COMPENDIUM

THE NCQA INNOVATION AWARDS 2020

Featuring Quality Accelerators in Health Care

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Improving health care.

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ABOUT THE NCQA INNOVATION AWARD

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. Patient and Family Engagement
3. Delivery System Design
4. Use of Technology
5. Customer Experience
6. Response to COVID-19

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 listed in alphabetical order.

WINNERS

WINNER

PROJECT TITLE: Albany Area Primary Health Care, Inc.'s Healthy at Home Initiative

Organization: Albany Area Primary Health Care, Inc

Topic: Response to COVID-19

Project Contact: Heather Dutton; Heather.dutton@aaphc.org

Project Overview:

Albany Area Primary Health Care (AAPHC) developed the "Healthy at Home" Initiative to complement its telehealth visits and add a way to communicate with high-risk patients. The goal was to keep patients safe at home, where there was reduced risk of contracting COVID-19.

The biggest barrier to bringing care to patients' homes was lack of information on patients' vital signs during telehealth visits. With an innovative approach and support of a foundation grant, AAPHC was able to purchase at-home vital kits for patients to complete their own basic triage. AAPHC also provided a delivery service with clinical staff who could educate patients on how to use equipment. This gave patients the ability to report crucial data to providers during televisits.

During the initial 60 days of the initiative, there were more than 300 patient care telehealth visits and there were no inpatient admissions from this patient group.

Innovation:

In rural Georgia, AAPHC cares for some of the most vulnerable people in the state. As the pandemic began, reached out to patients through different telehealth resources: Google Hangout, Facetime, HEALOWTELE and direct phone calls. To optimize virtual visits, AAPHC determined that information about basic vital signs was critical.

Step one was facilitating a basic kit of vital-sign equipment to distribute to patients. AAPHC purchased the necessary items, including self-monitoring blood pressure cuffs, thermometers and pulse oximeters. Through negotiating with vendors, it kept the cost of a basic kit to $77.56 per patient, which was funded through a donation to the AAPHC Foundation.

Step two was finding a way to deliver the vital kit to patients. AAPHC quickly identified a clinical team that could deliver the kits to a patient's home and teach the patient how to use it. Combining at-home care and at-home monitoring equipment in the middle of an unprecedented pandemic was a unique way to meet patients' needs during a challenging time.

Issue:

In March 2020, Albany, Georgia, was hit with a "super spreader event" that went off like a bomb in that small town. The community suddenly found itself ranked third in the world as the highest number of cases per capita. Many people were fearful to leave their home, even for doctor appointments. Finding a way to serve these

patients was critical to ensuring they stayed healthy and avoided a catastrophic health event; in addition to keeping patients from going to the ER during the height of the pandemic or burdening an already overwhelmed health system.

AAPHC began planning to care for patients in their homes—especially critical for patients with chronic health conditions and those in the high-risk category for coronavirus. While televisits grew in popularity with patients, providers felt that they were missing critical pieces that would make virtual visits more valuable: patients' vital signs.

The mission was clear. At-home vital kits would give providers access to real-time data from patients. Rather than hearing, "I'm having a hard time breathing," without a clear diagnosis, providers could immediately see the patient's oxygen levels and make a quick, decisive treatment plan.

Solution & Project Scope:

Objectives:

- Increase the ability of the patient to give the provider basic vital-sign information.
- Decrease face-to-face clinic visits to decrease exposure to coronavirus.
- Identify patients who needed anti-coagulation therapy appointments and perform test in the home.
- Identify patients due for HgA1C testing and perform the tests at the home visit.
- Identify patients due for colorectal screening thru FIT testing and leave instructions and a mail-back kit with the patient.
- Provide patients with tools to record their vital signs and instruction on the tools' proper use.

Budget: $50,000 (donated from the Dobbs Foundation). Funds were allocated for equipment, staff salary and mileage.

Resources: Multiple equipment vendors were accessed for supplies; two clinical staff members were allocated to the project.

Timeline: The initial plan began at the end of March 2020, with workflow development and equipment purchasing. Staff training was held on April 17 and initial patient care home visits began on April 20.

Outcome:

Clinical staff included a licensed practical nurse and certified medical assistant, who completed 323 visits in 8 weeks. Patients were screened by phone for COVID-19 related issues and again upon entering the home. Staff and patients were given masks. If additional family members were present, they were also screened and given masks.

Although the majority of patients met with clinicians in their home, some were uncomfortable with staff coming into their homes. In that event, the team met with the patient outside or through Facetime and then left the tools in the mailbox.

AAPHC providers identified high-risk patients, patients who had missed an appointment and/or who needed a telehealth visit. Provider staff would then create a referral to the home nurse in the EMR system, which helped clinical staff build their daily schedule based on patient location.

Strategic planning was vital. AAPHC covers eight counties; some patients live an hour and half away from the Albany headquarters. Typically, staff saw at least six patients each per day. Most visits took about an hour, with proper education and return demonstration by the patient on use of equipment. Lab work was processed at the closest clinic and results were forwarded to the provider. Emergent situations were immediately called into the provider for intervention.

