



2023-2024 INNOVATION AWARDS

Featuring Quality Accelerators in Health Care



COMPENDIUM

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ABOUT THE NCQA INNOVATION AWARD

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

› Topics:

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

› Selection Criteria:

Winners were selected based on the following criteria.

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

*Winners listed in alphabetical order.



WINNERS

WINNER

PROJECT TITLE: SWAT H2O—Access to Clean, Safe Drinking Water

Organization: UniCare Health Plan of West Virginia

Topic: Health Equity

Project Contact: Billie Moore, Director, Population Health

Project Overview: During the past decade, West Virginia and its residents have dealt with multiple issues regarding access to clean, safe drinking water. The UniCare Health Plan of West Virginia, Inc., Population Health team developed an initiative for clean, safe water after lead contamination was discovered in Harrison County in August 2021. Research of the resulting Safe Water Workgroup revealed that access to safe drinking water is a health equity issue. In response, UniCare developed SWAT H2O to provide immediate relief and resources while working with local and state partners on long-term solutions.

Innovation:

UniCare participated in lead screening events targeting Harrison County. To increase community participation at these events, UniCare provided \$25 gift cards for the first 50 attendees. These efforts served as a template for the UniCare rapid response SWAT H2O initiative. As a result of the rapid response to the Harrison County contamination, UniCare was invited to attend clean water strategy meetings organized by WV Department of Health and Human Resources, Bureau of Public Health. These meetings became a networking opportunity with state partners and community leaders. The state began to include UniCare as part of its early response action plan. In early 2023, the Bureau of Public Health notified UniCare of elevated lead levels in tap water affecting Mineral County, a small, rural community in the eastern panhandle. Once again, UniCare deployed SWAT H2O, working with federal, state and local leaders to develop a response strategy. As part of the continued collaboration, UniCare associates helped plan a back-to-school/lead screening event, where UniCare Population Health staff provided education on lead exposure. To eliminate the transportation barrier facing many Medicaid members, UniCare coordinated with local churches to provide transportation.

Outcome:

For the Harrison County water project, lead screening testing increased from 197 in 2020 to 235 in 2022. Mineral County data are not complete, but the first 6 months showed a testing increase from 105 in 2022 to 132 in 2023. Screening identifies individuals who have been exposed to lead and other toxins. More comprehensive testing is indicated for positive results.

WINNER

PROJECT TITLE: Specialty Provider Enablement Partnered with Value Based Care Solutions Achieve Better Maternal and Neonatal Outcomes

Organization: Elevance Health

Topic: Delivery System Design

Project Contact: Virginia Plaisance, Staff Vice President, Total Population Health

Project Overview: Between 2018 and 2021, the rate of maternal deaths (per 100,000 live births) increased by 80%.¹ Pregnant individuals who are covered by Medicaid are more likely to experience certain pregnancy risk factors, such as obesity, and have higher rates of severe maternal morbidity and mortality.² Elevance Health insures 12% of the nation's births, and 47% of those births are covered under Medicaid plans. A year-over-year data review of Elevance Health maternal and child health indicators, such as timeliness of prenatal care, postpartum visits and preterm and low birth-weight rates, demonstrated a need to drive meaningful engagement at the provider practice level to achieve desired maternal health outcomes.

Footnotes: ¹ The Centers for Disease Control and Prevention. (2023, March 16). Maternal Mortality Rates in the United States, 2021. Retrieved March 28, 2023, from <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm>. ² Medicaid and CHIP Access Commission. (2022, June).

Innovation:

OBPCs are nurses with OB specialty practice expertise who collaborate with providers through in-person and virtual touchpoints. They support quality improvement of health outcomes, serve as clinical liaisons and provide value-based data to providers to inform decision making. These provider partnerships consistently demonstrate meaningful results, leading to exponential growth of the OBPC initiative over the last 3 years.

Outcome:

Since the program's inception, 33 OBPCs have collaborated with more than 2,400 providers throughout 25 Medicaid markets. The program demonstrated the following during its most recent evaluation:

- 5% reduction in total birth costs.
- 5% savings in maternal first-year costs.
- 10% savings in baby first-year costs.

WINNER

PROJECT TITLE: Breaking Down Health Equity Barriers with Provider-Led Bundles

Organization: Vanderbilt University Medical Center

Topic: Health Equity

Project Contact: Tinsley Hastings, Marketing Development Manager

Project Overview: Four years ago, VUMC began to reimagine employee health benefits by piloting programs aimed at transforming patient care and reducing costs and, by extension, barriers to care. One program is Vanderbilt Health Employer Solutions' (VHES) MyHealth Bundles, a value-based approach to managing common and costly health conditions. Employers pay a predetermined fee for bundled services, and VHES assumes full risk for delivering an excellent clinical outcome. There are low to no out-of-pocket costs for the bundles, enabling patients of all economic positions to pursue necessary and appropriate care they may have otherwise avoided because of cost. Care coordination and guidance is provided to all bundle users, improving care access and adherence among people with low health literacy.

Innovation:

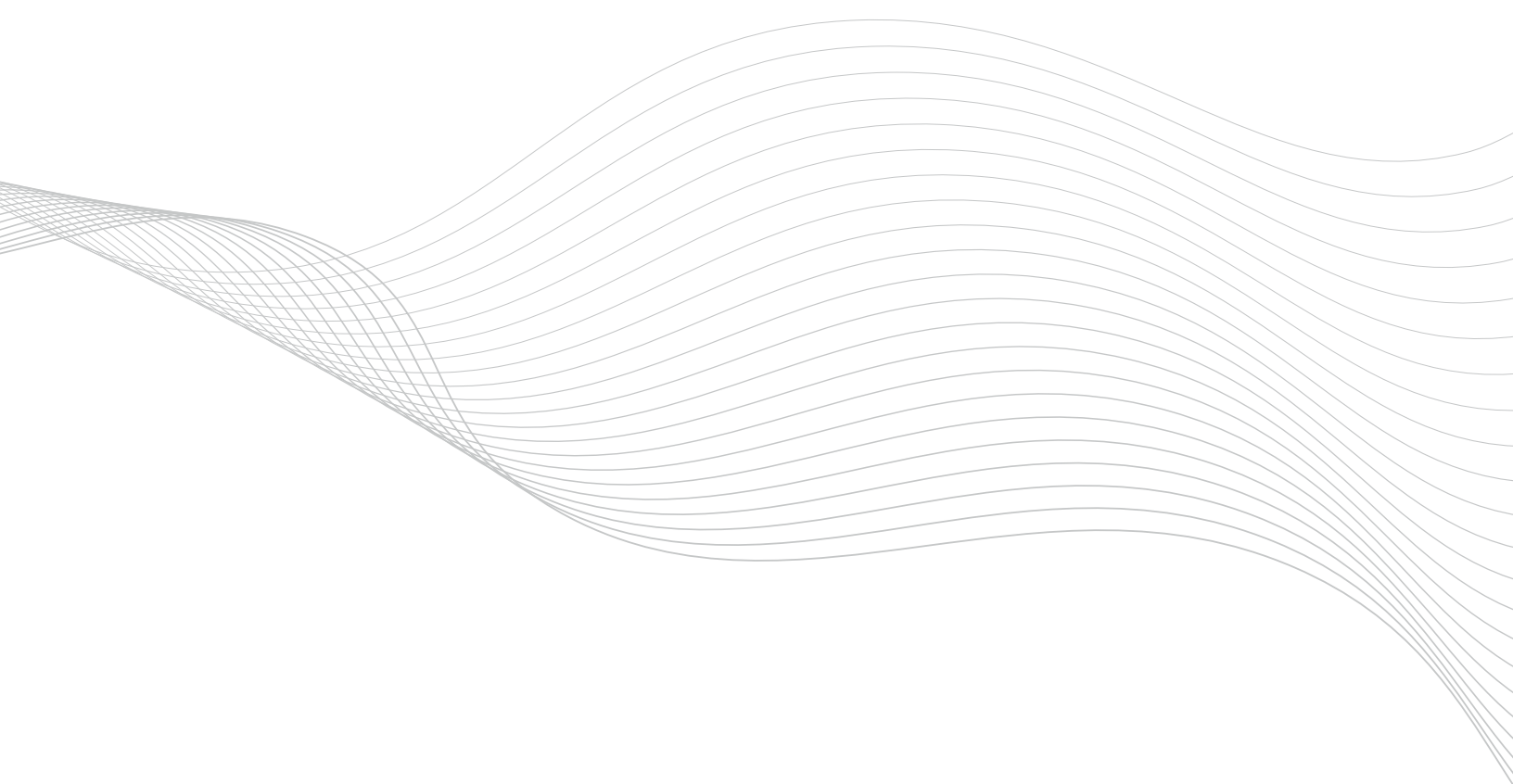
The MyWeightLossHealth Bundle “bundles” all services needed for a successful weight loss journey—all at no out-of-pocket cost to employees. Patients choose a medical weight loss bundle or a surgical weight loss bundle that offers either laparoscopic sleeve gastrectomy (“gastric sleeve”) or laparoscopic gastric bypass (“gastric bypass”). Each bundle also features highly tailored care navigation, nutrition, exercise, psychological support and enhanced patient communication through dedicated patient navigators who provide 1:1 support.

Outcome:

In 2022, patients who chose surgical weight loss had an average weight loss of 63.5 lbs. at 6 months post-operation and 81.2 lbs. lost at 1 year post-operation—an estimated savings of more than \$120,000. Patients who chose medical weight loss had an average weight loss of 17.4 lbs. at 6 months. A cohort study found that 60% of participants lost at least 5% of their weight, equating to nearly \$1,000 per year in savings per participating member. With the MyWeightLossHealth Bundle, employees have lost more than 7,000 pounds, and co-morbidities such as diabetes and heart disease have seen dramatic improvement. Utilization of the employee benefits plan has increased from 3% to 11%, leading to broader cost savings and higher employee satisfaction.



