create a sense of community and safety.

Partner: Other.

PROJECT TITLE: Oncology Home Based Infusion Model

Organization: Horizon Blue Cross Blue Shield of New Jersey

Topic: COVID-19 Solutions

Project Contact: Saira Jan, VP & Chief Pharmacy Officer, saira_jan@horizonblue.com

Project Overview: Horizon Blue Cross Blue Shield of New Jersey (Horizon) has partnered with Rutgers Cancer Institute of New Jersey (CINJ)/RWJ Barnabas Health and Qualitas Pharmacy Services to promote home infusion of oncology and other high-cost injectable drug treatments as an alternative to an infusion center. The goal of the project is to improve the patient experience while maintaining clinical quality.

The risk of exposure to COVID-19 for immunosuppressed cancer and other high-risk patients created an immediate need to establish an alternative to facility-based chemotherapy and related oncology treatment. Although home infusion is well established for other therapies and offers many potential benefits, oncology therapy typically has not been a target for the home setting.

An existing collaborative relationship allowed all parties to suggest a solution: Oncologists and other providers identified treatments that, under certain circumstances, could safely be delivered in the home; the health plan provided operational support that allowed the cancer center to quickly divert care to the home setting. Although the crisis called for expedited implementation, the parties clearly understood that lessons learned would be leveraged long after it abated.

Innovation: In response to the COVID-19 pandemic and as an opportunity to redefine the oncology care delivery model, Horizon partnered with CINJ/RWJ Barnabas Health to launch a pilot aimed at providing home infusion oncology treatments and other high-cost injectable drug treatments for eligible CINJ patients. The Horizon and CINJ teams started planning for the pilot by developing five key work streams that served to develop and identify eligible patients for the program, address and resolve operation barriers, and develop and track metrics.

Key objectives were to understand the operation and clinical aspects of oncology and other high-cost drug home infusion; prevent disruption of chemotherapy during COVID-19 and limit member exposure; develop products that provide similar benefits design for ambulatory and inpatient administered medications; determine the approach of total cost of care management; understand areas of opportunity and integration with community health workers and Episodes of Care Program; measure clinical outcomes, safety parameters, time to care delivery and patient/nursing satisfaction.

Patients to be screened were identified using a daily prior authorization file and a list of patients on eligible therapies. CINJ screened patients to determine eligibility into the pilot, Horizon assessed benefit design and out of pocket costs, Qualitas assessed capability for home infusion.

Outcome: As of June 2021, 71 patients had been screened for entry into the pilot. Eight entered the pilot; an additional 6 were pending initiation of treatment and 11 were in active screening. Patient and provider surveys

are collected to assess the overall experience.

Partner: Health system (ACO, hospitals)/Other.

PROJECT TITLE: Realigning Resources to Enhance Communications and Patient Care With Members/Patients

Organization: Portsmouth Community Health Center

Topic: COVID-19 Solutions

Project Contact: Phyllis Spellman, Quality Manager, pspellman@hrchc.org

Project Overview: Create a workflow that promotes the continuum of patient care and provides safeguards against patients and staff that were symptomatic for COVID-19. Utilize EMR features to enhance the patient experience and allow patients to receive care from home.

Innovation: Portsmouth Community Health Center implemented an infection control line for patients to speak directly with a nurse if they were symptomatic for COVID-19. Patients were then scheduled for in-house testing with Portsmouth's testing team. Positive patients received telehealth visits to keep the risk of spreading down. Vulnerable patients were also contacted monthly via phone or telehealth to maintain remote patient monitoring of chronic conditions. Portsmouth offered the flu vaccine curbside to prevent flu infections in vulnerable and underserved patients.

Outcome: Portsmouth Community Health Center was able to provide patients with quality care and diagnose and treat them for COVID-19. Patients could also speak with someone directly about possible symptoms or get vaccine information. The EMR respiratory illness assessment diverted patients from in-office visits and accommodated them with at-home care. Patients could receive care without fear of being infected with COVID.

PROJECT TITLE: RefuahHealth Launches Onsite Birthing Center to Improve Birthing Outcomes for Low-Risk Mothers and Infants During the COVID-19 Pandemic

Organization: Refuah Health Center, Inc.

Topic: COVID-19 Solutions

Project Contact: Amanda Salzman, Director of External Affairs, asalzman@refuahhealth.org

Project Overview: In October 2020, RefuahHealth, a Federally Qualified Health Center located in Rockland County, NY, opened the Esther Deutsch Birthing Center. Launched in response to COVID-19 and the challenges it created for hospitals, healthcare providers, and families, the birthing center offers a safe and welcoming experience for low-risk mothers and their babies. As one of the first low-risk birthing centers approved to operate in New York State during the pandemic, Refuah offers two private suites that combine the safety of a professional setting, the comfort of a home-like atmosphere and support of competent and attentive midwives. Expectant mothers designated as low-risk by their health care provider are eligible for delivery at Refuah. Birthing center staff collaborate with Refuah OB/GYNs and area hospitals to ensure a continuum of care.

Innovation: Refuah leadership contemplated ways to accommodate maternity patients during the pandemic and determined that an onsite birthing center was an innovative, effective and safe option for low-risk maternity patients to give birth. The birthing center is staffed by Refuah's team of midwives, who were already providing care at Refuah. Expectant mothers have at least one visit with a Refuah OB/GYN to ensure that they are a good candidate for a safe delivery.

Refuah operates the birthing center and provides all staff and services to patients directly, including clinical and administrative oversight and billing for services. It ensures that proper emergency equipment and supplies are approved by the medical director and available for use; birthing center staff members are trained in resuscitation and other emergency procedures; and a physician or registered professional nurse and another staff member, both trained in emergency procedures, are on duty when a mother is in the birthing center. Refuah has partnered with area hospitals to provide backup and emergency care as needed.

Outcome: Refuah patients rely on the center for nearly all of their health care needs, including prenatal and postnatal care and newborn care. Refuah is responsible for care of one of the state’s largest populations of women of child-bearing years and has an exceptionally low rate of c-sections (9.70% across all Refuah practices; 0.66% for Refuah’s midwife group). From January 1–March 24, 2020 (84 days), Refuah providers delivered 344 babies.

Refuah’s birthing center patients receive a continuum of maternity care, from primary care to prenatal services to post-partum care. It offers an attractive, safe and lower-cost option for maternity care while helping meet the NYSDOH’s goals of decreasing the c-section rate, increasing the percentage of women who breastfeed, improving maternal and infant outcomes and fostering strong family bonds.

Refuah’s birthing services will remain in demand post-COVID-19. New York State’s “COVID-19 Maternity Task Force” identified six recommendations to the Governor that approved birthing centers can provide an alternative and safe birthing option and can relieve the strain on hospitals.

PROJECT TITLE: [Using Analytic Software to Vaccinate Underserved Populations](#)

Organization: Blossom Road Medicine PLLC

Topic: COVID-19 Solutions

Project Contact: Sandra Boehiert, MD, CEO/Owner

Project Overview: Data show that some populations, such as the Hispanic population, receive a disproportionately small amount of vaccines. Blossom Road Medicine needed to develop an outreach system targeting patients who are less likely to be vaccinated. It used Arcadia Analytics to sort active patients by ethnicity and find the contact information and primary language of Hispanic patients. It then called these patients to ask if they had received the vaccine; if they hadn’t, they were if they would be interested in receiving it at the Blossom Road Medicine office or at another location. Patients were given the choice between the J&J and Pfizer vaccines (some patients prefer a single shot; some prefer the effectiveness of the Pfizer vaccine) and scheduled an appointment for patients who requested it.

Innovation: Planning for vaccine dispensing began in February 2020. Blossom Medicine appointed two vaccine champions and applied for NYDOH distribution of COVID-19 vaccines. Staff were trained on dispensing and documentation rules for the vaccine. Materials were already available and the DOH supplied syringes. The final step was determining the patient group that needed the vaccine; discovery of the vaccine hesitancy group led it to Hispanic patients. Arcadia Analytics created the list of patients for outreach. Programming was done internally and phone call outreach was prioritized over all other quality metrics.

Outcome: Of 800 active patients, 32 were categorized as Hispanic ethnicity. Of 13 non-vaccinators, 9 crossed over to the vaccinated group. The intervention involved patients’ families and friends as well, as information spread. The office and patients were educated and the message about getting vaccinated spread more easily after participating in this outreach. This small intervention consisted of a day’s work by an outreach staff member, a day of Arcadia Analytics by IT support and great innovative thinking from the office leader. Its effects spread out to benefit local public health.