Innovation/Creativity

"Healthy at Home" has evolved into a sophisticated quality improvement program. Using standard metrics for quality compliance, AAPHC identified areas that were suffering due to the pandemic.

Because HbA1c compliance was dropping due to the lack of clinic visits, AAPHC added this service, along with the INR fingerstick, for applicable patients.

Because April colorectal screening numbers had dropped, FIT kits were initiated and taken to patients' homes. Depression screening was based on the patient's response and assessment by the staff. Medications were reviewed to improve adherence.

Most patients in the program use the equipment and have the information readily available to give to the provider. These daily recordings allow the provider to improve treatment care plans based on data.

Patients have truly become an integral part of their own health care. AAPHC is investigating use of a computer tablet with preloaded data, to identify high-risk patients with transportation issues and/or who lack a smart device. AAPHC wants to evaluate Transitional Care Management under the home visit model for the Medicare population. Eyes in the home, assessing needs first-hand, would be a major win for patients.

Partners:

Dobbs Foundation, McKesson, LinCare Medical Equipment, Georgia Hypertension Control Project (Georgia DPH)

WINNER

PROJECT TITLE: Behavioral Health Homes

Organization: HealthKeepers, Inc. (Anthem)

Project Contact: William Nicoll, LPC; William.nicoll@anthem.com

Project Overview:

The Behavioral Health unit of Anthem's Virginia Medicaid team designed and implemented a treatment model focused on closing disease-specific gaps in care for persons with co-occurring behavioral health and chronic health conditions. Using NCQA's HEDIS® measures as a base, Behavioral Health Homes tackles wellness, disease management and prevention. At an individual level, the program has resulted in improved health outcomes; at the population level, Behavioral Health Homes has helped lower population metrics, ranging from ER utilization to behavioral health and medical inpatient admissions.

Innovation:

What makes Behavioral Health Homes innovative is the model's ability to take an idea like integrated care and turn it into tangible, measurable clinical practice through staffing, data and a flexible, initiative-based approach. In addition to a program manager, this model capitalizes on regional care coordination, leveraging existing relationships and expertise. Anthem provides data at the member level and in aggregate, allowing providers to see areas of clinical opportunity while monitoring their own progress. With their own Behavioral Health Homes Dashboard, each partner can see their data, monitor their progress and make updates. Through closing disease-specific gaps in care, Behavioral Health Homes uses an initiative-based approach to enrich lives while improving larger population metrics. Ranging from increasing PCP utilization to COVID-19, Behavioral Health Homes can pivot to address the needs of those being served.

Issue:

People with co-occurring serious mental illness and chronic physical health conditions are dying up to 30 years sooner than people in the general population. Metrics of success indicate there is room for improvement (e.g., ER rates, inpatient admission rates, utilization data, spend data). Despite the widely recognized value of integrated care, there remains a noticeable silo effect between the two disciplines of physical and behavioral health.

In 2014, Virginia's regulatory body for Medicaid and Medicare, the Department of Medical Assistance Services (DMAS), asked the six MCOs in the state to work with a community services board (CSB) of their choice to create a "Behavioral Health Home." From that pilot came a full-scale program.

Working to reduce such significant statistics and push for whole-person health falls in line with the missions of Anthem, Inc., DMAS, Virginia's Department of Behavioral Health and Development Services (DBHDS) and providers such as community service boards (CSB). At the same time, with the behavioral health field experiencing an increase in regulations while managing ongoing funding issues, there is a clear need for change in how behavioral health professionals work with clients.

Some treatment models posit that behavioral health professionals should be embedded in primary care settings. This makes sense for certain populations such as the "worried well" or the elderly because they tend to have ongoing relationships with their primary care providers. But in large part, persons with serious mental illness (SMI) are not known to regularly visit with their primary care doctor (if they even have one). Instead, persons with SMI often have long-term relationships with their local CSB. A solution, therefore, is to bring medical attention to the CSBs—the place where these people are served.

Solution & Project Scope:

As of July 1, 2020, there are five active Behavioral Health Homes, serving approximately 450 members across the central, eastern and northern regions of Virginia. Broadly speaking, the model's objectives are to better the lives of those served while lowering costs and impact on the health care system. More specifically, objectives can be looked at in two categories: program objectives and population objectives.

Program objectives comprise financials (cost of interventions delivered) and standards of care (based on NCQA's HEDIS measurements). Population objectives comprise ER utilization (rate of ER admissions), PCP utilization (rate of members who met with their PCP at least once annually), inpatient admissions and readmissions (for both behavioral and physical health).

Outcome:

Each Behavioral Health Home tracked five population metrics across the first year of the program. Performance in these metrics determines the potential incentive payment. Across two Behavioral Health Homes in the first year, 9 out of 10 categories improved in realms of physical and behavioral health and showed a savings of over $460,000.