BEHAVIORAL HEALTH



SUBMISSIONS ON BEHAVIORAL HEALTH

PROJECT TITLE: APP: The Unworked Measure

Organization: Elevance Health

Topic: Behavioral Health

Project Contact: Brittany Kuhns, CPHQ; LSSBB, Clinical Quality Manager
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Project Overview: Antipsychotic medications are often prescribed for nonpsychotic conditions for which psychosocial interventions are considered first-line treatment. Children and adolescents may unnecessarily incur the risks associated with antipsychotic medications. Healthy Blue began seeking possible interventions in 2022 for the HEDIS measure Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP). The measure requires a psychosocial visit to occur 90 days prior to being placed on medication, or within 30 days after being placed on medication. The health plan implemented interventions to ensure that members receive quality care and that providers are educated and incentivized appropriately.

Innovation:

During 2022, the following interventions were developed and implemented:

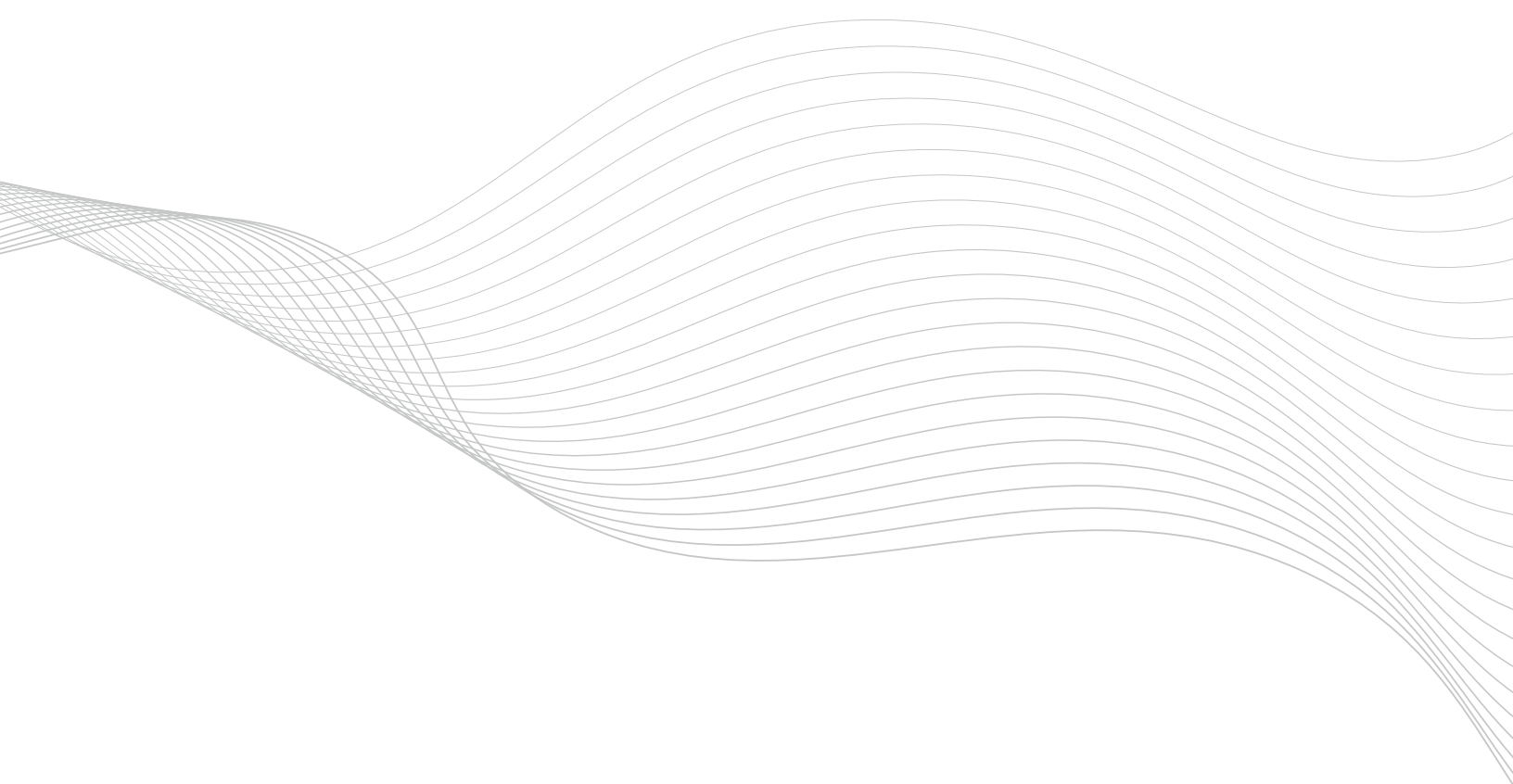
- A provider education flyer on the purpose of the measure, time frames and coding tips.
- A member call campaign utilizing pharmacy-level data: All parents/guardians of adolescent members on an antipsychotic medication received a call from Quality Management and were referred to Care Management as needed. Reports were received daily for timely calling.
- An internal health plan Care Management Care Gap contest focused on educating and helping members schedule appointments to close focused measure care gaps. In Q3–Q4 2022, Care Management logged 1,455 measure entries, closing 546 care gaps.
- Medical Record Database training to capture mandatory exclusions not captured in claims submitted by providers, and ensure that mapping issues are identified and corrected on all MY 2023 Admin and Hybrid measures so no (other) market encounters this issue moving forward.

Outcome:

APP 2021 2022 Ages 1–11 40.66% 61.29% Ages 12–17 63.16% 64.21% Total 56.10% 63.06%



DELIVERY SYSTEM DESIGN



SUBMISSIONS ON DELIVERY SYSTEM DESIGN

PROJECT TITLE: Summit Pacific Medical Center (Summit Pacific) Food Rx Program

Organization: Amerigroup Washington

Topic: Delivery System Design

Project Contact: Matania Osborn, MHA, Whole Health Director
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Project Overview: Amerigroup Washington, Inc. partnered with Summit Pacific to support the Food Rx program, serving vulnerable individuals and families in Grays Harbor, Washington. The program provides access to healthy foods for clinically and socially at-risk populations, and supports management of chronic disease by providing healthy food in combination with guidance of the primary care team, a registered dietician, a patient coordinator and monthly cooking classes. Fresh food is sourced from local farms, vendors and co-ops, enhancing the economic vitality of the community. The program has demonstrated promising results, including favorable trends in blood pressure, HBA1c and triglycerides.

Innovation:

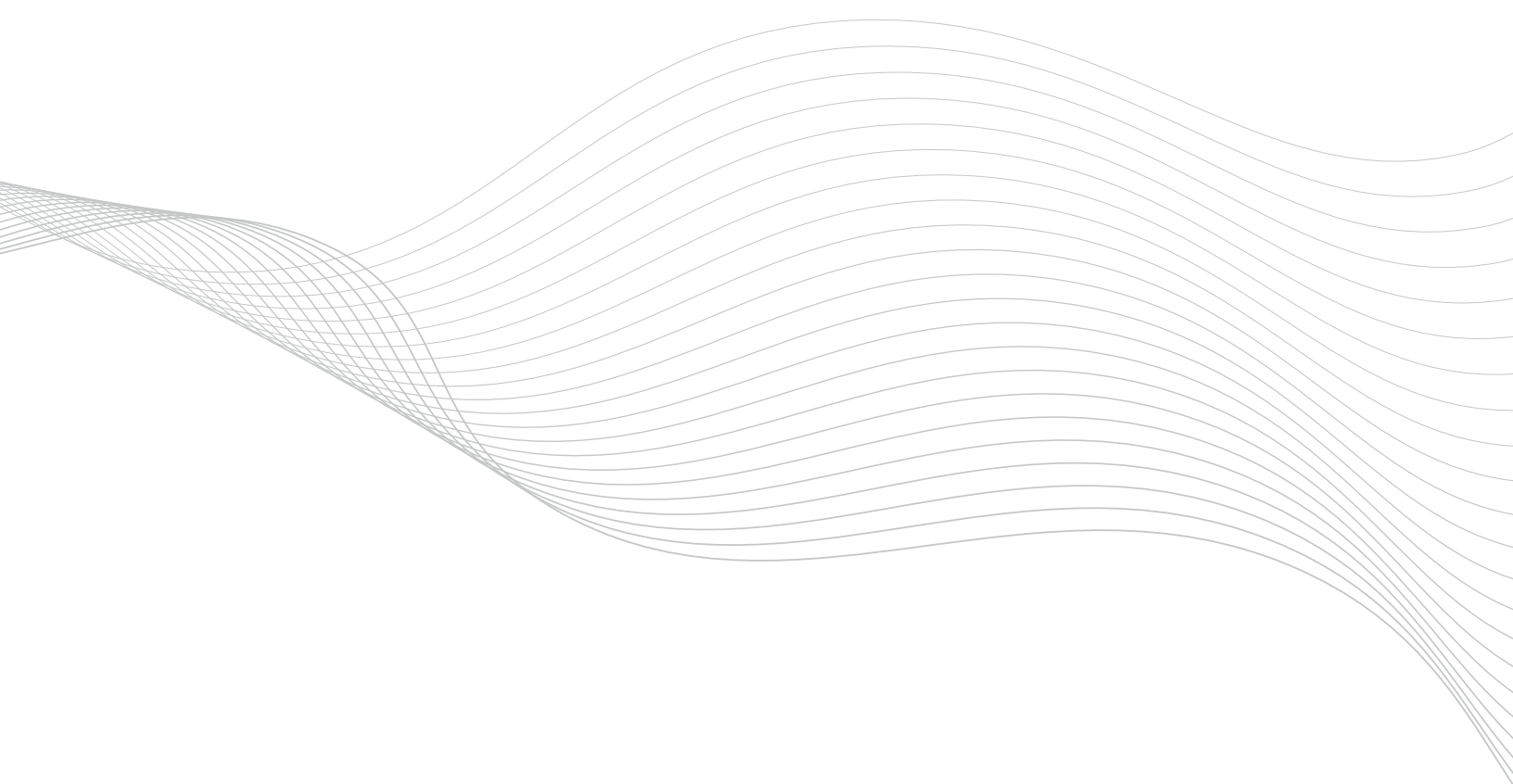
Program components include a prescription from a Summit Pacific primary care provider with a referral to a registered dietician. A patient coordinator educates patients on the program and process, and provides weekly and monthly check-ins throughout the program. A registered dietician performs a nutritional assessment to support the patient's care plan, and signs a letter of health commitment. After the dietician visit, the patient can pick up a weekly "subscription" box, free of charge, that includes five healthy meals and recipe cards, and access to monthly Summit Pacific onsite or virtual cooking classes. Ingredients change monthly based on availability and season. By working with local businesses and farms, Summit Pacific enhances the economic vitality of the community and the health of each person.