Partner: Primary care practice(s)

PROJECT TITLE: When Crises Collide: Engaging Members During a Pandemic, Social Upheaval and Natural Disasters

Organization: Medica

Topic: COVID-19 Solutions

Project Contact: Jean Hutchinson Leiger, NCQA Project Manager, Quality Improvement Specialist, jean.hutchinsonleiger@medica.com

Project Overview: Medica is headquartered in Minneapolis, Minnesota, with membership across nine states in the Midwest. The COVID-19 pandemic had a huge health, social and emotional impact on members. At the same time, the situation was exacerbated by widespread social unrest after the murder of George Floyd and destruction from a devastating derecho in Iowa. Access to basic needs, such as medications and food, was often unavailable due to shuttered buildings or reduced facility hours, road closures, limited transportation options and other factors. Medica launched initiatives to support communities affected by longstanding racial inequities and social unrest, and reached out to help providers and members meet basic needs after major power outages and property damage from the derecho.

Innovation: Medica contacted members at greatest risk of developing complications from these events. Members were offered support for their physical and emotional health and well-being, and were directed to community resources for information about keeping healthy during the pandemic. Medica also partnered with the Minnesota Department of Health to conduct tracing calls—essential in understanding and containing the spread of COVID-19. It distributed more than 200,000 disposable masks to at-risk members and an additional 450,000 masks and PPE to community organizations and skilled nursing facilities. Medica donated \$1.2M in emergency donations to 27 non-profit organizations in Minnesota and Nebraska that address health needs of vulnerable populations.

Medica launched several initiatives to support communities directly affected by racial inequities and social unrest. It created a program to ensure that members had access to essential services and products, such as transportation, medications and groceries. \$1M of reserves were deposited in community banks to be used in low interest loans to help hard-hit communities and organizations. Medica Foundation grants totaled \$750K for crisis relief to 20 minority-led and minority focused organizations and community health centers, to support health and mental health needs, youth and family support, food security and other issues of concern in minority communities. Medica doubled Volunteer Time Off hours available to employees; many employees helped deliver supplies, participated in community clean-up efforts, served meals and more. Medica immediately began outreach to members in areas hardest hit by the derecho, offering support for pharmacy needs, food pantry resources and contact information for electrical companies.

Outcome: A team of Medica employees developed three distinct initiatives for timely response to crises and support for members and communities that felt the direct and indirect results of each devastating event. From March–October, more than 140,000 outreach calls were made across the initiatives. Members who reported needs related to SDOH, behavioral health or medical symptoms were referred to appropriate resources.

Medica partnered with the Minnesota Department of Health to assist with COVID-19 tracing calls. Volunteer staff made calls to individuals diagnosed with COVID-19 as part of statewide tracing efforts. A food drive resulted in eight full-size vanloads of essential supplies. \$4,000 was collected through Medica employees, friends and families to purchase more than 3,000 items through a Target registry.

Medica redoubled its efforts to promote diversity and equity in its workforce and in the community. It hired a senior director of DEI, created the Health Equity Workgroup and opened an office in the Midway St. Paul neighborhood, to learn from the underserved community and support the neighborhood's economic rebuild. The office will provide \$2M annually in salary and benefits to local residents who staff the office.

Partner: Government agency/health system (ACO, hospital)/Non-profit.

SUBMISSIONS ON DELIVERY SYSTEM DESIGN



PROJECT TITLE: Case Rate Reimbursement Delivers Value Across the Value Chain

Organization: HS1 Medical Management, Inc.

Topic: Delivery System Design

Project Contact: Marjorie Dorcely, VP, Compliance, dorcelym@healthsystemone.com

Project Overview: Health System One (HS1) implemented a novel approach to utilization management in outpatient physical, speech and occupational therapy. It employs a case rate reimbursement—a severity-adjusted fixed payment—for each episode of care. Its use allows health plans to delegate not only UM to HS1, but also network management, claims management and credentialing, and to do so under full risk.

HS1 exclusively contracts with health plans through its affiliate, Health Network One (HN1). HS1 and HN1 share identical ownership and are co-located in the same facility. From a health plan’s vantage point, their contractual relationship is with a co-mingled HS1/HN1 enterprise, with zero distinction between the two entities. HS1’s effective and efficient deployment of case rate reimbursement is supported by continuous improvements across staffing, training, standards, process and technology. This “virtuous system” ensures the most appropriate plan of care for patients.

Innovation: At HS1, case rate reimbursement is part of the larger whole. Nearly every major aspect of the company operates to enable case rate. Its UM team is staffed with 25 licensed therapists; each authorization request is reviewed by a therapist in the request’s discipline. Decisions are informed by a detailed intake process that includes a physician’s prescription, standardized test results and other assessments. Final severity-level decisions are supported by more than 500 million patient-months of clinical data. Once an authorization is issued (60 days for acute cases, 180 days for developmental delay cases) no further contact with the UM team is required. Providers submit encounters and for 180-day authorizations must hit a visit threshold based on severity level, but there is no ongoing dialogue about additional visits because the number of visits is governed by the provider rather than by HS1.

Outcome: Health plans that delegate outpatient therapy to HS1 typically see an immediate medical cost reduction of at least 15%. Barring material changes in patient volume or other externalities, PMPM costs remain fixed for an average of 5 years. The denial rate is approximately 0.1%. Working hand-in-hand with providers and sharing the same level of knowledge and experience means that an agreeable severity level is easily established. HS1 also sees some of the highest provider satisfaction rates in the industry: more than 95%. Member complaints are almost nonexistent. In 2019, for example, HS1 fielded less than 20 Medicaid member complaints in Florida, where the membership population is more than 1M. Simply put, members are not denied care and because HS1 has the largest network, access is not an issue.

HS1 has never been terminated by a health plan. More than half its client engagements are at least 5 years old, and more than half include multiple geographies or lines of business. Through direct experience and extensive research, HS1 knows that traditional UM and fee-for-service provider reimbursement is ineffective in managing outpatient therapy. Case rate reimbursement supported by specialized people and processes delivers material improvements to medical cost management, enables high provider satisfaction and virtually eliminates member complaints related to access to care.

Partner: Other.

PROJECT TITLE: Defining Value-Based Care and the Unique Approach to Population Health for the Rural Community

Organization: Mountain Laurel Medical Center

Topic: Delivery System Design

Project Contact: Jonathan Dayton, Community Relations & Pop Health Supervisor, jdayton@mtnlaurel.org

Project Overview: Mountain Laurel Medical Center seeks to address health-related social needs in local rural communities by going on the road to meet community members where they live, work and spend their leisure time. A significant barrier to receiving appropriate and adequate health care is rurality, combined with a lack of transportation to locally available resources. Mountain Laurel uses a one-of-a-kind mobile community outreach van that was been custom built to allow community health workers to travel to locations of greatest need. This “Wheels to Wellness” van is a medical-grade vehicle equipped with personal workstations for up to four people at a time. When on location, the team administers a brief survey inquiring about health-related social needs such as food insecurity, utility assistance, housing assistance and childcare resources, among others. If a community member screens positive for one or more need, they are referred to locally available community resources. The community health team also dedicates time to preventive care outreach of specifically identified value-based, payer-driven measures.

Innovation: The intervention was developed from a larger approach to population health to address socially driven issues that affect the health and well-being of community members. The evidence to develop this approach came from the overwhelming success of the organization’s monthly community food drives, which are held during the warmer months and rotate between different communities. Food is brought to communities that need it most. At each event, at least 6,000 pounds of fresh produce is distributed to up to 250 households, in addition to health promotion materials provided by community partners us at no cost. The center feels that addressing health-related social needs of community members will allow them to focus on their physical and mental health and well-being. Additionally, it allows providers to focus on actual measures pertaining to the physical and mental health of the individual, rather than attempting to sift through a tangled web of complex, socially driven issues. In short, a healthier social life increases one’s chances of living a healthier physical and mental life, and therefore reduces their chances of succumbing to any number of measures of morbidity and mortality. In turn, reduced occurrences of measures of morbidity and mortality leads to money saved or even earned across the organization.

Outcome: While improved holistic health outcomes for patients lie at the forefront of the approach, it is not the only benefit. The more visible the organization’s brand in communities, the more traffic will be driven to its clinics, the more aware local communities will be of its brand and what it stands for, and the more other local community organizations will look to partner with the organization to make positive impacts in the communities they serve. Through this approach to community outreach and population health the organization does the most good for those who need it most—by meeting them where they live, work and play.

Partner: Other.