In addition to measuring progress along the five metrics, programs worked to close gaps in care through disease-specific interventions. Broken into initiatives lasting 30–90 days, interventions were monitored and communicated using the Behavioral Health Home Dashboard. At monthly meetings, Anthem care coordinators and CSB staff had the opportunity to talk about members and their needed care. This opened the door for greater communication, fostered a sense of camaraderie and partnership and has influenced the quality of care members receive from their combined knowledge and efforts.

Innovation/ Creativity:

Care coordinators are assigned by region, allowing them to utilize local knowledge and resources. Because they are already assigned to CSBs across the state, Behavioral Health Homes leverage existing relationships to bolster the work force. A full-time program manager and a part-time medical management specialist are also assigned. Together, they meet live with each site on a monthly basis to review initiative updates, staff cases and work through issues.

Using the state's Emergency Department Care Coordination system, staff can see real-time updates on ED admissions across the state for nearly every Medicaid member. Each quarter, providers get member-level information on total spend, medical loss ratio, per member per month costs and outcome measures related to incentive payments.

Each Behavioral Health Home has its own Dashboard, which contains member-specific data, initiative workflows, self-updating progress graphs, built-in project management functions and resources.

Initiatives reflect the clinical needs of the membership. For example, because over half the membership had a diagnosis of hypertension, the decision was made to target blood pressure medications, order blood pressure monitors and teach self-management techniques to members. With the start of the COVID-19 pandemic, face-to-face service delivery was put on hold. Behavioral Health Homes responded by designing a phone-based COVID-19 initiative based on guidance from the CDC and the Virginia state health department, targeting needs such as food banks, free pharmacy delivery, safety tips and testing site locations. The PHQ-9 was used to understand potential effects of the pandemic on mental health. The ability to collaborate and pivot based on the shifting needs of the membership demonstrated the model's flexibility.

Partner:

Community Service Boards, which are the local mental health centers in Virginia.

WINNER

PROJECT TITLE: Well Fed

Organization: UVMHN Elizabethtown Community Hospital

Project Contact: Amanda Whisher; awhisher@ech.org

Project Overview:

The Well Fed Collaborative was established to combat the dietary crisis in Essex County. Working together with Essex County and community-based organizations, farms and retailers, the collaborative provides nutrition education, increasing consumption of fresh fruits and vegetables and improving the affordability of local foods.

Innovation:

The Well Fed Collaborative encompasses five key projects; two fall under the umbrella of UVMHN Elizabethtown Community Hospital.

30 percent of families residing in Essex County are classified as ALICE (Asset Limited, Income Constrained, Employed). Many are identified as working but with an income just above the federal poverty level, making them exempt from social services but below a sustainable wage.

The highest priority was directly related to consumption. Decreasing the percentage of adults and children who consumed less than one fruit and one vegetable per day was identified as the objective that would have the highest impact on the population partners wanted to reach.

Issue:

Essex County is the second largest county in New York State, yet is one of the least populated (just under 39,000 people). Many of its residents struggle with obesity, diabetes and heart disease. UVMHN Elizabethtown Community Hospital is a Critical Access hospital in the center of Essex County. It serves county residents and a large number of seasonal residents and visitors, and comprises the main hospital, a satellite campus and six primary care health centers.

The 2016 Community Health Assessment noted that access to and affordability of local, healthy food was an issue. The Well Fed Collaborative was created in November 2018. Wellness RX and food pantry co-location were identified as possible solutions to an overarching goal of reducing obesity and risk of chronic disease. Following the Prevention Agenda, UVMHN Elizabethtown Community Hospital looked to increase access to healthy and affordable foods while providing nutrition education to directly support healthy eating.

Once goals were in place, internal meetings were conducted to set objectives. The highest priority was decreasing the percentage of adults and children who consumed less than one fruit and less than one vegetable per day.

Solution & Project Scope:

There have been 51 referrals to the Wellness RX program. Participants are educated on nutrition and given food vouchers—to date, 253 vouchers have been redeemed for a total of $2,795.20 spent on produce. Local farms and artisans collaborate on ways to address affordability of local foods and UVMHN Elizabethtown Community Hospital continues to support an at-risk population through nutrition education and financial assistance related to food access. Hosting a pantry in a health center greatly reduced the stigma surrounding utilization. After three months of operation, 83 families had accessed over 3,900 pounds of food.

Teaching participants how to prepare and work with local, fresh ingredients has encouraged lifestyle modifications that positively impact the health of the population. Working with local farms, retailers and artisans and maintaining partnerships developed through the collaborative supports organizations and connects those in need with the resources throughout the community. Establishing relationships with local leadership identified necessary policy changes to address barriers and encourage innovative solutions.

Although the collaborative and projects are just over a year old, they have profoundly affected the community. Participants are excited to participate in education sessions and have access to healthy food; the stigma associated with a food pantry is markedly reduced as a direct result of its co-location in a health center. The health and quality of life is improving for many patients and community members.

Outcome:

Consistent and frequent communication keeps partners informed and current. Remaining open to change based on feedback from participants, clients, partners and team members gives projects flexibility to meet population needs.