Outcome:

Summit Pacific has enrolled nearly 100 individuals in the program. Those who maintain adherence show favorable trends in BMI, blood pressure management, management of A1C levels, LDL and triglycerides. An enrolled member's success story was featured in Summit Pacific's July 2023 Population Health Newsletter. Before enrolling in the program, the member experienced deteriorating health, including poor management of type 2 diabetes. Since enrolling 6 months ago, the member has experienced dramatic changes: lost 32 pounds, and insulin requirements decreased from 99 units a day to 12 units. A1C, a long-term marker of diabetic control, improved from 7.6% to 5.9%. The new lifestyle has also positively impacted the member's blood pressure, and they stopped taking a diuretic and supplemental potassium.



HEALTH EQUITY



SUBMISSIONS ON HEALTH EQUITY

PROJECT TITLE: Partnership with Community-Based Organization to Bring Mobile Food Pantry to Rural Communities in Need

Organization: Geisinger Health Plan

Topic: Health Equity

Project Contact: Nicole Matrey, Health Services Specialist
nmmatrey@geisinger.edu

Project Overview:

This mobile food distribution pilot addresses food insecurity in a rural population in north central Pennsylvania. In partnership with the New Love Center, the mobile food pantry travels to multiple locations in Clinton and Lycoming Counties. Patients and members can be referred to mobile distribution via Neighborly, and distributions are open to anyone in the community who is food insecure. Clinicians and care teams can easily refer patients and members who have a food need seamlessly on the Neighborly platform—connecting directly to the New Love Center.

Innovation:

Geisinger and the New Love Center launched the first Fresh Food Farmacy Satellite location in 2019, providing food insecure adults with diabetes the ability to receive fresh and healthy food to help treat their chronic condition. A choice-style pantry, transitioned to a mobile unit, broadens program reach and can be driven to targeted areas where needs are high and resources do not exist. The New Love Center manages day-to-day operations and utilizes Neighborly for referrals and connections. Geisinger identifies food insecure patients and members through social needs screening. Neighborly allows closed loop referrals—the ability to view referral status in real time.

Outcome:

The program served more than 226 households in the first quarter since program launch, translating to over 493 individuals served (approximately 82 were children). Almost half of all individuals referred electronically attended a distribution and received food. The ability to see referrals in real time gives valuable insight into the demographics of individuals served, most notably if there are locations with an exponentially higher rate of referrals. This model is a bridge between patients in need of food and a trusted resource that can go “on the road.”

SUBMISSIONS ON HEALTH EQUITY

PROJECT TITLE: The Barbershop Initiative: Barbers as Trusted Health Navigators

Organization: Anthem Kentucky Managed Care Plan, Inc

Topic: Health Equity

Project Contact: Kate Miller, LCSW, CCM, Whole Health Director
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Project Overview:

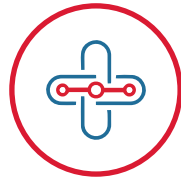
Along with a local community-based organization, Anthem Medicaid supports a partnership between local barbershops and community health workers (CHW) to bring health education and awareness to Black and Latino populations. The initiative is designed to develop and strengthen relationships between CHWs and barbers so clients, especially Black and Latino men, receive information through monthly health topics and educational events to become more proactive about their health.

Innovation:

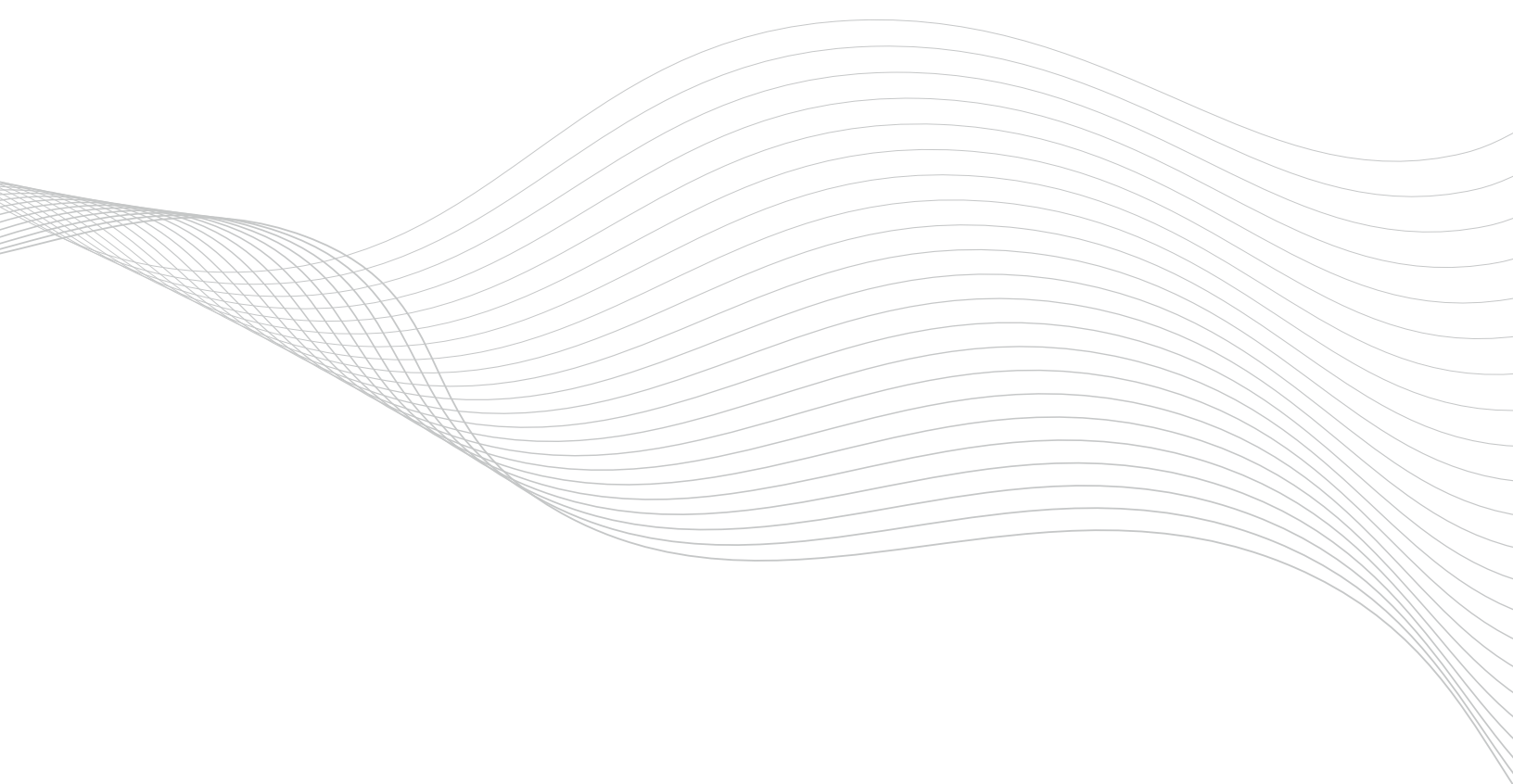
Barbers and CHWs are trained to discuss topics such as stress reduction, preventive health screenings, mental health, smoking cessation, social drivers and supports and other topics to improve the health of Black and Latino communities. Barbers use naturally occurring conversations to educate their clients about health and wellness. There are also monthly information sessions and onsite health promotion materials barbers can guide their clientele to use. The CHWs build support, encourage participation in programs and make sure clients know about the importance of taking care of their health. They use the Anthem Medicaid platform, FindHelp, to search for resources or make referrals for social needs. Barbers are trained in crisis intervention, such as Question, Persuade, Refer (QPR), a nationally recognized best practice for suicide intervention, and can help reduce the stigma of seeking mental health care.

Outcome:

Barbers are matched with certified CHWs to ensure awareness of health topics. Comfort discussing topics is continually developed; each month introduces additional information. Pre- and post-assessments evaluate barbers' level of comfort and awareness of health topics. Through the CHWs, clients are connected with resources to address barriers such as social needs, along with awareness of how to access health care. Initial indicators from health events show that about 50 clients, and their waiting family members, are impacted per event. Barbers indicate they are developing more confidence in discussing health information in their regular interactions.



INTEGRATION OF CARE



SUBMISSIONS ON INTEGRATION OF CARE

PROJECT TITLE: Nevada Mobile One Docs—Care Campus

Organization: Community Care Health Plan of Nevada, Inc. dba Anthem Blue Cross and Blue Shield Healthcare Solutions

Topic: Integration of Care

Project Contact: Regina DeRosa, LMSW, MBA, Business Change Manager & Justice Program Manager
regina.derosa@anthem.com

Project Overview: The Nevada Cares Campus in Reno, Nevada, is one of the largest homeless shelters in the country. Washoe County leadership reported to Anthem Blue Cross and Blue Shield Healthcare Solutions that residents were using 911, ambulances and the ER as their primary source of care. Anthem facilitated an arrangement/memorandum of understanding with the county for a contracted primary care provider to come to the shelter, to improve access to care for members. As a result, Mobile One Docs began offering primary care services at the Cares Campus, and agreed to become the assigned primary care provider for consenting member residents, to divert them from utilizing the ER as their primary source of care.

Innovation:

Anthem started with a 23-month pilot program in which Mobile One Docs was on site at the Cares Campus 5 days a week. Mobile One Docs helps ensure consistent, high-quality physical and behavioral healthcare management, and coordinates nonclinical and SDOH services as needed, with collaboration of the integrated internal Anthem team. Anthem provides direct support to the provider, which ultimately improves access to care (e.g., specialist referrals, claims questions, durable medical equipment coordination, case management support) The program is scalable, and has provided increased value by having a mobile provider in the area who can reach members in rural communities as well.