PROJECT TITLE: Improving Diabetes Related Outcomes with Zero Dollar Insulin Copays

Organization: Health First Health Plans

Topic: Delivery System Design

Project Contact: Gene Terkoski, Director, Managed Care Pharmacy, eugene.terkoski@hf.org

Project Overview: Health First Health Plans reduced member cost shares to zero dollars for all formulary insulins and diabetic testing supplies. The goal of this intervention was to improve the health of its member populations through increased insulin adherence, A1C reduction and improved diabetes-related outcomes.

Innovation: To promote adherence to prescribed insulins, Health First Health Plans removed member copays from insulins and diabetic testing supplies. When prescribed, members were able to fill their formulary insulins and testing supplies with zero-dollar copays.

Outcome: Removing the member cost share from insulins and diabetic testing supplies led to a significant increase in utilized insulin and medication adherence. Medication adherence improved at all measured points and led to better A1Cs for insulin-dependent members. The median A1C percentage decreased by 17.3%, from 8.1% to 6.7%. This objective improvement resulted in improvement to diabetes-related outcomes for insulin-dependent members, which included a 58% reduction in ER visits related to treatment of diabetes complications. Also observed was a 48% reduction in hospital admissions related to diabetes complications. Most notable was the reduction in diabetes related readmissions by 74%.

Partner: Health System (ACO, hospital).

PROJECT TITLE: Mobilizing Health Center Infrastructure to Meet Community Needs During a Pandemic

Organization: Delaware Valley Community Health, Inc.

Topic: Delivery System Design

Project Contact: Timothy Stewart, Administrative Assistant to the COE, stewartm@dvch.org

Project Overview: Overnight, the majority of Delaware Valley Community Health, Inc.'s (DVCH) 300+ workforce switched to teleworking. It went from providing only in-person health care to nearly 50,000 patients to offering telehealth appointments—in less than 3 days. Communication, teamwork and partnership proved invaluable for ensuring the same high-quality, culturally competent care that DVCH has provided for over 50 years was delivered without interruption to patients. DVCH began testing for the COVID-19 virus and mobilized nearly one-third of its nonclinical workforce to help set up, run and data-validate four COVID testing locations across two counties. All departments were included in the testing process. When vaccines became available, teams switched from testing to administering vaccines. Within that effort, teams were formed to outreach to local, often non-English speaking populations, to provide education and access.

Innovation: Implementing Microsoft Teams pre-pandemic was pivotal to the success of the COVID-19 prevention operations at DVCH. Comprehensive technology integration for teleworking staff, including Wi-Fi boosters and laptops, was a vital function of the information systems team. Testing models were integrated to make use of clinical expertise and available administrative staff. Flow mapping moved patients through the testing process. Rotating teams managed self-swab testing at each sites. The facilities and operations staff erected open-air testing tents to ensure the safety of patients and staff. It was crucial that vaccine delivery methods did not create new barriers to care. Changes to the organization's website allowed direct addition to the waitlist as vaccines became available. An interdepartmental team managed the list and used surveying technology to ensure that patients on the list still needed vaccination. Data managers tracked how vaccine administration patterns aligned with traditional patient demographics. Community partnerships with local

religious groups and schools ensured that care was reaching vulnerable populations.

Outcome: Delivery of culturally competent care is the primary objective of DVCH. More than 15,000 vaccines have been administered across all sites. No members of the patient-facing testing or vaccine team were diagnosed with COVID. A healthy workforce and a healthy community are the most significant markers of success. Recognition of the testing and vaccine model came from organizations at the local, state, and national level. DVCH continues to provide vaccination and testing, moving now to deliver these services to homebound individuals.

PROJECT TITLE: Overcoming Barriers to Biosimilar Adoption Through Coordinated Efforts Within an Integrated Delivery Network

Organization: Health First Health Plans

Topic: Delivery System Design

Project Contact: Gene Terkoski, Director, Managed Care Pharmacy, eugene.terkoski@hf.org

Project Overview: Health First pharmacy departments developed and implemented interventions within all settings of its integrated delivery network (IDN) to address barriers to biosimilar utilization. This ubiquitous and coordinated effort was designed to make biosimilars preferred throughout the IDN. The goal of these interventions was to make biosimilar products the most utilized products in the organization.

Innovation: In the IDN setting, barriers to biosimilar adoptions were overcome through the ubiquitous promotion of biosimilars. The pharmacy departments developed and implemented interventions throughout the IDN, including the hospitals, infusion centers and health plan. Coordinated efforts by different teams in the IDN were designed to make biosimilars preferred across all facilities. Interventions in hospitals included targeted physician training led by organization leaders, updates in the EMR that direct providers to use biosimilars and automatic substitutions of orders to biosimilar alternatives when available. Physician education emphasized the biosimilar approval process and data demonstrating the safety and efficacy of biosimilars. Interventions in infusion centers included physician training led by organization leaders and biosimilar-experienced physicians, proactive 1:1 meetings with affected specialists prior to biosimilar approval and follow-up with progress reports. Physician education emphasized real-world evidence surrounding the interchangeability and immunogenicity of these products. Interventions in the health plan included removing authorization requirements for biosimilars and adding step therapy requirements for originator products. A common physician concern was reimbursement and pricing. Additional education was provided to these physicians to ensure that they knew how they would be reimbursed and the expected reduction in copays their patients would receive.

Outcome: Interventions led to a significant increase in utilization of biosimilars. The IDN converted most utilization to biosimilars within a few months of a product's launch. By the end of the first year in the market, IDN biosimilar utilization is often at or above 90% of the market share. A culture of biosimilar acceptance led to a \$54,671.48 reduction in IDN hospital costs and a \$1,410,645.70 reduction in infusion clinic costs. At the above-national average biosimilar market share achieved, the health plan will spend \$1,490M less every year. Member copays were reduced by \$200,000.

Partner: Health system (ACO, hospital).

SUBMISSIONS ON HEALTH EQUITY



PROJECT TITLE: Designing and Implementing a Complex Care Model in a Safety Net Health System

Organization: NYC Health + Hospitals

Topic: Health Equity

Project Contact: Gene Terkoski, Director, Managed Care Pharmacy, eugene.terkoski@hf.org

Project Overview: In 2018, NYC Health + Hospitals, the largest public health care delivery system in the country, developed a primary care model in complex care. One segment comprised patients experiencing housing instability and homelessness, including people who sleep in public spaces or shelters, with multiple medical conditions and unmet behavioral and social needs. This group historically lacked access to traditional primary care services, suffered poor health outcomes, were more likely to be hospitalized and visit the ER, and had high prevalence of medical mistrust. A complex care model, the Primary Care Safety Net Clinic, was piloted in Manhattan and subsequently expanded to a second site in Brooklyn.

Innovation: The Primary Care Safety Net Clinic was established with an interdisciplinary care team of ambulatory care medical and nursing staff, care coordinators and social workers. It offers an intensive outpatient medical and social support system to vulnerable homeless patients, with the ability to connect patients to hospital-based specialty care and acute care services efficiently. Safety net staff provide services in addiction medicine, mental health, housing progression and chronic disease to patients in a dedicated primary care setting, separate from adult medicine. Patients are also linked with wound care, dermatology, cardiology and other specialties to address chronic disease and obtain preventive treatment. Clinic schedules allow more frequent revisits and extended visit times, accommodation of walk-ins and flexible missed-appointment policies that trigger outreach to patients and encourage returning for care. Its success hinges on a relationship-driven approach, interdisciplinary team care, an organically built referral network and collaboration with community partners. Housing navigation is a key service feature; Safety Net patients receive tailored support to complete supportive housing applications, expedited completion of supporting medical and psychiatric assessments for housing programs, assistance with housing voucher program navigation, advocacy in engaging with homeless shelter based housing staff and preparation for housing interviews. Core elements of the model can be replicated at other public hospital settings.

Outcome: A quality improvement team identified high-priority quality measures and designed and implemented a framework for evaluating outcomes. 225 patients met criteria for engagement with the clinic; 499 were considered moderately engaged. Compared to the months prior to engaging with the clinic, both engaged and moderately engaged patients had reduced utilization of the ED at all time points in the post-period. Compared to the year prior to engagement with the clinic, engaged and moderately engaged patients experienced similar relative reductions in ED utilization in the 1-year post-engagement. Ongoing efforts to measure the success of the clinic using additional metrics will be critical to improving the quality of care delivered.

Permanent housing is a key outcome that affects the health of the homeless. As a result of engagement with the clinic services, 37 patients were placed in permanent housing with SafetyNet Clinic staffing support from September 2019–January 2021. The navigator directly supported housing packet applications for 29 chronically street homeless patients, while providing advocacy support with NYC Department for Homeless Services shelter-based clients who had existing housing specialist support in their shelters, resulting in more permanent housing placements for patients.