Collaborating and identifying available resources allows disease prevention, rather than treatment, and in the long run will show a savings in health care costs. Financial support of UVMHN Elizabethtown Community Hospital, fundraising events, grant funding opportunities and increasing the number of partnerships will allow growth the programs' growth throughout Essex County and surrounding communities.

The food pantry joined the Regional Food Bank of Northeastern New York in April 2020. The reduced price of food allows the hospital and hospital auxiliary to sustain the pantry. Food and monetary donation events will be held annually to aid with its operating budget. UVMHN Elizabethtown Community Hospital and health centers screen for food insecurity. Once a disparity is identified, patients are supported through a referral process and connected with community resources to address barriers to food access and affordability.

Working collaboratively to connect people in need with the appropriate organizations for SNAP and WIC enrollment, referrals to programs such as Wellness RX or the food pantry co-location and working with local farms directly aligns with the goal of the collaborative: Increase consumption of fruits and vegetables, educate the community and address food insecurity.

Innovation/Creativity:

The focus of Wellness RX is the educational component of addressing food access and affordability. The program is referral based; referrals can come from any member of the patient's care team. Once enrolled, patients must attend monthly education sessions with a nutritionist or diabetes educator in exchange for four fruit and vegetable vouchers valued at $5 or $10 each, depending on the size of the household. Vouchers are good for a month and are accepted at eight redemption sites throughout the county; three sites are a direct result of partnerships created through the collaborative.

The concept behind healthy pantry co-location was to address the barrier of food access in Essex County. Because Medicaid transportation can be used for medical appointments but not for access to food, co-locating the pantry in a health center gives Medicaid recipients access during medical appointments. Shortly after the decision was made to move forward with this project, the sole grocery store in Port Henry closed, creating another barrier for residents. Cornell Cooperative Extension and Church of the Good Shepard Food Pantry staff and team members trained hospital staff on how to operate a food pantry and with their help the pantry opened. It has been a huge success, serving 83 unique families and distributing almost 4,000 pounds of food. The pantry joined the regional food bank in April 2020.

Partners:

Primary Care Practices

SUBMISSION ON CUSTOMER EXPERIENCE

SUBMISSION ON CUSTOMER EXPERIENCE

PROJECT TITLE: Preventing Financial Toxicity in Oncology

Organization: Grand Valley Oncology

Topic: Customer Experience

Project Contact: Gail Jones, MAOA, MICT®; gjones@gjhosp.org

Project Overview:

You were told you have cancer and you are still reeling from the news. The provider explains that you will receive drugs that will cost more than your house. You are scared and have no idea what to do. This scenario plays out every day in oncology centers across the country. Cancer treatment frequently leads to bankruptcy—but it doesn't have to.

The Grand Valley Oncology team realized there was "a climate of financial toxicity" that needed to be corrected. The clinic set a goal to meet every existing patient and all new patients on chemotherapy. Targeting these patients ensured that the team could catch missed opportunities to offer financial counseling. Now all new patients meet with staff and have an opportunity to be considered for programs.

Innovation:

The focus of the financial counselor shifted from minimizing/collecting payments to increasing access to cancer treatment through medication assistance programs. Grand Valley Oncology created an introduction/authorization letter for financial counseling services and an educational fact sheet outlining available programs, and shared them with non-oncology clinics throughout the organization. A vendor estimated that the oncology clinic could save up to $750,000 annually, but this goal was surpassed in seven months with an organizational savings of $812,092.

The team also helps the oncology pharmacy obtain replacement medication and conducts chart audits to assess missed or underpaid charges—it found that insurance companies often underpaid claims.

One staff member is in charge of the process, which saves the organization a monthly average of $500,000. This savings keeps patient costs down and avoids unnecessary increases.

Outcome:

The program began in January 2019 with pharmacy preauthorization staff, pharmacy director, service line director and social worker. A financial counselor was hired to help patients directly and a coding analyst tracked insurance company payments. The coding analyst determined that on average, the clinic was being paid below contract agreement by $400,000 per month.

Grand Valley Oncology staff started looking for ways to reduce expenses and were able to verify a cost savings of over $46,000 per month for clinic supplies. Patient satisfaction went from 95.5 to 97.5 over the project's scope.

Partner: Hospital pharmacy and rheumatology

SUBMISSIONS ON DELIVERY SYSTEM DESIGN

SUBMISSIONS ON DELIVERY SYSTEM DESIGN

PROJECT TITLE: Implementing Team Care Medicine

Organization: Centerpoint Health

Topic: Delivery System Design

Project Contact: Lorie Glenn; lorie.glenn@centerpointhealth.org

Project Overview:

Centerpoint Health implemented Team Care Medicine, LLC, in May 2019. In the TCM model, clinical staff members become team care assistants empowered up to the limit of their license. Team care assistants conduct most of an exam room visit without needing the provider to be present. This innovative treatment strategy strengthened Centerpoint's capacity to deliver high-quality care, improved clinical efficiency, created consistency in documentation and gave providers a better work/life balance, all without eroding Centerpoint's high level of patient satisfaction and quality outcomes.