Outcome:

There is minimal investment at the plan's expense, other than on the administrative end, and a strong potential for return on investment, since many members are frequent users of the ER. Roughly 40+ unique members have been served in the program since implementation—improving shelter services in numerous ways and highlighting other gaps in care for members at the shelter. The program has helped improve delivery of medication (prescribed by Mobile One Docs), shown the need to add labs/imaging to the route of transport from the shelter and helped create a supply closet of regularly used durable medical equipment supplies (e.g., wound care, A1C testing kits). Members can remain under the care of Mobile One Docs after they transition out of the shelter system. Mobile One Docs makes referrals to community resources and specialists in the Anthem network, and coordinates with the physical health clinical team on needs that may require prior authorization or assistance with finding in-network providers. This helps reduce unnecessary hospitalizations.

SUBMISSIONS ON INTEGRATION OF CARE

PROJECT TITLE: Nevada Pathway Forward Partnership

Organization: Community Care Health Plan of Nevada, Inc. dba Anthem Blue Cross and Blue Shield Healthcare Solutions

Topic: Integration of Care

Project Contact: Regina DeRosa, LMSW, MBA, Business Change Manager & Justice Program Manager
regina.derosa@anthem.com

Project Overview: Launched in 2018 in partnership with WC Health, Anthem Blue Cross and Blue Shield Healthcare Solutions offers a re-entry program for Anthem members released from incarceration at a Nevada Department of Corrections (NDOC) Facility. Homeless members re-entering society are provided with transitional housing assistance and wraparound services post release.

Innovation:

The program goal is to promote self-sufficiency, connect this vulnerable population to necessary treatment and prevent recidivism. It offers 60 days of transitional housing assistance and wraparound services post release (vital document assistance, case management, job placement assistance, transportation, connection to primary care, behavioral health providers/treatment/pharmacy services.) Marketing staff conduct orientations in local prisons to help educate potential members about the program and other Anthem benefits. NDOC staff refer potential candidates directly to WC Health prior to their release date, to ensure they are linked to the program as soon as they exit incarceration.

Outcome:

In 2022, 107 members were served. 70% of program participants exited to stable housing; 65% completed the program with increased income; and the overall recidivism rate was 4%. Since program inception, 525 unique members have been served.

SUBMISSIONS ON INTEGRATION OF CARE

PROJECT TITLE: Network Tables Pilot Program

Organization: Elevance Health—Anthem HealthKeepers Plus Virginia Medicaid Plan

Topic: Integration of Care

Project Contact: Elizabeth Ramsey, Clinical Quality Program Manager
elizabeth.ramsey@anthem.com

Project Overview: From February 2022–February 2023, HealthKeepers, Inc. implemented a pilot SDOH program in partnership with a non-profit, Open Table, for the Network Tables Pilot Program. Utilizing volunteers trained with Open Table’s evidence-based model, the pilot leveraged social capital, community connections and member-driven goals to improve members’ quality of life, downstream health outcomes and promote equitable access to quality health care. Three groups of Open Table volunteers—Network Tables—provided direct SDOH services to Anthem HealthKeepers Plus members. The Network Tables program is unique in its use of volunteer interventions to address social needs and improve health outcomes, emphasizing the importance of social support and community connection. Solutions offered by Network Tables focus on sustainability, enabling a comprehensive closed-loop referral process.

Innovation:

The Network Tables Pilot Program was available to all Anthem HealthKeepers Plus members in the Central, Tidewater and Roanoke/Alleghany regions of Virginia. Priority populations included pregnant or parenting members with substance use/opioid use disorder, transitions of care (including inpatient, nursing facility, transitions from incarceration), high ED utilizers and youth in or aging out of foster care. Open Table volunteers were trained to form a “Network Table” connecting to social networks in the community to link supports, including relationships, goods and services, to referred members. Each Network Table worked to solve the challenges of up to four members simultaneously. Referred members received an array of SDOH supports, including donated parts and labor for car repairs, home modifications and repairs improving safety and mobility, links to sustainable housing solutions and social support, facilitating access to critical medical procedures and ongoing support for recovery goals.

Outcome:

Outcomes of the pilot program reveal an 85% closed loop, sustainable SDOH need resolution rate. All referrals who maintained contact and coverage eligibility were linked to a sustainable SDOH solution. As of January 31, 2023, Network Tables linked members with \$79,800 of total value in volunteer hours and donated goods and services. In a six-over-six analysis of pilot members who completed the program and had at least 3 member months pre- and post-program referral, behavioral health inpatient visits decreased by 100% and ED visits decreased by 41%. It is expected that planned inpatient medical/surgical procedures may be a positive indicator of SDOH-need resolution.

SUBMISSIONS ON INTEGRATION OF CARE

PROJECT TITLE: Population Health Nurse Clinics

Organization: Sharp Healthcare

Topic: Integration of Care

Project Contact: Janet Appel, RN, MSN, CCM, Director of Population Health
janet.appel@sharp.com

Project Overview: Implementation of Case Management Population Health Clinics across clinical sites supports primary care through embedded RN case managers working to achieve blood pressure control for hypertensive patients, diabetes HgA1C control and care gap closure. What started as a response to COVID became a solution for clinic access, quality outcomes and patient engagement in population health programs. Visits provided blood pressure readings, labs, eye exams and vaccines. This sustainable program demonstrated value and scalability: Over 3,400 patients have visited a population health nurse to date, improving BP control from 79% to 86% and diabetes management compliance from 38% to 51%. Success was demonstrated by surpassing goals for hypertension and diabetes control, but more important was the reduction in risk of heart attack and stroke for patients.

Innovation:

The initiative began as a pilot at one site that focused on achieving blood pressure control for the hypertensive population, and expanded to 13 sites. Nonclinical staff and community health workers took on outreach and scheduling of patients, and assisted in patient check-in. MCG Chronic Care Guidelines provided materials for processes, education and protocols created for elevated blood pressure and diabetes management. Implementation to all sites was completed within 2 years using data-driven decision making, demonstrating successful achievement of goals.

Outcome:

The pilot began in April 2020 with an emphasis on blood pressure control. Roll-out to all sites began in 2021, providing 795 nurse clinic visits, with an end-of-year control of 85%. In 2022, HgA1c testing and Retina Vue eye exams were added for the population with diabetes. That year ended with over 2,200 nurse visits, 75% in-control compliance and an overall blood pressure in-control rate of 86%. After adding adult vaccine administration to close care gaps, the program received the American Medical Group Association award for most improved in the administration of pneumococcal, influenza, TD/Tdap and zoster. The organization reached its goal of blood pressure control rate of 86%, and the case management engagement rate increased from below 30% to 45%–50%.

SUBMISSIONS ON INTEGRATION OF CARE

PROJECT TITLE: Hepatitis C Member Outreach and Engagement Project

Organization: Elevance Health

Topic: Integration of Care

Project Contact: Jennifer Joseph, PharmD, Health Services Director
jennifer.joseph@wellpoint.com

Project Overview: The Hepatitis C Member Outreach and Engagement Project started in 2021 at Elevance's West Virginia health plan affiliate, where there was significant need for members who were diagnosed with chronic hepatitis C virus (HCV or hep C) but were not receiving treatment. The HCV population was increasing, and the regulations imposed by the state to obtain curative direct-acting antiviral (DAA) medications were extremely strict. The project goal is to increase the number of members engaged in care and cured of HCV. Pharmacy claims data are integrated with clinical claims data to help identify members and monitor their adherence/success with testing and treatment. Care managers assist with access to HCV care, testing and treatment, coordinate care and remain engaged until members are cured. This often means assisting members with substance use disorder (SUD) services and support prior to initiating DAA treatments.

Innovation:

Eligible members are assigned a nurse care manager trained in HCV infection and treatment who engages them in specialized and high-touch care management and assesses their physical, behavioral and social needs before establishing a plan of care. If needed, care managers assist members with access to care and ensure they are engaged in treatment of their HCV; they also work with behavioral health partners to help members enroll in and complete treatment for their SUD as part of the care plan. Care managers monitor members throughout testing (up to 6 months) and treatment (typically 8–12 weeks) to ensure adherence and provide support. Once a member has completed treatment, care managers ensure they receive follow-up labs at least 12 weeks post treatment to test for evidence of a cure.

Outcome:

This program has facilitated eradication of HCV in many members, reduced overall health care costs and begun closing the health equity gap tied to this disease. After success in West Virginia, the program was expanded to 8 additional Medicaid affiliate health plans. Since expansion, treatment completion with confirmation of a cure has occurred in more than 70% of enrolled members for whom there are complete data. These members do not require as much ER and inpatient care, contributing to a reduction in health care costs by at least 33%. The program has successfully enrolled Black, Hispanic and rural members. Providers appreciate the coordination between payer, pharmacy, provider and member. Members have also provided positive feedback regarding care managers helping them navigate health care benefits, taking time to provide them with a firm understanding of the disease process and treatment plan and guiding them toward their goal of becoming HCV free.

SUBMISSIONS ON INTEGRATION OF CARE

PROJECT TITLE: High Cost DME: Integrating Care for a Medicaid Population with Mobility Impairments

Organization: Elevance Health, Medicaid

Topic: Integration of Care

Project Contact: Cheryll Bowers-Stephens, MD, MBA, Manager, Medical Director
cheryll.bowers-stephens@healthybluelia.com

Project Overview: In the High-Cost Durable Medical Equipment (DME) Initiative, a team of five board-certified physical medicine and rehabilitation (PM&R) physicians review, monitor and measure trends and medical necessity of high-cost DME supports for people with functional mobility needs. The goal of the initiative is to increase efficiency in completing complex, high-cost DME requests for authorizations. PM&R physicians approve/deny requests for items such as pediatric hospital beds, specialty cribs, adult/pediatric specialty wheelchairs, pediatric specialty adaptive strollers and pediatric specialty bath equipment. This initiative illustrates how using evidenced-based quality tools and processes can successfully improve member experience and population health while reducing costs and refining the utilization management process.

Innovation:

The key intervention is a clinical program ensuring that impaired mobility, high-cost DME requests are reviewed by experienced PM&R specialists, in compliance with Medicaid requirements. The expertise of PM&R physicians allows improved efficiency and consistency of high-cost DME requests to address the needs of medically complex members. The process increases submission of correct codes, thereby reducing administrative denials based on coding errors. To reduce variability in processes, a standardized process, including developing a denial rationale library, building consensus among health plans and initiating office hours, resulted in improved uniformity across plans, reducing utilization review time and improving turnaround time metrics.