Partner: Government agency/health system (ACO, hospital)/primary care practice(s).

PROJECT TITLE: Mobilization Health Equity, Value-Based Care and Quality Through Collaborative Learning

Organization: SmartRise Health

Topic: Health Equity

Project Contact: Vanessa Guzman, MS, ME, Chief Executive Officer, vg2110@gmail.com

Project Overview: SmartRise Health's focus on promoting overall health and well-being through the integration and coordination of care and services is driven by its desire to confront avoidable inequalities that lead to disparate health outcomes. SmartRise designed a collaborative learning platform to promote health equity while integrating value-based care and change management concepts. The framework uses stakeholder engagement to enable a culture of change while building the infrastructure necessary to drive change over time and evaluate interventions using the Institute for Healthcare Improvement's collaborative model. Since its development in 2020, it has been used across stakeholders including provider networks, community-based organizations, pharmaceutical and technology organizations to promote equitable access to care. The framework is designed for organizations looking to integrate health equity into their services, quality standards and clinical improvement activities. The learning collaborative includes case studies, real-world tips and best practices, a toolbox designed with customer content to support an organization's core competencies and a fellows training program to ensure long-term workforce success and foster sustainability.

Innovation: The learning collaborative promotes a framework and content over 6 months–5 years to improve awareness of health disparities in specific health topics:

- *Awareness:* Increase awareness of the significance of health disparities, their impact on the nation and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations.
 - *Leadership:* Strengthen and broaden leadership for addressing health disparities at all levels.
 - *Health System and Life Experience:* Improve health and healthcare outcomes for racial, ethnic and underserved populations.
 - *Cultural and Linguistic Competency:* Improve cultural and linguistic competency and diversity of the health-related workforce.
 - *Data, Research, and Evaluation:* Improve data availability and coordination, utilization and diffusion of research and evaluation outcomes.
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Outcome: The learning collaborative models and fellowship programs demonstrated impact by facilitating resources and structure processes. Pneumococcal vaccinations improved by 58%; flu immunizations improved by 22%; depression screenings improved by 67%. Development of a care coordination team and patient outreach to close gaps in care resulted in ACO savings of +\$1M for the group.

Most of the success can be attributed to the leadership team's commitment to prioritizing program design that included the community and partnerships, and to the long-term vision of leveraging technology and alignment with quality improvement initiatives as a mechanism for scalability and sustainability over time.

Partner: Health system (ACO, hospital).

PROJECT TITLE: Retinal Eye Camera Program

Organization: Anthem

Topic: Health Equity

Project Contact: Kathryn Kranitzky, Quality Growth Director, Kathryn.kranitzky@amerigroup.com

Project Overview: As part of Anthem’s efforts to reduce health care disparities, it is working with providers to help purchase a retinal eye camera for diabetic eye exams in their offices. This will reduce barriers of a second appointment with a specialist and ensure that members get the care they need. Providers are given a grant in an agreement to meet quality improvement goals related to the Comprehensive Diabetes Care (CDC) Dilated Retinal Exam (DRE) measures and must adhere to quality management improvement criteria.

Innovation: Providers receive a one-time payment of \$10,000 to purchase a telehealth-enabled eye exam camera and are responsible for ongoing costs associated with maintaining the camera. Providers submit the appropriate codes for billing and receive education and training for coding and billing, if necessary. If there are any questions regarding coding or billing, Amerigroup will educate and train to support the provider.

Outcome: 12 providers purchased cameras in Tennessee in 2021; 10 have met at least one quality improvement goal. Tennessee was the first Anthem Medicaid Plan to pilot this intervention and is working on launching it in several other states.

Partner: Primary care practice(s).

SUBMISSIONS ON INTEGRATION OF CARE



PROJECT TITLE: CareCar: Member-Focused Medical Transportation to Expand Access and Inclusivity

Organization: CareCar

Topic: Integration of Care

Project Contact: Noelle Freschet, Assistant PR Coordinator, nfreschet@gmail.com

Project Overview: CareCar, a tech-enabled benefit manager and value-based health care services platform, developed its disruptive medical transportation model as a way to improve access to care and expand inclusivity. CareCar helps people get the services they need to remain independent despite physical or psychosocial factors that would limit access to care and/or heighten risk in traditional medical transportation environments.

Members can access medical transportation services with a click, and CareCar can help health plans identify ancillary needs as indicated (e.g., home health care, meal services) to maintain independence and prevent trips to the ER and/or hospitalization.

CareCar also pioneered a marketplace platform that gives trained Care Partners who provide medical transportation services guaranteed pay for meaningful work, access to training and the ability to earn a living wage while enjoying a flexible schedule.

Innovation: CareCar invented a medical transportation model that addresses two pressing trends: the rising cost of care for older Americans and people with chronic conditions, and the desire of these populations to remain independent for as long as possible. The Care Partner network provides transportation while focusing on member wellness, gathering and rapidly transmitting data with every encounter. Not only can Care Partners provide new data that is unavailable to health plans that use rideshare services to transport members, such as assessment of support resources and suitability of the home for members who use a wheelchair or are bedbound, it can transmit data in a timely way so that health plans or primary care providers can act. For example, if a member misses a dialysis appointment, Care Partners transmit the data immediately. CareCar data can help health plans identify at-risk members and provide services they need to ensure the best outcome. With caregiver training as well as CPR and first aid certificates, Care Partners are uniquely positioned to provide the basic care members need, including nonemergency medical transportation, and keep the health plan and primary care team apprised of the member's status. This fulfills the goals of all parties by helping to prevent acute health episodes that require care level escalation and enabling members to stay in their homes as long as appropriate. It also allows Care Partners to earn a living wage on a flexible schedule, which helps them fulfill their educational, family and career goals while serving their communities.

Outcome: Care Partners provides insights that help health plans and clinical care teams prevent hospitalizations and address the needs of at-risk members. This can help keep health plan costs under control and immeasurably improve quality of life for members, who can avoid an acute episode of illness and the stress and expense of inpatient hospital care or admission to a long-term care facility.

CareCar achieved a 99.4% success rate on request fulfillment. On-demand services are met with a 13-minute wait time. User satisfaction is high, with just a .04% complaint rate. These metrics far exceed the success rates, wait times and satisfaction rates of traditional ride-share services.

CareCar is disrupting the medical transportation industry by shifting the focus from logistics to member health. Logistics is at the core of medical transportation, but in the CareCar model, each encounter means another chance to ensure member well-being, alert health plans and clinicians to the need for additional support and generate data to drive ongoing improvement.

Partner: For-profit/other.

PROJECT TITLE: Collaborative Community Health Worker Model to Address Health Disparities in Metro Counties

Organization: Blue Cross and Blue Shield of Minnesota (Blue Plus)

Topic: Integration of Care

Project Contact: Jessica Titus, Accreditation Program Manager, Jessica.titus@bluecrossmn.com

Project Overview: To address COVID-19's disproportionate impact on Black, Indigenous and people of color (BIPOC) in Minnesota, Blue Plus identified three counties with higher-than-average percentages of BIPOC residents to provide targeted community health worker outreach and support. In 2020, Blue Plus partnered with WellShare International (WellShare) to deploy community health workers in those counties to bridge cultural and language barriers, convey information related to COVID-19 and connect members to community resources. Blue Plus selected Spanish-, Hmong-, Somali-, and Karen-speaking members for this outreach effort.

Innovation: The original objective was to help prevent COVID-19 spread and provide support during the pandemic to vulnerable members by contacting and establishing member engagement with 15%–20% of these members. The Quality Improvement team created materials to answer common member questions and concerns and make it easy for CHWs to refer members to resources. CHWs also offered complimentary COVID-19 care kits to members containing masks for adults and children, hand sanitizers, a digital thermometer for easy reading, bar soaps to prevent virus spread and a multi-lingual letter written in English, Somali, Karen and Hmong to share how to use these items properly. Within 3 months of the project's launch, there was a decline in well-child visits across all ethnicities and races (20%–30% lower rates in 2020 than in 2019).

CHWs heard from members that they were afraid to go to in-person preventive care visits and to get flu shots. In response, Blue Plus enhanced the resource guide and member information to include household members who were behind in well-child visits or pregnant. The resource guide was also leveraged by the Minnesota Department of Health and the Minnesota Departments of Human Services in its launch of a vaccine equity partnership with Minnesota health plans. Blue Plus plans to continue to leverage learnings from this project for future CHW initiatives, including one that addresses high ER utilizers.