Innovation:

With Team Care Medicine, LLC, providers are team captains of a larger clinical support team. This frees them to focus on the central elements of the patient exam, medical decision making and treatment planning, which then creates space on the calendar to bring care and attention to an increased number of patients. Centerpoint Health paved the way as the first Federally Qualified Health Center in Ohio to implement the TCM model. As the state leader, it had the opportunity to create modifications to the templates and workflow to make them function harmoniously with eClinicalWorks.

Outcome:

Eight months after implementation, productivity had increased by an average of 9% for providers who were trained in Team Care Medicine, LLC, and incomplete charts decreased by 47%. Data are being gathered about provider, patient and staff satisfaction, but overall, providers attribute the decrease in their time spent working to implementation of the model.

Quality outcomes were a driving factor for the change in process, as well. Depression screenings were the first focus: In April 2019 Centerpoint screenings were at 55.7%; by April 2020 screenings had increased to 85.7%. Preventive screenings improved also, and Team Care Medicine continues to develop ways to improve other outcomes.

Partners:

Ohio Association of Community Health Centers (OACHC); Nonprofit Team Care Medicine, LLC; Business (private)

SUBMISSIONS ON DELIVERY SYSTEM DESIGN

PROJECT TITLE: Implementation of Central Practice Administration Office

Organization: MyHealth, Long Island

Topic: Delivery System Design

Project Contact: Jennifer Piscitelli; jpiscitelli@licommunityhospital.org

Project Overview:

MyHealth, Long Island, is a group of primary care and surgical practices under the only standalone hospital on Long Island, New York. MyHealth implemented a central hub for both patient outreach and incoming billing and scheduling functions, to ensure a systematic approach among locations for ease of scheduling, outreach to reduce no-shows and ensuring that post-hospital follow-up appointments are made and kept.

The project included collaboration with the Hospital Observation Unit; discharge lists were provided to the Scheduling and Outreach department to ensure that follow-up appointments were booked for all patients. This resulted in a reduction of no-show rates and increased post-hospital discharge follow-up appointments. It also improved patient satisfaction regarding billing; a live person answers the phone from 8am–8pm to schedule appointments, discuss insurance coverage and assist with issues or questions about billing and co-pays.

Innovation:

To truly remain "community" based, MyHealth has tried to stay independent from larger health care systems. Budgets are tight and all areas run lean staffing, but the central practice administration office was created with a large number of phone lines and hardware/software, and seasoned and patient-experience savvy staff man it all.

Giving community members a venue to get questions answered and have a personal interaction with knowledgeable teams—both at practice level and beyond—has sparked an increase in patient satisfaction. Being able to access certified billers to answer questions, review sliding scale payment assistance and explain benefits has eased a stressed patient population.

Outcome:

Patient satisfaction, call volume and payment postings/denials are monitored monthly. Call volume has increased by more than 26% since implementing the program three years ago, and volume at practices, including same-day appointments, has increased by more than 30%.

Partners:

Primary Care Practice(s)

SUBMISSIONS ON DELIVERY SYSTEM DESIGN

PROJECT TITLE:

Clinical Nurses Having Authority to Make Decisions within Full Scope of Nursing Practice

Organization: Schneck Medical Center

Topic: Delivery System Design

Project Contact: Meghan Warren, MSN, RN; mwarren@schneckmed.org

Project Overview:

Schneck Medical Center developed a Care Management Program that improved the performance of its Medicare Annual Wellness Visit rates from 8% to over 50%—surpassing its benchmark. A registered nurse works at the top of her nursing license, allowing physicians to generate revenue through more high-priority office visits.

Innovation:

Schneck Primary Care was performing less than 10% of Annual Wellness Visits on its MSSP population. A financial analysis revealed that revenue generated by these visits would surpass the cost of employing an RN. Schneck created an RN position specifically to perform Wellness Visits while allowing providers to generate revenue simultaneously with other office visits.

This resulted in raised awareness of Annual Wellness Visits and received buy-in from providers, because additional revenue was generated, and delivered good quality of care through Annual Wellness visits.

Outcome:

Schneck Primary Care not only looked at the revenue generated from Annual Wellness Visits, but also at the revenue generated from mammograms, colonoscopies and other services covered by insurance. In addition to generating revenue, getting patients in to see their doctors more frequently and closing care gaps help drive down cost.

Schneck continues to work with payers outside Medicare and was recently recognized by UHC as the top performer in Indiana. It was able to carry over this practice from a specific population to all patients, ensuring delivery of high-quality care.

Partners:

Primary Care Practice(s)

SUBMISSIONS ON INTEGRATION OF CARE

SUBMISSIONS ON INTEGRATION OF CARE

PROJECT TITLE: Integration of Health

Organization: AccessHealth

Topic: Integration of Care

Project Contact: Jared Williams, MBA; JWilliams@myaccesshealth.org

Project Overview:

AccessHealth successfully integrated behavioral health, nutrition, care coordination, dental, women's health, pharmacy, pediatrics and family practice into every step of the visit experience. All departments are under one EMR, NextGen. This project resulted in greater compliance rates in diabetes results, hypertension screening and nutrition and counseling for both adults and children.