Outcome:

This program has reached 63% of the savings projection, and illustrates how state Medicaid agencies can reduce overall costs for DME. Data reveal that as of May 2023, 62% of service lines are handled by PM&R DME specialists. Overall, specialists approve 73% of cases they review (compared to 62% for health plan physicians) thereby increasing access to this medically necessary equipment. Of services that were initially determined to be not medically necessary, only 567 were overturned to date upon appeal, representing a 3.8% overturned rate. In summary, the gap in supports and services for the 12.5% of Americans with functional mobility needs can be improved within a targeted population whose medical care is paid for by Medicaid. Although authorizations and access increased, total costs decreased.

SUBMISSIONS ON INTEGRATION OF CARE

PROJECT TITLE: Point of Care (POC) Testing for Diabetic Retinopathy at Primary Care Facilities

Organization: United Healthcare Community Plan of New Jersey

Topic: Integration of Care

Project Contact: Lorrie Jones-Smith, RN, MSN, CPHQ, Medicaid Quality Consultant
lorrie_jones-smith@uhc.com

Project Overview: UnitedHealthcare Community Plan of New Jersey (UHCCP NJ) partnered with an organization to launch a pilot program for point of care (POC) testing at primary care facilities. The pilot utilized the company's diagnostic system that autonomously diagnoses patients for diabetic retinopathy, including macular edema. The system provides diagnostic results at the point of care; there is no need for specialist overread or telemedicine call-backs, and customized workflow integration solutions are available. System outputs can direct more actionable referrals, identifying patients with diabetes who are not already under the care of an eye care provider and are most likely to need timely vision-saving interventions.

Innovation:

UHCCP NJ and participating FQHCs collaborated with the vendor and integrated the software into the facility's IT systems, including the EMR. Clinical guidelines for participation were members with a diagnosis of diabetes who had not been diagnosed with diabetic retinopathy and were 22 years of age or older. Screening ran from April 2021–April 2022. Eligible patients were identified through clinical alert or chart review, and the provider ordered an exam through the EMR. The exam was performed during a patient appointment and provided one of three results. Results were routed through EMR integration and were immediately available to share with the patient during the appointment.

Outcome:

Prior to implementation of POC testing, only 12% of 548 patients with a diagnosis of diabetes completed an eye exam in the past 12 months in April 2021. With POC testing, 30.6% of the 548 patients completed a retinopathy exam without dilation or need for specialist oversight. This represents an increase of 102 patients and an increase of 18.61 percentage points. In February 2022, of 168 screened patients, 75% tested negative and avoided a referral to an eyecare specialist; 25% were identified as having eye disease due to diabetes and received a referral to an eyecare provider.

The speed at which this pilot could be activated was attractive; staff remained engaged because implementation was not drawn out. Another strength was patient feedback; comments were positive and included not having to make additional appointments, not having to have eyes dilated and immediate diagnosability. This pilot confirms the ability of POC testing to deliver quality, accessibility and affordability.

SUBMISSIONS ON INTEGRATION OF CARE

PROJECT TITLE: Opioid Use Disorder Hospital Medication Assisted Treatment Value-Based Care and Toolkit

Organization: United HealthCare Community Plan of New Jersey

Topic: Integration of Care

Project Contact: Lorrie Jones- Smith, RN, MSN, CPHQ, Medicaid Quality Consultant
lorrie_jones-smith@uhc.com

Project Overview: In national Medicaid membership, 46% of individuals with an opioid use disorder (OUD) have at least one hospital event per year; about half have multiple visits. The majority of visits are not directly related to OUD. Most hospitals do not universally screen for substance use disorder, and few initiate medication-assisted treatment (MAT) in the ED or inpatient setting. With many members with an OUD disengaged from primary care, initiating treatment in the hospital setting meets members where they are physically to connect them to life-saving treatment. Through UHC's OUD Hospital MAT Value-Based Care and Toolkit, funding and tools create a sustainable, standard process aligned with best practices to integrate OUD screening and treatment in the hospital setting.

Innovation:

The toolkit includes two incentive payments for the facility, one when a member is initiated on MAT, either while in the hospital or within 3 days of discharge, and a second when the member fills the first prescription refill, within 7–14 days after discharge from the ED or inpatient setting. In addition to incentive payments, UHC provides a performance dashboard with actionable data on a quarterly basis. The dashboard includes successful treatment initiations, as well as missed opportunities with members who had a triggering event but did not get treatment within the 3-day time frame. Number of follow-ups that met time frames is also included. In 2023, the dashboard added outcomes by racial group to allow monitoring for disparities in treatment initiation. The last piece of the Toolkit is supportive resources. UHC works with configurable set of resources and supports to set up hospitals to be successful.

Outcome:

Analysis of members with an OUD, with evidence of buprenorphine treatment, demonstrated that members treated with buprenorphine are more engaged in primary care and use the hospital less.

- Members with buprenorphine treatment had a 7% greater decrease in total cost, including a 60% greater decrease in inpatient cost, compared to the control group.
- Members with evidence of medications for OUD treatment saw a 21% higher increase in primary care.

This demonstrates the positive outcomes of OUD treatment, including the potential to improve overall health engagement, and supports scaling of the Value-Based Care and Toolkit. This program is now live in 4 states and 23 hospitals, and there is an active pipeline of an additional 8 states and over 50 hospitals.

SUBMISSIONS ON INTEGRATION OF CARE

PROJECT TITLE: Firearm Related Injury Case Management Program and Toolkit

Organization: United Healthcare Community Plan of New Jersey

Topic: Integration of Care

Project Contact: Lorrie Jones- Smith, RN, MSN, CPHQ, Medicaid Quality Consultant
lorrie_jones-smith@uhc.com

Project Overview: In 2020, a UnitedHealthcare Community Plan of Pennsylvania (UHCPP) nurse case manager saw an opportunity to identify UHCPP members who received care for a firearm-related injury and support them to achieve positive clinical and personal well-being outcomes. She constructed an innovative case management program inclusive of member engagement protocols, data tracking and documentation, and received approval to pilot approach in the Philadelphia area. She and a community health worker teammate put the program into action. They established relationships within the community to confirm availability of resources and support. Since November 2021, the Gun Violence Program team's collaboration, performance and outcomes have progressed from a grassroots response to a pattern of need in Philadelphia, to UHC's Firearm Related Injury Case Management Program and Toolkit.

Innovation:

Staff use a trauma-informed approach to personalize recovery goals. Internal data systems are reviewed for a comprehensive picture of the member's status and resource needs. Care management staff receive training on medical, behavioral and social impacts of firearm related injuries, as well as strategies to navigate the member's experience of stigma, retaliation and traumatic stress. Members receive support until goals are met, gaps in care are resolved and stable natural and chosen supports are in place. They are connected to culturally responsive and inclusive community resources, benefits and providers to assist with transportation, victims' assistance, finances, behavioral health, support groups, food and nutrition, legal assistance and housing resources.

Outcome:

The program identified 206 UHCPP members. Of those, 42% were enrolled in the program. Only 2 enrolled members were readmitted for unavoidable and ongoing clinical needs. In addition to readmission avoidance, nonclinical successes with the program have been shared through member stories. Firearm-related injuries have lasting impact on physical, behavioral and community health. Without intervention, members are at risk for worsening health and social conditions. The most impactful approach recognizes and encompasses a trauma-informed environment. The pilot, developed out of compassion and innovation, informed development of the UHC Community & State Firearm Related Injury Toolkit available to all UHC health plans in other states and UHC lines of businesses.

SUBMISSIONS ON INTEGRATION OF CARE

PROJECT TITLE: Gaps in Care Closure through Mobile Crisis Assessment (MCAT) and Crisis Stabilization Housing

Organization: Community Care Health Plan of Nevada, Inc. dba Anthem Blue Cross and Blue Shield Healthcare Solutions

Topic: Integration of Care

Project Contact: Hilal Arshad, MBA, Nevada Medicaid Quality Management Health Plan Director
ilal.arshad@elevancehealth.com

Project Overview: Community Care contracts with two Mobile Crisis Assessment Team (MCAT) providers that assess members in the ED to determine whether they meet criteria for inpatient psychiatric hospitalization. If so, admission and follow-up care are arranged, supporting closure of the Follow-Up After Hospitalization for Mental Illness (FUH) HEDIS measure. Members who do not meet inpatient criteria are diverted to outpatient services, and receive follow-up care. The provider completes a mental health assessment the same day of the ED visit, or coordinates a visit within 7 days. MCAT providers offer direct housing integrated with behavioral health and primary care services. Members experiencing homelessness are placed in short-term housing, to stabilize behavioral health and SDOH needs.

Innovation: Upon the member's discharge from the ED, the MCAT provider completes a follow-up assessment. Members who decline follow-up are offered a telephonic visit the same day, or an outpatient visit is scheduled the same day as discharge or within 7 days. Members who meet inpatient criteria are followed by the MCAT provider through their inpatient stay, and supported with follow-up after hospitalization. Housing is provided for members experiencing homelessness. Members who need further comprehensive assistance managing their behavioral, physical or SDOH needs may be referred to care management programs. Case management is tailored to member needs, and may include multiple care managers, RNs, licensed mental health counselors and community health workers, with an outreach timeline that meets member needs with a minimum contact of at least once a month. The integrated approach allows timely and successful connection to member resources.

Outcome: Initial analysis of the program (CY 2022) demonstrated that outcomes tied to using the MCAT provider to complete the FUM assessment are statistically significant. Anthem members who interacted with an MCAT provider in the ED were twice as likely to meet compliance for the FUM 7-Day measure and 1.5 times more likely to meet compliance for the FUM 30-Day sub-measure. Among the 162 members who received an MCAT assessment, 44% met compliance for the FUM 7-Day measure; 51% met compliance for the FUM 30-Day measure. From January–May 2023, MCAT providers offering behavioral health-integrated housing to members experiencing homelessness, post-ED or hospitalization discharge for mental illness achieved a 100% compliance rate for the FUM or FUH measure and a 98.5% compliance rate for the Adults' Access to Preventive/Ambulatory Health Services (AAP) HEDIS measure.