Outcome: In 2020, CHWs provided outreach to more than 3,400 households and 14,000 individuals in the Metro Area, with a strong 35% member engagement rate. In addition to providing COVID-19 information and resources to 3,400 households, Blue Plus has sent more than 350 COVID-19 care kits.

The CHW initiative was expanded to improve immunization rates and prenatal and postpartum care. There have been positive results in claims data for pregnant members whom WellShare successfully contacted. An additional 7.6% of pregnant women had both a timely prenatal appointment and a postpartum visit. An additional 4.7% of pregnant women received their prenatal immunizations, including influenza and Tdap vaccinations.

Partner: Non-profit.

PROJECT TITLE: Implementation of Collaborative Drug Therapy Management Services in a Large, Public Health Care System in the United States

Organization: New York City Health + Hospitals

Topic: Integration of Care

Project Contact: Joshua Rickard, Sr. Director, Ambulatory Care Clinical Pharmacy, josh.rickard@nychhc.org

Project Overview: New York City Health + Hospitals (NYC H+H) is the largest public health care system in the United States. The patient population it serves is disproportionately affected by chronic disease. The prevalence of diabetes among its patients is 22.6%, compared to 13.0% nationally. Of these, 36% do not meet their HgA1c goal. More than 90% of patients with diabetes identify as an ethnic minority; 40.7% prefer to receive care in non-English languages. Most patients are uninsured or rely on public insurance programs to access health care.

Collaborative Drug Therapy Management (CDTM) lets pharmacists co-manage patients under a collaborative practice agreement with a patient's primary care physician. This intervention focused on integrating clinical pharmacists with CDTM privileges into primary care clinics to improve patients' clinical outcomes, increase access to care and connect patients to other members of the health care team. lth First pharmacy departments developed and implemented interventions in all settings of their integrated delivery network (IDN) to address barriers to biosimilar utilization. This effort was designed to make biosimilars preferred throughout the IDN and make biosimilar products the most utilized products in the organization.

Innovation: CDTM-certified pharmacists were hired to perform collaborative chronic disease management in primary care clinics at 5 NYC H+H sites. Patients eligible for co-management by the CDTM pharmacist were identified by the patient's primary care physician. During the patient's first visit with the pharmacist, there is a comprehensive medication reconciliation, disease state education and an assessment of the patient's medication adherence, pharmacotherapeutic regimen, laboratory parameters and lifestyle habits. Based on this visit, the pharmacist adjusts the patient's pharmacotherapeutic regimen utilizing the health system-approved treatment algorithm and patient-specific factors such as comorbidities and patient preference. The pharmacist also refers patients to podiatry, ophthalmology and nutrition, to ensure they receive recommended screenings and education. Patients continued to see their pharmacist for ongoing medication-related adjustments until they reach their A1c goal, at which point they are "discharged" to the primary care physician for continued management.

Outcome: As of May 2021, 5,597 patients had been referred to the CDTM pharmacists across NYC H+H for a total of 32,030 completed visits. Of the 1,989 patients with uncontrolled diabetes, 47.0% have met the goal of <8.0. On average, patients engaged in this program had 4.61 encounters with the CDTM pharmacist. Recommended annual kidney function screening tests (urine microalbumin) were also higher in this intervention group (66.3% of patients had this test, compared to 33.3% of all patients with diabetes in primary care). The program has been approved to grow systemwide at all remaining primary care sites. The pharmacist-physician collaborative practice agreement has been expanded to include management of hypertension, hyperlipidemia, type 1 diabetes, anticoagulation and smoking cessation.

Partner: Health system (ACO, hospital).

PROJECT TITLE: Improving Connection to and Continuity of Care for Justice-Involved Patients

Organization: New York City Health + Hospitals

Topic: Integration of Care

Project Contact: Amanda Johnson, MD, AVP, Office of Ambulatory Care & Population Health, johnsona31@nychhc.org

Project Overview: NYC Health + Hospitals/Correctional Health Services (CHS), in partnership with NYC Health + Hospitals/Office of Ambulatory Care, created Point of Reentry and Transition (PORT) Practices to address disruption of care in the immediate post-release period for individuals leaving incarceration. PORT Practices operate in outpatient settings at two NYC H+H hospitals. Patients can obtain treatment, including medication, regardless of insurance status and can connect with insurance or other health care coverage options based on eligibility. Each PORT Practice team includes a community health worker (CHW), nurse, patient care associate and provider. CHWs have lived experience of incarceration and help patients navigate the medical system and connect to social services. Additional support is provided through CHS' contracted Community Reentry Assistance Network (CRAN). CRAN helps patients obtain identification and apply for benefits and housing, and offers a range of other services directly or via referral. People leaving NYC jails learn about the PORT Practices from CHS staff or through its dedicated reentry support hotline (PORTline). Patients are also referred by clinicians, community-based social service providers and legal counsel.

Innovation: PORT Practices are ambulatory care practices embedded in Manhattan and Brooklyn. The most critical feature of PORT is the inclusion of CHWs with lived experience of the criminal legal system in the care team. A CHW is on site during every session and is available to escort patients around facilities, assist with registration and check-in, make referrals for social services, help schedule appointments, facilitate medication pick-up at hospital-based pharmacies and arrange transportation. CHWs are patients' primary point of contact and are available by text and phone. The care teams include CHS physicians and hospital-based clinicians who have self-selected to care for this patient population. PORT staff can access jail-based medical records in real time, helping inform clinical decisions and ensuring greater continuity of care. The Manhattan PORT integrated a CHS psychiatrist into the practice twice a week. As a result, PORT is an alternative for avoiding disruption in psychiatric medication, including long-acting injectables, and ensures that patients do not fall out of treatment. This model has also helped reduce stigma around seeking mental health care because the psychiatrist shares the same physical space as the other providers and relies on the same support staff and CHWs.

Outcome: PORT was launched in July 2019. As of the end of March 2021, 178 unique patients were seen at the practices, with 546 visits completed. Although the practices offer telehealth visits, 80% of appointments are conducted in person. The majority of patients are single adult men of color. 70% of patients have a recent history of NYC jail incarceration, typically having their first PORT appointment within 3 months of release from custody.

Patient engagement with PORT clinical services declined during the initial wave of the COVID pandemic. From March 15–September 15, 2020, 106 visits were completed, but the majority of patients remained in contact with the CHWs.

Efforts to create custom PORT documentation in the EHR are ongoing. In the meantime, many patients report that PORT provided their first positive experience with the health care system.

Partner: Health system (ACO, hospital)/Non-profit.

PROJECT TITLE: Increasing Lipid Screening Rates in Children ages 9 and 17 years

Organization: Cleveland Clinic Martin Health

Topic: Integration of Care

Project Contact: Deborah Bordner, Admin Program Coordinator, Pediatric Population Health, bordned@ccf.org

Project Overview: Cardiovascular disease is a leading cause of morbidity and mortality worldwide. Risks factors are dyslipidemia, family history, obesity and genetic predisposition. Knowing that dyslipidemia is a significant risk for heart disease, lipid screening for the pediatric population is an effective tool for early detection. A universal lipid screening guideline was put in place by the National Heart, Lung and Blood Institute for pediatric patients 9–11 years and 17–21 years, and was adopted by the American Academy of Pediatrics. The quality improvement project used the guidelines to study two pediatric age groups, 9-year-olds and 17-year-olds. It aimed to increase the lipid screening orders, completions and follow-ups in three different outpatient pediatric sites within the Cleveland Clinic Martin health system, with the goal of improving the rate of completion. Cleveland Clinic Martin Health partnered with third- year medical students at Florida State University to perform a quality improvement project in their offices. They observed the lipid screening process in each office, identified areas for improvement and implemented measures to increase screenings.

Innovation: Data were collected on the number of lipid screenings performed at 9 years and 17 years of age, completed with results and followed up in patients with an abnormal result (cholesterol > 175, Trig > 100, LDL > 130). Initial data collection was June–August 2020. The second data collection was November 2020–January 2021. Interventions implemented for quality improvement included adding a laminated card to each nurse’s station as reminder to test; adding “lipid screening” to each well-child visit schedule for 9- and 17-year-olds; and completing the lipid screenings with vital signs, to ensure the provider had results to review before the visit and discuss abnormal results and next steps. Each office had office champion who oversaw the process and monitored adherence. If the in-office result was abnormal, a fasting outpatient laboratory test was ordered or a follow-up in-office test was scheduled.

Outcome: 443 patient charts were reviewed for this quality improvement project. The pre-intervention data analysis had 217 charts.