As a PCMH Level 3 Recognized organization, AccessHealth has seen increased compliance in 95% of clinical quality measures, Uniform Data System measures and HEDIS measures. Increased integration put AccessHealth on the cutting edge for COVID-19 pandemic; it was able to flip to telehealth quickly for all qualifying appointments.

Innovation:

What made this initiative unique was that AccessHealth switched EMRs in the middle of the year, but was able to have everyone up to speed and ready to see patients on Go-Live day. The new EMR introduced patient portal communication, payments, electronic forms, mobile documentation, population health dashboards for cohort creation and more. Even with the one-month slowdown for Go-Live, AccessHealth still saw 20,011 patients, with close to 76,000 visits. Patient care increased with the added technology and capabilities the new EMR offered.

Outcome:

Quality measures improved significantly to ensure that patients and AccessHealth were meeting goals.

Partner:

EMR

SUBMISSIONS ON INTEGRATION OF CARE

PROJECT TITLE: Complex Community Care

Organization: BlueCare Tennessee

Topic: Integration of Care

Project Contact: Lauren Roberts, MBA, CPHQ, PAHM; LaurenL_Roberts@bcbst.com

Project Overview:

BlueCare Tennessee developed a community-based care coordination model for a small (less than 1%) subset of its population that had generated high per capita medical costs through frequent and persistent use of hospital-based services. In spite of high utilization and spending, these members were not getting healthier. And although they were targeted for complex case management services, engagement was low and they were largely disconnected from primary care and community-based behavioral health services.

Through an iterative, disciplined approach to innovation and a systematic quality improvement process, BlueCare developed a program that has been scaled statewide, yielding better health and lower overall per member per month costs. These improvements have been sustained over time.

Innovation:

BlueCare Tennessee realized that a new approach was needed to engage these members, understand their goals and help them move toward better health. The traditional approach to case management was not working, BlueCare committed to literally "meet these members where they are" and engage them in redesigning their own care. Its mantra was "start with the few and learn for the many."

BlueCare joined other organizations from across the U.S. and Canada that were committed to high-quality work with high-needs, high-cost individuals in the Better Health and Lower Costs (BHLC) Learning Action Community, facilitated by the Institute for Healthcare Improvement (IHI).

Outcome:

In June 2019 BlueCare Tennessee conducted a formal ROI analysis for members engaged in its Complex Community Care program. Analysis revealed an average total PMPM savings of $837 for members who had been successfully engaged through a face-to-face visit with a nurse case manager.

The program of short-term, highly person-centered work to address social and behavioral health needs and reconnect members to primary care led to sustained reductions in inpatient medical admissions.

PCP response has been overwhelmingly positive and case managers involved in this work have expressed high levels of satisfaction. Findings from this program informed a comprehensive redesign of BlueCare's care coordination and complex case management interventions for its entire membership in 2019.

Partners: Primary Care Practice(s)

SUBMISSIONS ON INTEGRATION OF CARE

PROJECT TITLE: Centene Member Connections® Preventable Readmissions Coaching Program

Organization: Centene Corporation

Topic: Integration of Care

Project Contact: Cynthia Williams, MSW, LCSW; cywilliams@centene.com

Project Overview:

Avoidable hospital readmissions reflect suboptimal care before, during or after hospitalizations for Medicaid beneficiaries. In 2017, Member Connections developed the Preventable Readmissions Coaching Program to reduce avoidable hospital readmissions within 30 days of hospital discharge. Teams of community health services representatives deliver four face-to-face in-home coaching visits, providing high-touch interactions that build rapport and trust.

Community health services representatives guide Medicaid members to become active participants in their physical and behavioral health, focusing on health education, self-management, lifestyle and behavior change. Members are screened for understanding of their condition, including physical and behavioral health needs, medication review, housing security, healthy home, food security and primary care engagement.

Binomial regression analysis of 5,329 members from 5 health plans (OH, IL, MD, LA, and KS) demonstrates that completion of the Preventable Readmissions Coaching Program significantly reduces 30-day all cause readmissions (6.5%), compared to no visits or partial completion.

Innovation:

The Coaching Program stems from the grassroots outreach inherent in the Member Connections program. Member Connections community health services representatives are hired from within the communities they serve; consequently, culturally competent outreach to members is conducted by people who know the unique characteristics and needs of each region. One aspect that sets this program apart is the formalized range of activities, such as community education, informal counseling, social support and advocacy, which stems from the partnership between member and community health service representative.

Staff address members' psychosocial needs, which is the largest single predictor of health outcomes, while addressing cost-saving solutions. Community health services representatives complete targeted, person-centered training for the program to identify barriers and needs of Medicaid members at risk for hospital readmissions. Coaches screen members for both physical and behavioral health conditions and medication safety, in addition to social needs including housing security, food security and overall safety.