SUBMISSIONS ON INTEGRATION OF CARE

PROJECT TITLE: Providing Performance Increase With Rewarding Method in Patient Care

Organization: Health Professionals

Topic: Integration of Care

Project Contact: Cigdem Anbarpinar
anbarpinarcigdem@gmail.com

Project Overview: People who work with patients in health care need to know that they work well and that their efforts and working hours are seen and approved. These hidden heroes must be supported to keep their motivation to work at the highest level and encourage others through their example.

Innovation:

Implementation of a support system is based on showing the hidden heroes as an example through implementation of a reward system: a reward box for employees who have not received any complaints from patients or their families.

Outcome:

The employee fund was created to operate this system and distribute rewards equitably; it applied only in regions with high financial performance. It was used to increase motivation in other “invisible” jobs (e.g., cleaning, patient care, patient admission). It is based on the principle of supporting and increasing motivation.

SUBMISSIONS ON INTEGRATION OF CARE

PROJECT TITLE: Wellvolution: The Value-Based Digital Health Solution Enables Members to Achieve Health Goals

Organization: Blue Shield of California

Topic: Integration of Care

Project Contact: Angie Kalousek, Sr. Director, Lifestyle Medicine
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Project Overview: Blue Shield's Wellvolution is a digital platform that offers lifestyle-based clinical solutions for physical and mental health. Solutions can be personalized, and are based on scientific evidence and result-based outcomes. While the platform is available to all members, Blue Shield uses member data to reach higher risk members with specific chronic conditions such as hypertension, diabetes and obesity. Providers are paid on a value-based care, pay-for-performance model. Providers that do not garner member engagement and deliver clinical outcomes are removed from the platform.

Innovation:

Wellvolution includes a variety of programs from leading providers. Blue Shield collaborates with Solera Health to select and maintain program offerings and create networks to address critical issues facing Blue Shield members. The Wellvolution network of solutions is monitored for performance to ensure continued quality, and solutions are regularly added to the platform. All partners are evaluated regularly against milestone-based goals, and must consistently meet the goals to remain in the Wellvolution network. On the Wellvolution web page, members are invited to complete a health assessment that allows Blue Shield to guide them to the program that will address their health goals. This provides members with the right support, rather than having to navigate the system on their own. As a member improves scores or biomarkers associated with their condition, the partner can submit a claim for payment based on the achievement or milestone.

Outcome:

Members enrolled in Virta, the first and only digital treatment clinically proven to reverse type 2 diabetes, reduced their A1c level by 1.6pt on average; 68% eliminated a diabetes-specific prescription; 76% reduced their insulin dosage; the average weight loss was 5.6%. Of members enrolled in Ginger, the mental health app, 78% with moderate to severe depression, and an equal number with anxiety, reported improved symptoms. More than 37,300 members enrolled in Headspace since its inception in Q4 2021, and participated in more than 3 million hours of meditation; 22 million minutes (about 42 years) have been logged using Headspace content. 66% of members engaged in Wellvolution's tobacco cessation remained tobacco-free for a 7-day period. Significant weight loss is reported by members enrolled in diabetes management or weight loss programs. Members enrolled in diabetes prevention, weight loss management and diabetes management programs lost 5% or more of their body weight during an 18-month period.

SUBMISSIONS ON INTEGRATION OF CARE

PROJECT TITLE: Implementing a Mobile Integrated Health Partnership through Community Paramedicine

Organization: Molina Healthcare

Topic: Integration of Care

Project Contact: Deborah Wheeler, MSPH, VP, Quality
deborah.wheeler@molinahealthcare.com

Project Overview: Molina partners with community paramedics to help members at high risk navigate the complex health care system. The program focuses on high-risk members who have had 5 or more ED visits, or more than 5 inpatient stays, in the prior 7 months. After an initial in-person visit, or when appropriate, a community paramedic works with the member to ensure they follow the treatment plan for critical health conditions (diabetes, renal failure, heart failure, asthma, COPD, opiate use disorder), and address hospice and behavioral health needs. The paramedic encourages the member to re-engage with their primary care physician via telehealth if the member has challenges related to mobility, transportation or anxiety. Community paramedicine staff report all activity to Molina’s case management staff and to the member’s care team. For targeted high-risk members in the Mobile Integrated Health program, Molina’s goals are to reduce preventable ED visits by 30%, and preventable hospitalizations by 25%, within 6–8 months of program implementation.

Innovation:

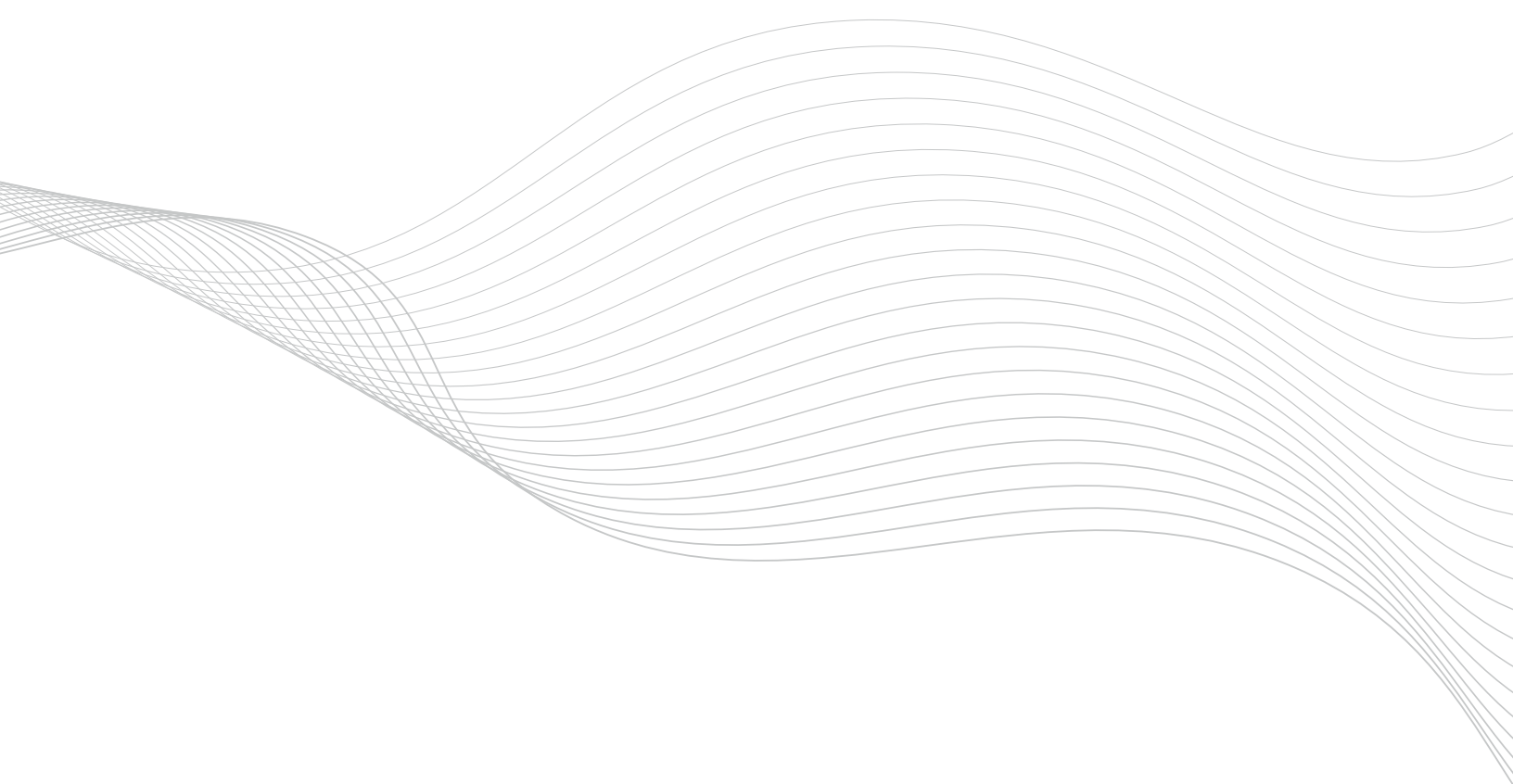
Molina’s Mobile Integrated Health Program educates members about chronic conditions and completing post-hospitalization follow-up visits, providing or connecting members to primary care and providing personalized in-home care. Community paramedics make contact and conduct the initial health and social needs assessment with members. The paramedic performs 1–3 in-person visits per week to identify and address member needs and barriers, including SDOH that impact ED utilization. Community paramedics also maintain an EHR, where services performed are documented in addition to diagnoses, challenges and solutions/interventions. Paramedics may also perform clinical tests, such as labs, and connect members to resources, like transportation or other services to support their health.

Outcome:

Program outcomes highlight its effectiveness. For members who have graduated from the program, there have been key reductions in critical health care metrics. The rate for avoidable ED visits has decreased by 28%; inpatient medical and surgical inpatient hospitalizations have decreased by 40%; inpatient behavioral health hospitalizations have decreased by 60%; the claims rate PMPM has been reduced by 11%.



PATIENT/FAMILY ENGAGEMENT



SUBMISSIONS ON PATIENT/FAMILY ENGAGEMENT

PROJECT TITLE: XpertPatient.com

Organization: XpertPatient LLC

Topic: Patient/Family Engagement

Project Contact: Risa Arin, MBA, CEO & Founder

Risa.arin@XpertPatient.com

Project Overview: XpertPatient.com is a transformative, online experience taking on the global challenge of empowering patients, fueled by smart thinking, scalable technologies and partnerships. The mission is to reach as many people as possible and build an army of confident health consumers, so they and their loved ones can achieve the best possible health outcome.

Innovation:

XpertPatient.com is a next-gen website providing patients and caregivers crucial information and support early in their cancer journey.

Outcome:

It has been proven repeatedly that educated and engaged patients achieve better treatment outcomes.