Follow-up for abnormal lipid screening had a 25% rate for 9-year-olds and a 17.6% rate for 17-year-olds preintervention. Post-intervention, this increased to 39% for 9-year-olds and 32% for 17-year-olds. Although this project was successful, it showed there is still have room for improvement in this important screening metric.

Partner: Other.

PROJECT TITLE: Integrating Care for Members in New Jersey

Organization: Horizon Blue Cross Blue Shield of New Jersey

Topic: Integration of Care

Project Contact: Suzanne Kunis, VP, Behavioral Health, Suzanne_kunis@horizonblue.com

Project Overview: The Integrated System of Care program is a virtually integrated system of behavioral, physical and SDOH health providers collectively manage care of members with serious mental illness and/or substance use disorder. The program is built on the belief that all three components must be addressed in order for a person to achieve long-term recovery and remission.

The Integrated System of Care program aims to empower New Jersey health care systems in their journey to improve the health of local communities by reducing barriers, increasing patient navigation support to high-quality behavioral health services and strengthening the integration of behavioral and physical health management while addressing compelling social needs. It engages community-based behavioral health providers to provide care coordination, clinical delivery of services, bidirectional data sharing and SDOH wraparound supports. Participating provider organizations drive integration.

Putting an “integrator” at the center of a patient’s complex health care journey significantly impacts the quality of health care delivery.

Innovation: Providers engaged in a member’s health and well-being are coordinated by the program provider or “integrator,” who is responsible for delivering and coordinating care through relationships with community providers addressing the behavioral, physical and SDOH needs of members. The objectives of the program are to reduce delivery system fragmentation through enhanced integration of care, to increase access and improve navigation and to improve quality and reduce total health care cost. Multiple channels engage members, including referrals from providers, ED, inpatient facilities and community resources. After a referral is made, the integrator determines the member’s health needs and delivers the appropriate care/treatment (e.g., targeted case management, Medication Assisted Treatment, crisis mental health services, outpatient mental health and substance use services, vocational training). Horizon is the liaison between the integrator and local health systems. It notifies providers about the program, describes its benefits and discusses referral streams. Integrators connect with primary care practices and other behavioral health treatment programs to enhance communication and coordination, and build relationships.

Outcome: The approximately 400 members who were part of the pilot reported significant improvement: 100% reduction in hospital admissions, 58% reduction in ER visits, 90% reduction in days of alcohol use, 96% reduction in days of illegal drug use, 59% improvement in quality of life.

These outcomes are based on member responses to the Government Performance and Results Act (GPRA) survey at admission and 3, 6 and 9 months. Corresponding claims validate client-reported data.

Based on the initial success of the pilot, Horizon recruited additional providers to replicate and stretch the program’s reach at the beginning of 2021 and again in the middle of the year. The goal is to offer services to members throughout the state by early 2022.

Partner: Other.

PROJECT TITLE: Integration of Care—Hepatitis C Clinic

Organization: RiverStone Health

Topic: Integration of Care

Project Contact: Breann Streck, Sr. Director of Operations, Breann.str@riverstonehealth.org

Project Overview: In 2019, RiverStone Health recognized a need to develop an integrated hepatitis C treatment program in its Federally Qualified Community Health Center. Restrictions were lessened to not restrict providers from prescribing hepatitis C treatment drugs and make these treatments within the scope of a family practice provider. An interdisciplinary team, with provider advisement and involvement, was created to develop a treatment pathway for patients that included access to consultants when needed for more complex patients.

Innovation: The hepatitis C treatment pathway included screening recommendations, diagnosis and an integrated multidisciplinary treatment pathway. Screening recommendations aligned with USPSTF recommendations. Screenings included all pregnant women and any patient who asks, in addition to risk-based screenings for patients with “street tattoos,” intranasal drug use and intravenous drug use. Patients could obtain all screenings and bloodwork at any RiverStone Health clinic per a sliding fee scale. This meant that treatment was available to patients regardless of their ability to pay. Treatment included integrated behavioral health, the Live Well Center and a care team. It emphasized the recovery plan, relapse prevention and harm reduction. Patients are educated about their responsibility to follow the plan of care, take medications and participate in post-treatment viral load testing.

Outcome: To date, the current SVR conversion for all patients treated is 100%. 140 patients have been cured of hepatitis C and have completed treatment through the hepatitis C pathway. 30–35 unique patients each month begin treatment.

PROJECT TITLE: Taking a Team Approach to the Top 5 Percent

Organization: Health First Health Plans

Topic: Integration of Care

Project Contact: Ruthan Tattersall, Director, Population Health, ruthan.tattersall@hf.org

Project Overview: Health First Health Plans partnered with Health First Medical Group to implement the Integrated Care Program, to provide enhanced, coordinated care to highest-cost, highest-need members. This program encompasses the quadruple aim approach improving patient health and experience, reducing health care costs and increasing clinician satisfaction. It is designed for members whose medical needs require frequent medical attention and office time. The goals of the program are to improve quality of care and reduce avoidable costs and promote member independence and self-management by improving access to care, overcoming social barriers and engaging members and/or family/caregivers with the medical team and community resources.

Innovation: The Integrated Care Program is an opt-out program offered at no additional cost to eligible health plan members, and complements and supports the care they already receive from their established primary care and specialist providers. The health care team includes a physician, nurse practitioner, pharmacists, clinic nurse, case managers and social worker, located at a clinic in a medical group complex, which provides immediate access to laboratory, diagnostic and community pharmacy services. Transportation is coordinated when needed.

Caregivers or family are encouraged to attend the initial in-depth visit, where a thorough medical history is obtained, barriers to health are assessed and a comprehensive medication review is conducted. After the visit,

a plan of care is developed, and monthly follow-up visits are scheduled to review progress. Members have access to more frequent and same-day appointments if needed. They are assigned a telephone case manager who contacts them between clinic visits to check on their progress and care coordination needs. An onsite social worker works with members when needed or when SDOH are identified. Pharmacists provide consultations and education about medication use and work on medication-related issues such as adherence. The member's providers are kept informed of the care plan and ongoing progress. Other program components include tools to promote self-management, home monitoring logs, updated medication lists, community resources and educational handouts, and pillboxes to improve adherence.

Outcome: Patients enrolled for a minimum of 6 months demonstrate a savings of over \$1,100 per member per month, a 35% reduction in ER utilization, a 46% reduction in hospital admissions and a 38% reduction in readmissions. The program expanded in 2021 to include an additional location and care team.

Partner: Health plan/Primary care practice(s)

PROJECT TITLE: Utilizing Behavioral Health in Medication Assisted Treatment for Opioid Use Disorder

Organization: RiverStone Health

Topic: Integration of Care

Project Contact: Tammi Anderson, Behavioral Health Program Manager, tammi.and@rivestonehealth.org

Project Overview: Participating patients have access to the Medication Assisted Treatment Opioid Use Disorder (MAT-OD) program, which incorporates behavioral health services, including a licensed addiction counselor and mental health therapist, care management and a primary care provider for skills, support and medication.

Innovation: Patients who are within the level of care for RiverStone Health's MAT-OD program and have a readiness to change meet with an addiction counselor to complete a chemical dependency evaluation, create a plan of care with the patient and be scheduled for a visit in the MAT-OD clinic. During the first appointment, patients are educated on the treatment process and given materials on withdrawal, buprenorphine and a prescription for Narcan, and begin a recovery plan. Patients are encouraged to visit with the behavioral health team to address relapse prevention, recovery skills and skills to reduce symptoms of poor mental health. The nurse calls the patient daily for 3 days to assess symptoms, ensure the patient takes the medication correctly and determine if triage is necessary. Patients must come in weekly for the first month of treatment. Patients who do well graduate to a visit every 2 weeks, then to monthly after 3 months. At every visit, the MAT-OD team monitors the patient through urine drug testing and the prescription drug registry. The team also monitors for celebrations and give incentives when appropriate. The MAT-OD team identifies patients who have followed the clinic protocol and refers them to transition to a MAT-OD trained primary care provider for ongoing treatment.

Outcome: All primary care providers (other than first-year residents) are trained in the MAT-OD process. The team meets monthly to review processes and procedures. Ongoing MAT-OD training is ensured for primary care providers, licensed addiction counselors and other support staff. A behavioral health provider is available during the MAT-OD clinic to discuss patients. Clinicians working together to determine the patient's progress and compliance level and recognize when patients are ready to transition or need a higher level of care.