Outcome:

Analysis established a significant correlation between reduced readmission rates and participation with Member Connections and demonstrates that completion of the program significantly reduces 30-day all cause readmissions by 6.5%, compared to no visits.

Reflections from members who participated in the program further demonstrate its effectiveness.

SUBMISSIONS ON INTEGRATION OF CARE

PROJECT TITLE: The Value of Connected Cigna Medical, Pharmacy and Behavioral Benefits

Organization: Cigna

Topic: Integration of Care

Project Contact: Julia Rosenfield, MBA; julia.rosenfield@cigna.com

Project Overview:

For the fourth year in a row, Cigna's Value of Integration study shows real engagement and real savings. A retrospective analysis using methodology reviewed and validated by KPMG in 2018 continues to demonstrate that connecting medical, pharmacy and behavioral care through integrated benefits enables support of the whole person, engages customers and reduces total medical costs for clients.

Innovation:

When studying the impact of managing multiple health benefits, Cigna includes not only medical and pharmacy, but behavioral as well. The annual study continues to prove that integrated benefits drive significant improvement in customer engagement and customer and client savings.

Outcome:

When comparing integrated Cigna Medical, Pharmacy and Total Behavioral Health vs. Cigna Medical and Basic Behavioral (with pharmacy carved out), the result is:

- Integrated customers are 17% more engaged through chronic condition counselling programs, lifestyle or wellness coaching or case management
- Integrated customers are working to improve their health by closing a gap in care, counseling or additional treatment support.
- More customers stay in network and have 4% lower out-of-network costs.
- Clients see a ~$207 PMPY savings in total medical costs across the entire population.

Partners: Not applicable

SUBMISSIONS ON INTEGRATION OF CARE

PROJECT TITLE: Embarc Benefit Protection

Organization: Cigna

Topic: Integration of Care

Project Contact: Maryann Martini; maryann.martini@cigna.com

Project Overview:

Embarc Benefit Protection brings together the health services, medical benefit management and specialty pharmacy expertise of Cigna—including Express Scripts, eviCore and Accredo, to make breakthrough and potentially life-changing drugs more affordable and to ensure access for those who need it.

Innovation:

Embarc Benefit Protection addresses a critical need facing the entire health care system—delivery of better care, affordability, access and predictability. Embarc Benefit Protection is a low-cost network solution providing protection for members who might need the gene therapy drugs Luxturna® and Zolgensma®. Embarc Benefit Protection minimizes out-of-pocket costs for these drugs; in addition, this program helps Cigna provide personalized and expert care to help members through their health journey and create predictability for payers and clients through a PMPM charge. Additional therapies may be added in the future.

Luxturna® is a registered trademark of Spark Therapeutics, Inc., and Zolgensma® is a registered trademark of AveXis, Inc.

Members with an HSA must meet the applicable minimum deductible required for a high-deductible health plan.

Outcome:

Because this is a new offering (effective July 2020), this information is not yet available.

Partners:

This program is administered in concert with the member's Cigna medical and pharmacy programs, including case management, chronic condition management and other health advocacy programs and services.

SUBMISSIONS ON INTEGRATION OF CARE

PROJECT TITLE: Therapeutic Resource Centers

Organization: Cigna

Topic: Integration of Care

Project Contact: Maryann Martini; maryann.martini@cigna.com

Project Overview:

Accredo, Cigna's specialty pharmacy, has 15 Therapeutic Resource Centers (TRC) that focus on helping members with bleeding disorders, cystic fibrosis, pulmonary arterial hypertension and oncology. The goal is to address nonadherence through motivational interviewing techniques. TRC specialist pharmacists speak with targeted members about the importance of using medications as prescribed, help uncover barriers to adherence and help members come up with practical solutions to barriers.

Innovation:

Motivational interviewing makes this program unique. Members are invited to take charge of their health and become part of the solution. Specialist pharmacists counsel members on medications and adherence. Nonadherence is a big issue in health care and has negative effects on health outcomes and quality of life.

Proprietary rules target nonadherent members and members who are at risk of becoming nonadherent, then TRC pharmacists reach out to counsel them on their medications. If appropriate, pharmacists also discuss programs that may help the member.

Outcome:

Immune Disorders TRC: Members have access to Accredo clinicians 24 hours a day, 7 days a week, for prescription education, clinical counseling and assistance with medical devices. Cigna also uses proprietary algorithms for some treatment regimens to assess factors such as member motor function and mobility, to determine optimal dosing and improve outcomes. This level of support helps prevent catastrophic events for members and avoid costs for payers.

Multiple Sclerosis TRC: During clinical assessments, Cigna performs depression screening for each member, because of the high prevalence of depression among individuals with multiple sclerosis and because depression has been shown to affect member adherence. Recognizing that members with multiple sclerosis require a broad range of additional support services, Cigna also offers multiple sclerosis-specific online resources and social worker support.