SUBMISSIONS ON PATIENT/FAMILY ENGAGEMENT

PROJECT TITLE: Concierge Care

Organization: Elevance Health/Anthem

Topic: Patient/Family Engagement

Project Contact: David Rauch, Chief of Staff for Elevance Chief Clinical Officer
david.rauch@elevancehealth.com

Project Overview: Concierge Care is a digitally enabled chronic disease management program delivered through an intuitive, omni-channel app that lets members access educational content, trackers, tools and on-demand chat with care teams that empower members to manage their health. Care managers are accessible via the member's communication channel of choice; they support and educate members on self-care when managing a chronic condition, progressing through a pregnancy for optimal birth outcomes or taking steps to prevent readmission after discharge from the hospital.

Innovation:

Concierge Care puts members in control of their health by providing on-demand access to care support, when, how and where they need it. Members can fill out daily symptom surveys, link data from their personal devices to the app, set medication reminders and earn points for completing daily missions. Members can also research their condition through a content library. What's most valuable for many is daily contact with their care manager. The digital program enables care managers to triage, monitor and engage with members to build personalized care plans and help them achieve and sustain their health goals. While the connection with a care manager may be digital, members are not talking to a robot. The empathy and support come from a real person who can help them understand a situation and offer help when it is needed.

Outcome:

57% of enrolled members initiate chats; 63% are actively engaged in the app; 52% remained active in maintenance mode after the final program week; 77% of enrolled members use the app to complete surveys and track health data.

Preliminary claims analyses showed a 39% decrease in outpatient ER utilization and a 60% reduction in chemotherapy side effect-related admissions for oncology. Based on member self-reported data in the app, there is a 25% improvement in Crohn's disease symptoms and flares; lower anxiety/depression levels for members in the Behavioral Health Concierge Care program; and lower hemoglobin A1C scores for type 2 diabetes.

SUBMISSIONS ON PATIENT/FAMILY ENGAGEMENT

PROJECT TITLE: Whole Family Health Blitz

Organization: Amerigroup Community Care

Topic: Patient/Family Engagement

Project Contact: JoAnne Hunnicutt, RN, Director I, Clinical Quality Management
joanne.hunnicutt@amerigroup.com

Project Overview: Amerigroup Community Care conducted a pilot program, “Whole Family Health Blitz,” from July 1–August 31, 2022. The intent of the pilot was an increased focus on reconnecting families with providers, to improve HEDIS rates and meet the state partner’s (TennCare) required goal for preventive services. Medicaid pediatric members 0–21 years of age must meet a minimum participation rate of 80% for EPSDT services (well child visits, vision/dental, immunizations). Amerigroup welcomed all providers in the initiative, and provided a one-time incentive payment of \$1,000 for participation. The provider who completed the most wellness visits and closed the most HEDIS gaps received a one-time bonus payment of \$10,000. Providers had to actively engage patients with identified HEDIS gaps in care. They chose the method of re-engagement and contacted patients. Outreach focused on educating patients on the need to complete preventive screenings, immunizations and EPSDT services.

Innovation:

The Whole Family Health Blitz was an inter-departmental collaboration between Amerigroup Provider Liaisons and the Quality Team to connect, monitor and follow up with providers throughout the pilot time frame. Providers completed the Whole Family Health Blitz Enrollment form. Amerigroup sent the providers a list of members with a gap in care, based on family units. Providers assisted in outreach to the members, and the Quality Team sent text messages to encourage office visits with primary care providers. Providers sent data weekly to the Quality Team. Data analysis used MY 2021 as baseline data and compared with December 2022 HEDIS benchmark report data to validate program impact. Ninety-three providers participated. Total cost for the Whole Family Health Blitz was \$103,000.

Outcome:

A statistically significant increase was seen in the Immunization for Adolescents (IMA)—Combo 2 and the Child and Adolescent Well-Care Visits (WCV)—Total HEDIS measures. The IMA—Combo 2 measure had a 0.88% higher rate of gap closure during the Whole Family Blitz, as opposed to the same period in 2021. At a statewide level, there were 0.06% more gaps closed in 2022 during the blitz than during that time in 2021. The ROI for each gap in care was approximately \$58/member.

Amerigroup noted a statistically significant increase in two HEDIS measures, IMA—Combo 2 and WCV—Total. Even though the increase in percentages was low, the population is large enough that the intervention was impactful. A review of barriers related to the intervention provided insight on the effectiveness of the activity for a planned re-creation of the intervention in 2023.

SUBMISSIONS ON PATIENT/FAMILY ENGAGEMENT

PROJECT TITLE: Health Tech Navigators: A Novel Community Health Worker Program to Increase Patient Access and Bridge the Digital Divide in the Safety Net Organization: Department of Health Services, Los Angeles County (LA Health Services)

Topic: Patient/Family Engagement

Project Contact: Anshu Abhat, MPH, MPH, FACP, Director of Patient Engagement, Office of Patient Access aabhat@dhs.lacounty.gov

Project Overview: LA Health Services (Department of Health Services, Los Angeles County) is an integrated health system of 26 health centers and 4 acute care hospitals. The LA Health Portal, the patient portal, is a free and secure website and mobile app designed to connect patients to their care teams. Patients can access critical health information such as lab results, doctor's notes, video visits and immunization records. However, in safety net communities, patients reported lack of confidence to enroll in and use digital tools like patient portals. Based on this critical need, a new community health worker program, the Health Tech Navigator (HTN) program, was launched. The Health Tech Navigators have more than doubled LA Health Portal enrollment and use. The HTN program bridges the digital divide for vulnerable, low income and limited English proficiency patients in Los Angeles County to improve the health and well-being of families and communities.

Innovation:

The HTN program provides in-person, 1:1 patient assistance to enroll in the portal, download the mobile app on a smartphone and use portal features. Navigators are on site 5 days a week, mirroring the clinic schedule. Each Navigator is required to enroll at least 45 patients per week. They also help at least 20 additional patients per week navigate the portal (e.g., access lab results, view upcoming appointments, join video visits). Staff are encouraged to send Navigators patient referrals in person via the EHR and Microsoft Teams. Navigators also enroll patients via the phone, and reach out to patients who have not enrolled in the portal. Navigators train onsite staff on the portal, and collaborate with site supervisors on performance improvement.

Outcome:

Pre-program, patient portal enrollment hovered below 20%. Post-launch (November 2021), enrollment grew to 43% by July 2023. Over 30,000 patients had been enrolled in the LA Health Portal by August 2023. Navigators increased enrollment of monolingual Spanish speaking patients 5-fold since the program launched. Navigators trained staff, ensured prompt follow-up on portal invitations and introduced innovative strategies to enhance engagement. Beyond enrollment, Navigators advocated for portal benefits in staff meetings and local community events, fostering a culture of digital empowerment and equity. The Health Tech Navigator Program transcends numbers, reshaping patient empowerment, staff collaboration and health care efficiency. Through its dynamic outcomes, the program embodies a transformative shift toward a more informed, inclusive health care experience.

SUBMISSIONS ON PATIENT/FAMILY ENGAGEMENT

PROJECT TITLE: High School Young Adult Community Health Worker

Organization: Morehouse School of Medicine: Family Medicine (Innovation Learning Laboratory)

Topic: Patient/Family Engagement

Project Contact: Christie George, Program Coordinator
christie.george@snhu.edu

Project Overview: The Innovation Learning Laboratory for Population Health created a program for high school and young adult community health workers, to increase the number of trained student community health workers in underserved communities and improve local health equity. The program encapsulates community health workers' core competencies, thereby inducing better health and wellness strategies. While helping the community, the program provides a health careers pipeline program and mentorship for underserved students. It provides health monitoring and health literacy activities to students' families and community members, and supports and promote the community health worker field.

Innovation:

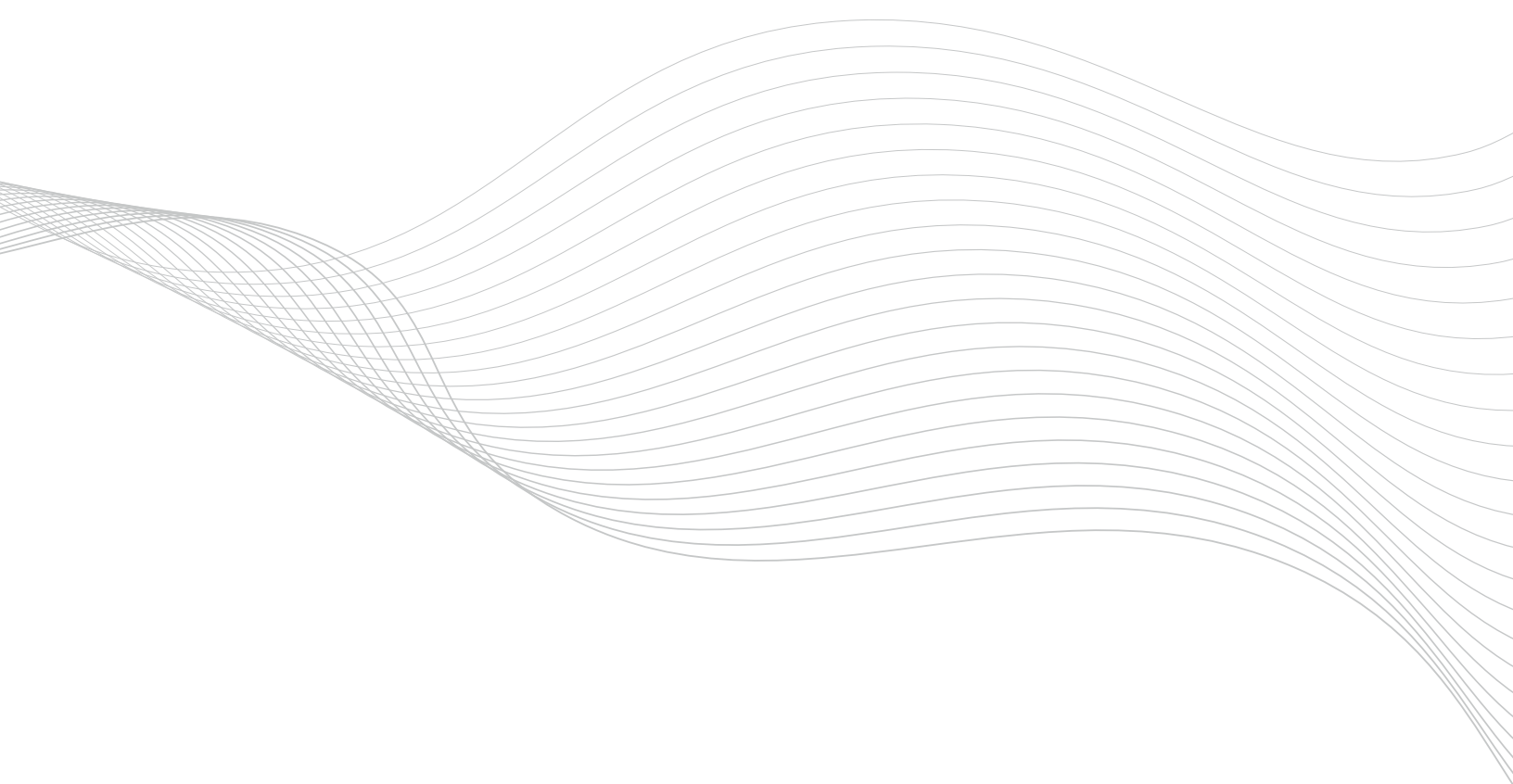
The Innovation Learning Laboratory for Population Health aims to design and implement demonstration projects that generate innovative technology-driven health care models and fuel teaching and learning for population health improvement. The laboratory's purpose is to identify, design, develop, demonstrate and disseminate innovative models of health care improvement.