SUBMISSIONS ON PATIENT & FAMILY ENGAGEMENT



PROJECT TITLE: “Know More: HPV”—Improving Vaccination Uptake and Closing Health Disparities With A Digital Patient Intervention

Organization: CenCal Health

Topic: Patient and Family Engagement

Project Contact: Rachel Ponce, Supervisor Population Health, rponce@cencalhealth.org

Project Overview: CenCal Health identified a marked health disparity in adolescent vaccination uptake between North and South Santa Barbara County: North Santa Barbara County’s HPV vaccination rate was 48.72%; South Santa Barbara County’s rate was 31.03%.

After searching unsuccessfully for an existing intervention, CenCal Health decided to develop one “from scratch.” It collaborated with the American Cancer Society to create a multimedia, interactive, tablet-based educational program, “Know More: HPV,” to educate parents on the importance of the vaccination at a critical moment: when the child is already at the provider’s office. During the COVID-19 pandemic, this delivery mechanism was adapted to accommodate contactless visits.

CenCal partnered with a local Federally Qualified Health Center to implement this innovative patient education, which resulted in a significant increase in adolescent HPV immunization compliance and closed the health disparity for adolescents ages 11–12 in Santa Barbara County in just 9 months. Since launching the program in 2019, its HPV vaccination rates have continued to increase. CenCal reported a 59.12% HPV vaccination rate for HEDIS 2020 and a rate of 64.62% for HEDIS 2021 in Santa Barbara County—both rates surpassed NCQA’s established 95th percentile benchmark for those years.

Innovation: Human papillomavirus (HPV) annually infects 14 million people and causes more than 33,000 men and women in the U.S. to develop HPV-related cancers each year. The HPV vaccine prevents the infections that can lead to six common types of cancer later in life, yet the rate of HPV vaccination remains low. Some reasons include the prevalence of antivaccination messaging, misconceptions about the vaccine’s correlation to sexual activity and a general lack of awareness that the vaccine is recommended for adolescents.

Healthy People 2020 and the American Cancer Society set a goal to reach 80% HPV vaccination for both males and females by 2030 and 2026, respectively. Medicaid plans nationwide are far from meeting this goal—even the top 10% achieve a vaccination rate of 50.85% in 2016. CenCal Health, the Medicaid health plan serving Santa Barbara and San Luis Obispo Counties, had only a 38.36% HPV vaccination rate for adolescents living in Santa Barbara County in 2016. With NCQA’s addition of the HPV antigen to the Immunizations for Adolescents HEDIS measure in 2017, CenCal Health began monitoring HPV vaccination compliance and identified a significant geographic health disparity. There were no potential existing programs to adopt that could close this disparity. The program needed to meet health literacy and threshold language requirements, be low cost, easily implemented and provide accurate outcome data.

Outcome: Success of the “Know More: HPV” program is measured in several ways, including HPV vaccination rate data, parent/guardian satisfaction data and anecdotal provider satisfaction feedback. An in-house dashboard that calculates measure rates through HEDIS-certified software captures vaccination rate data and monitors program impact. As of June 30, 2021, the HPV vaccination rate at SBNC was 52.8%, a 33.8% increase from the provider’s original rate of 19.05%. Patient satisfaction with and knowledge gained from “Know More: HPV” is measured through a survey at the end of the program. Survey results report that patient satisfaction is very high. 82.9% of survey respondents said they agreed/strongly agreed that the content was enjoyable; 95.6% said they learned something new about the HPV vaccine; 92.4% said “my child will get the HPV vaccine today.”

CenCal Health received the 2019 California Department of Healthcare Services’ Innovation award, which highlighted the importance of HPV vaccination to the community, as well as CenCal Health’s commitment to providing creative interventions that improve member care. The program implementation is also cost-effective:

CenCal Health offers it at no cost to providers and other health plans and it can be accessed on any type of smart device—a cell phone, computer or tablet.

Partner: Non-profit, primary care practice(s).

PROJECT TITLE: Determining Patient Experience Within Digital Parameters

Organization: Peachtree Pediatrics, PLLC

Topic: Patient & Family Engagement

Project Contact: Marissa Peck, Practice Administrator, marissas33@yahoo.com

Project Overview: Peachtree Pediatrics uses a third-party system to engage families and patients through digital surveys about the patient experience.

Innovation: Peachtree uses a third-party system that uses demographic information to automatically send patients a satisfaction survey within a couple of days of a visit. Responses can be anonymous; patients can also post them to the public. Survey results are “graded” in a system that relates the number of completed surveys and responses regarding the quality of patient experience, the timeliness of getting an appointment, cleanliness of the facility and other topics. The third-party system also sends visit-reminder/confirmation texts and gives patients the ability to confirm appointments and request annual appointments, which has decreased no-show rates and increased revenue by allowing the practice to fill appointment slots that otherwise would have been unused. Communication and family engagement has increased as well because the majority of the population prefers communication via text and email.

Outcome: Using this system, Peachtree can access current feedback to assess and make appropriate changes, where warranted, to improve the patient experience and deliver efficient, quality care. It has also benefited from a >10% decrease in patient no-shows because the reminder and confirmation systems allow ample time to reschedule appointments. This has led to less lost revenue from no-show appointments because those slots are filled with patients who need an appointment in the available slot. Patient engagement has allowed Peachtree to evaluate its processes as well as receive feedback. The ability for patients to publish reviews publicly has let Peachtree evaluate its online reputation and manage changes for improvement. During the height of the COVID pandemic, the ability to communicate in a digital format led to a safe, noncontact way of gathering valuable quality information.

Partner: For-profit.

SUBMISSIONS ON USE OF TECHNOLOGY



PROJECT TITLE: Expanding Access to Telemedicine Through Novel Video Visit Technology

Organization: New York-Presbyterian Hospital

Topic: Use of Technology

Project Contact: Zehra Abedi, Senior Analyst, zea9011@nyp.org

Project Overview: New York-Presbyterian Hospital (NYP) is a nonprofit academic medical center in New York City. Since early 2016, its Digital Health team has provided comprehensive digital health services to patients across New York State.

The COVID pandemic forced NYP to find new ways to improve services. As demand for telehealth services increased exponentially and visitations were restricted, it had to ensure these services were accessible to everyone, regardless of their technical capabilities, and that families could continue to be included in care. NYP we piloted an intervention using Jamf technology. This technology is now being operationalized enterprise-wide, with plans to roll out across NYP's 10 hospitals.

Innovation: When the COVID pandemic hit New York, NYP realized the potential of virtual health offerings. It expanded video visits to 4,000 providers and expanded access, allowing new patients to schedule a video visit with physicians. Video visits now make up ~30% of outpatient visits. To address disparities in care by providing an alternative workflow for consumers who were less technically savvy or had connectivity issues, or who could not visit loved ones in hospital or babies in NICU due to COVID, NYP piloted a new workflow, launching video visits in the NICU with Jamf technology. The software allows seamless connection with iPads available in NICU. At the end of the visit, the information is wiped to ensure no patient data are stored. NYP expanded video visits to other service lines, including palliative care, postpartum care and pediatrics exercise therapy. NYP is also working on expanding to patient services, lactation education and tele-nutrition.

Outcome: In 2021 alone, over 1000 JAMF visits have been completed, with over 3400 participants. Since the beginning of our telehealth services in 2016, we have prioritized the use of telemedicine to address health disparities, however technical competency and connectivity issues have been a recurring issue. JAMF video visits allow us to reduce disparities in access to telehealth services, by providing an easy, accessible way to connect virtually with patients or providers. Due to the success of the program, JAMF video visits are now being rolled out enterprise-wide, allowing us to reach more of our population. Many parents express that they feel more at ease knowing that the program is available to them particularly if they live at a distance or if they have multiples and one twin or triplet goes home before the other(s) do. We also have families asking for virtual visits so that siblings or extended family can meet the baby – particularly if they expect a lengthy stay.

Partner: For-profit.

PROJECT TITLE: Improving Blood Pressure Control Through a Pharmacist-Led Virtual Hypertension Clinic

Organization: Kelsey-Seybold Clinic

Topic: Use of Technology

Project Contact: Curtis Curry, Manager, Quality Improvement Programs, Curtis.curry@kelsey-seybold.com

Project Overview: Kelsey-Seybold Clinic's (KSC) Virtual Hypertension (vHTN) Clinic is a pharmacist-led, protocol-driven collaboration that optimizes a patient's anti-hypertensive therapy by providing patient education, medication adjustments and lab monitoring. Patient access and communication are enhanced through video visits, phone calls and messaging through KSC's web-based patient portal, MyKelseyOnline (MKO). The program began as a pilot in May 2019 to address health disparities in the African American male population, which continues to struggle with maintaining BP control (BP <140/90) in comparison to other racial and ethnic groups.