Outcome:

Since 2016, 8 cohorts and over 180 high school young adults have participated in and completed the program. Around 20 rising 10th–12th-grade students each year undergo a 5-week intensive summer training to learn about chronic illnesses, health issues and primary health monitoring techniques. For the rest of the academic year, they monitor and set health goals with community members and work in teams to organize a community project, such as a health fair, virtual or in-person community events.



USE OF TECHNOLOGY



SUBMISSIONS ON USE OF TECHNOLOGY

PROJECT TITLE: Cultivating Collaboration: Uniting Quality and Value-Based Contracts for Provider Harmony and Success through Inovalon’s Converged Quality and Provider Enablement solutions

Organization: Inovalon

Topic: Use of Technology

Project Contact: Courtney Breece, Associate Vice President, Payer
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Project Overview: Inovalon partnered with Geisinger Health Plan to streamline and simplify the provider experience by leveraging Inovalon’s advanced data analytics and technology solutions. By integrating quality measures and value-based care contract requirements, providers can focus on delivering care without the stress of navigating multiple reporting sources and contract documentation. Integration allows a transparent approach to the health plan/provider relationship in value-based care arrangements, and brings immediate awareness to patient care needs and incentive opportunities that were not uncovered during the measurement year. By aligning incentives with outcomes, providers are motivated to prioritize preventive care, patient engagement and population health management, resulting in improved patient experiences and population health.

Innovation: Providers have difficulty identifying opportunities to meet their goals in value-based full or partial capitation arrangements. Health care organizations must navigate through multiple systems, data sources and reporting requirements, resulting in increased administrative burden and potential data inconsistencies. The intervention of a single view harmonizes these two critical components. By consolidating measures and value-based care requirements, health care organizations gain a comprehensive understanding of their performance across quality metrics and risk adjustment models. This unified view allows more accurate identification of care gaps, enabling targeted interventions to improve patient outcomes.

Outcome: The tool can aggregate quality measure results, show value-based contract performance, identify areas of opportunity and provide patient-specific gap reports, improving the health plan-provider workflow and increasing transparency through collaboration and clear understanding of value-based contract performance. There is a notable advantage for leveraging Converged Provider Enablement: Measures perform significantly better as a result of actively using the tool. Results shed light on the opportunity to leverage technology and data to improve outcomes. For the HEDIS MY 2022 measurement period, Geisinger included 73 measures in the program. Of those, 66 performed better for provider users that logged in at least once; 90% performed better when supported using Inovalon’s Converged Provider Enablement. For the HEDIS MY 2023 measurement period, Geisinger included 79 measures in the program. Of those, 71 are performing better for provider users that logged in at least once; 90% performed better when supported using Inovalon’s Converged Provider Enablement.

SUBMISSIONS ON USE OF TECHNOLOGY

PROJECT TITLE: MyUCSDHealth—Doubling Patient Satisfaction Scores, Increasing Revenue and Expanding Healthcare Access

Organization: UC San Diego Health

Topic: Use of Technology

Project Contact: Benyam Alemu Sood, Master's in Computer Science, Mobile Applications Developer
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Project Overview: UC San Diego Health offers an iPhone/Android application, MyUCSDHealth, which presents news from UC San Diego Health, provides visitor information and allows users to interact with their EHRs. Patients can also schedule appointments, pay bills and message their health care providers. In 2019, there was a high crash rate (42% of users had at least one crash), and users reported a very poor experience. The App Store rating was 2.4 out of 5 stars. Patients were not happy; clearly, something needed to change. In January 2020, UC San Diego Health hired a full-time mobile applications developer to transform technology and operations, with the goals of improving the patient satisfaction score, reducing the crash rate and introducing virtual visits as a revenue opportunity.

Innovation:

UC San Diego Health lowered the crash rate per session by 94% by introducing defensive programming techniques to better handle unknown values, and by introducing test-driven development and a comprehensive human verification and validation process, making core experiences faster and simpler (e.g., reducing the login process from 10 seconds to 2 seconds). A technology upgrade and operational changes enabled telemedicine: UCSD Health patients can video call their providers to conduct virtual appointments anywhere across the world. An accessibility audit resulted in support for Apple VoiceOver (so software can read aloud) and increased font sizes, button sizes and contrast ratios. Support for SMART Health Cards on the login screen allows users to access to their vaccination and booster status. In addition, features such as push notifications allow sending dynamic messages to all users, and Deep Links allows customization of the app experience based on a text or email received.

Outcome:

Patient experience improved, the crash rate was reduced and revenue increased. Telemedicine delivered video visits for over 820,000 patient encounters during COVID-19. App downloads increased by over 1,200%, usage rate by over 2,200% and the App Store rating doubled—from 2.4 stars to 4.7 stars. The crash rate (per session) was reduced by over 94%. These changes resulted in over \$115 million in additional revenue and a strong operational playbook for the Mobile Team. After these successes, UC San Diego Health built other pilots for clinical use cases (e.g., for physical therapy, surgical recovery and pregnancy).

SUBMISSIONS ON USE OF TECHNOLOGY

PROJECT TITLE: Using Automation to Augment Nursing Staff

Organization: Geisinger

Topic: Use of Technology

Project Contact: Emily Fry, MHA, Vice President, Innovation
elfry@geisinger.edu

Project Overview: Geisinger's Steele Institute for Health Innovation's Intelligent Automation Hub helps audit patient charts for completion of suicide watch, non-violent restraints and violent restraints documentation, and outputs this automatically to an electronic Excel file, allowing audits to be handled in a timelier manner, minimizing delays in follow-up and leading to a 100% completion rate of quality audits. Automation also provides data visualization through a Tableau dashboard that reports audit volumes and compliance tracking, ensuring that patient chart audit forms are completed per DOH and Joint Commission requirements, and that they are available at the time of reviews and inspections. This also helps unit nursing managers work to the top of their license and focus on process improvement and quality of care initiatives related to audit compliance.

Innovation:

All patient information is exported from the documentation system and inserted into chart audit forms per patient. The bot reviews admitted patients for certain requirements, completes an Excel file with specific documentation elements required of an audit and outputs this into an exported file in a shared location for review by nursing leaders. This information is then tabulated per unit, per hospital, into the Tableau dashboard that displays the volumes and compliance information. The automation, fueled by Geisinger's robust EMR, will provide a data-driven, automated workforce that can flawlessly perform repetitive steps for completing chart audits.

Outcome:

The bot is expected to process around 100 patients for suicide watch, non-violent restraints or violent restraints every 4 hours, every day, ensuring a timely turnaround time, which will reduce human delays or missing documentation issues. It is anticipated that the bot will save 150 hours of nursing and nurse leaders time per day, thus allowing them to focus on direct patient care and other tasks. The bot will reduce incomplete chart audits or missing information. Automation will open doors for nursing workflow-related automations and for EMR chart audit-related automations.

SUBMISSIONS ON USE OF TECHNOLOGY

PROJECT TITLE: Firefly-Follow-Up Post Emergency Department Visit for People with High-Risk Multiple Chronic Conditions

Organization: United Healthcare Community Plan of New Jersey

Topic: Use of Technology

Project Contact: Lorrie Jones-Smith, RN, MSN, CPHQ, Medicaid Quality Consultant
lorrie_jones-smith@uhc.com

Project Overview: Firefly is a platform created to establish a new method of engaging managed care members post-ED discharge, at relevant health moments when they are receptive to support. The program identifies members being discharged from the hospital as a key opportunity to drive engagement while closing multiple hospital Star Measures and preventing readmission. This process drives improvement in total affordability. Admit, discharge and transfer (ADT) notifications are leveraged to drive timely follow-up. This is the first time ADT data are used to support a Stars Measure, and for a program to engage members post-ED visit. While a provider completes the telehealth visit and submits a claim, the operations, data management, reporting, and outcome monitoring remains internal.

Innovation:

The ability to have early discharge data aligned with specific members helps drive relationships with providers and members in a timely manner. Utilizing ADT data feeds generated through multiple aggregators, direct hospital and health information exchanges provides early notification of member discharge. Historically, engaging a member post-hospitalization, from any level, depended on the member communicating with their provider, or the health plan identifying discharges through claims. These methods add a time delay in responding to members' needs, and can allow readmissions. Understanding member patterns, through predictive modeling and algorithms based on historical utilization, aligned with early notification data, drives targeted engagement, thus meeting Stars Measure requirements and driving down medical spend.

Outcome:

This program was a pilot in 2021, and was expanded 2022 to targeted health plan contracts, with final expansion in 2023 to include 50 states and 44 contracts. Member reach rates have remained consistent between 45% and 49%, and engagement rates are between 70% and 73%. The completion rate for Follow-up Post Emergency Department Discharge for People with High-Risk Multiple Chronic Conditions (FMC) is between 98% and 100%, driving gap closures. Without Firefly platform ADT data, members with substance abuse issues or homelessness, or who need transportation to dialysis, would go unserved and risk continued emergency, observation or inpatient discharges.



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