Innovation: Invitation letters from the primary care provider are automatically sent to qualifying patients, who then schedule an appointment with one of the vHTN Clinic's pharmacists and are instructed to complete baseline labs. The pharmacist conducts the new enrollment appointment via an initial video visit, where the patient is given education on BP, taught to perform monitoring and log into the MKO. The pharmacist also works with the patient to set goals to improve diet, exercise, and lifestyle. Every 2–4 weeks, a pharmacist conducts an assessment call. A pharmacy technician provides BP upload reminders via phone or MKO messaging and encourages patients to monitor BP twice a day. Program participation is anticipated to last 6 months but may be extended to reach the goal. If a patient completes or disenrolls from the program, their primary care doctor is notified, and the patient is instructed to schedule a follow-up appointment.

Outcome: 129 vHTN Clinic patients with a last in-clinic BP >140 during 2019/2020 had an average drop in BP reading of 10.9%, compared to 159 standard care patients with an average drop of 3.6%.

74% of vHTN Clinic patients reached the clinic goal of <140 in 2019/202; 22% of standard care clinic patients reached it.

PROJECT TITLE: Rapid Cycle Analytics of Real-World Data to Manage High-Risk, High-Cost Patients

Organization: Horizon Blue Cross Blue Shield of New Jersey

Topic: Use of Technology

Project Contact: Saira Jan, VP & Chief Pharmacy Officer, saira_jan@horizonblue.com

Project Overview: Horizon leveraged rapid-cycle analytics and integrated pharmacy and medical member data to identify clinically appropriate pharmacy interventions that improve patient outcomes and reduce total cost of care. It applied the interventions to four complex, high-cost diseases: type 2 diabetes, COPD, non-valvular atrial fibrillation (NVAfib), and atherosclerotic cardiovascular disease (ASCVD). Although the interventions are specific to each disease state, the general process is uniform for each use-case and can be applied to other complex, high-cost patient cohorts. In 2020, approximately 1,300 Horizon members had successful interventions, resulting in ~\$4.4M in total cost of care savings.

Innovation: Each use-case follows the same systematic process:

1. Identify high-risk/undertreated patient populations.
2. Deep dive to understand the drivers of negative outcomes and/or costs that are changeable via intervention.
3. Test the impact of planned interventions on reducing negative outcomes and total cost of care.

4. Model scenarios to forecast the impact of interventions.
 5. Prioritize and execute pharmacy interventions, leveraging internal/external resources.
 6. Track improvement in outcomes and reduction in total cost of care via data.
-

Outcome: To date, interventions have been implemented for type 2 diabetes and COPD use cases. 2020 outcomes:

Type 2 diabetes

- 808 eligible high-risk members.
- ~52% increase in adherence among eligible high-risk users.
- ~\$3.4M estimated total cost of care savings via reduced avoidable medical events.

COPD

- 189 eligible high-risk members.
 - ~37% increase in adherence among eligible high-risk users.
 - ~\$1M estimated total cost of care savings via reduced avoidable medical events.
-

Partner: For-profit

PROJECT TITLE: Sustaining a Culture of Continuous Improvement and Reducing Variation for Care Navigators with an Audit Feedback Loop & a Kaizen Suggestion System

Organization: Kettering Physician Network

Topic: Use of Technology

Project Contact: Trevor Gundlach, Sr. Project Manager, trevor.gundlach@ketteringhealth.org

Project Overview: Kettering Physician Network, a large, multispecialty medical group in Southwest Ohio, used a model (Collaborative) for creating and sustaining a culture of continuous improvement. The Collaborative added quantitative and qualitative value for the care navigator role in a decentralized medical network. Care navigators assist practices in meeting defined quality goals. Following the deployment, there were observations of variability in care navigator performance, which contributed to unpredictability of patient experience and outcomes.

Innovation: Kettering Physician Network created a multidisciplinary Collaborative. Weekly Collaborative meetings are led by an improvement specialist, using a Kanban system of management to track progression of tasks. The team includes members from IT, Operations and Education; nine subject matter experts (SME) lead the Collaborative. Care navigators submit ideas on a digital platform for review. Each idea is tested by SMEs before being launched. IT launched a dashboard in the EMR to consolidate all reports and work queues to one screen. Reports are automated to trigger for action when clinical criteria are met. The dashboard was further augmented to include quality metrics and links to frequently accessed resources. The Collaborative built reportable sensors into each process, triggered in the EMR when a care navigator does the job duty correctly. A subgroup of the Collaborative meets monthly to audit of the triggered sensors by each care navigator. Using a scripted message, each SME schedules peer-to-peer coaching with care navigators who did not trigger a sensor.

Outcome: Between August 2020 and May 2021, care navigators posted an average of 300 times each month on the digital platform. Of 228 improvement ideas, 129 have been implemented. Implementing an audit with sensors in the EMR showed immediate improvement from 23% of care navigators who “follow the organization’s training completely” to 53.4% (132% increase) within 1 month on all auditable job duties. Peer-

to-peer coaching increased the number of care navigators following the standard work to 88.8% (286% increase) in 4 months, and to 92% (300% increase) by 7 months on all auditable job duties.

The Collaborative equipped 11 care navigators with a second computer monitor and equipped 26 care navigators with a hands-free telephone headset. The number of reports extracted from the EMR was reduced from three to one by launching automated reports that can be worked directly in the EMR. Automating reports has saved the centralized quality teams 24 hours each month.

The Collaborative reduced the number of questions in the pre-charting checklist from 17 to 1. The new process reduces pre-charting time from an average of 13 minutes to 1.5 minutes per patient. The new process saves each care navigator 5.1 hours per week.

Partner: Primary care practice(s)

PROJECT TITLE: Using Remote Physiologic Monitoring and Asynchronous Engagement to Improve the Control of Blood Pressure

Organization: Family Doctors, LLC

Topic: Use of Technology

Project Contact: Peter Barker, MD, Medical Director, pbarker@partners.org

Project Overview: Two primary care practices, Family Doctors of Swampscott, Massachusetts, and Ashley Clinic of Chanute, Kansas, used asynchronous engagement and remote physiologic monitoring to facilitate out-of-office BP documentation by patients whose BP was high (>140/90 mmHg). Using the EHR, providers were prompted to enroll these patients in a “Controlling Blood Pressure” clinical pathway. Patients and providers could opt out or were automatically enrolled using secure SMS text messaging or email notifications. After a 14- or 30-day cycle, all BP readings, as well as a calculated mean systolic/diastolic BP, were automatically sent back to the patient’s medical record in the EHR.

Innovation: In Phase 1, for patients 18 years and older with a systolic BP >140 mmHg or a diastolic BP >90 mmHg, provider/staff automatically received a message that BP was higher than goal and to repeat it 5 minutes apart. For patients with an average systolic BP >140 mmHg or a diastolic BP >90 mmHg, the Controlling Blood Pressure Pathway was automatically launched. A prompt was given to provider/staff to give the corresponding handout to the patient, stressing the importance of checking their BP at home.

Phase 2 modified the age range to include patients 18–80 and the message was modified to allow providers to document opt-out reasons for not enrolling the patient in Controlling BP Pathway. Once enrolled, patients received an SMS text message or secure email inviting them to participate. Patients received daily reminders. Results of patients with cellular or Bluetooth devices were automatically uploaded. Patients with nonconnected devices manually entered their results. Upon completion of the cycle, all BPs were sent to the patient’s chart in the EHR, along with an automatically calculated average systolic and diastolic BP, to facilitate efficient follow-up office or telehealth visits.

Outcome: 1,254 patients were enrolled over 3 months; after the initial 3 months, the participation (completion) rate was 40%.

For patients completing just one cycle, 80%–85% had an average systolic BP/diastolic BP of <140/90; 40%–45% had an average systolic BP/diastolic BP of <130/80; 15%–20% had an average systolic BP/diastolic BP of >140/90. Results emphasized the inaccuracy of in-office BP readings. Both practices significantly improved their clinical quality measure scores for Controlling Blood Pressure, but more important, improved their ability to accurately diagnose and manage patients with elevated BP. Providers avoided misdiagnosis and overmedication while achieving recommended BP goals to reduce cardiovascular risk. These results emphasize the importance for using out-of-office BP readings to confirm the diagnosis of hypertension and for

care management to treat to goal. The practices used synchronous engagement and remote physiologic monitoring to streamline the process and make it feasible in all clinical practices.

Partner: Other.



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