Partners: Not applicable

SUBMISSIONS ON INTEGRATION OF CARE

PROJECT TITLE: Life with Blue

Organization: Health Care Service Corporation

Topic: Integration of Care

Project Contact: Sonja Hughes, MD; Sonja_J_Hughes@bcbsok.com

Project Overview:

The Life with Blue Program was developed to transform the FEP's current performance position to one that delivers demonstrable improvements in member care. The program targets a subset of members and their families experiencing oncology, diabetes, hypertension, cardiovascular disease with a prescribed statin medication or a behavioral health condition involving alcohol and/or substance abuse or mental illness. The program takes a concierge approach to addressing clinical quality gaps and includes a multispecialty team of customer service advocates, care management clinicians, a clinical pharmacist and behavioral health clinicians, along with supportive medical directors and utilization management resources.

During the first phase of implementation, there was a 22% increase in case management screening, a 4.4% increase in case management enrollment and an average 5% improvement in HEDIS results for 26,000 targeted members.

Innovation:

The Life with Blue model provides a member-centric and unified experience from start to finish. Customer advocates are trained to listen for trigger words to better understand members' overall health care needs. If it is determined that a member would benefit from clinical intervention, the customer advocate can immediately connect them with a nurse, pharmacist, behavioral health clinician or medical director. Family members were included in this approach; family support for chronic conditions is invaluable to improving outcomes. This model enables the FEP team to support members along their end-to-end FEP journey and throughout their life.

Outcome:

Success metrics involved monitoring operational and clinical functions and were based on performance requirements of the FEP Director's Office and other regulatory agencies. Operational reports included daily assessments to monitor call volume, responsiveness, resolution, handle times and customer satisfaction.

Metrics measured performance for nonclinical customer advocates to determine if the Life with Blue approach increases performance of measures, compared with the non-Life with Blue population. The success of the project was supported by achieving and/or surpassing established goals of key operational metrics.

Significant improvement was noted in HEDIS quality measure results and in achieving operational metric goals. Life with Blue members were five times more likely to enroll and/or engage in case management, and had better performance in 8 of 14 targeted HEDIS metrics.

Partners: None

SUBMISSIONS ON INTEGRATION OF CARE

PROJECT TITLE: Network Health's Clinical Integration Paving the way to a Bright Future

Organization: Network Health

Topic: Integration of Care

Project Contact: Kimberly Swanson, MPA; kswanson@networkhealth.com

Project Overview:

Network Health is a local provider-owned health plan that is committed to creating healthy and strong communities throughout Wisconsin. It engaged in aligned incentive work with its provider partners in 2018 so that member experience, quality care and cost-effective care were mutual priorities. Focus areas included PCP attribution, data integrity and clinical analytics, coding and documentation of care, quality and member experience and provider satisfaction with clinical integration. Network Health and its partners leverage data, technology and best practice care delivery methods to offer what members need and to support providers.

Innovation:

Network Health strives to facilitate efficient, high-quality care for members when they need it. It leverages data sharing to ensure that providers are knowledgeable about members' care needs and can advocate and guide members to high-quality health outcomes. It is important to have a documented clinical story; this impacts treatment decisions, patient medications and care timing.

Outcome:

Network Health has evidence of improvement across many facets of care for members attributed to clinically integrated provider partners, including improvement in quality of care, documentation of chronic conditions, member satisfaction and provider satisfaction with clinical integration. Providers who engage members in primary care visits are more likely to have a higher quality of care gap closures and improved documentation of chronic conditions.

As of January 2020, 73% of Network Health members were attributed to a clinically integrated provider partner, up from 59% in 2018. Member engagement in care with primary care provider was 88% for new members and 90% for existing members in 2019.

Controlled Blood Pressure improved for Medicare members by 6% and for commercial members by 9%. Controlled A1c (<8%) improved for Medicare members by 2% and for commercial members by 11%.

Partners: Health System (ACO, Hospital)

PATIENT AND FAMILY ENGAGEMENT

PATIENT AND FAMILY ENGAGEMENT

PROJECT TITLE:

Technology and Community Outreach: A Winning Combination for Member Engagement

Organization: Anthem Blue Cross and Blue Shield in Indiana

Topic: Patient and Family Engagement

Project Contact: Ryan Chizum, MPH; ryan.chizum@anthem.com

Project Overview:

Anthem BCBS Indiana Medicaid ("Anthem") established an innovative and member-centric approach to member engagement that blends technology and high-touch approaches. It sends text message reminders to members about care and education and how to access benefits. Members who do not respond receive phone calls. If data indicate that a member's health is at risk and the member remains unreachable, Anthem uses a team of live-outreach employees, known as QMORE, to make personal connections. The statewide QMORE team locates and engages members "where they are" to meet face-to-face. With a focus on connecting complex members to community resources by helping them overcome social barriers and improving health literacy, QMORE has achieved a 40% success rate in a difficult-to-reach population.

Innovation:

Blending technology with "feet on the street," this approach understands that each member is unique and that their engagement style may differ as well. Anthem designed and implemented various strategies to reach members, including texting, email, telephone calls and employees working in the field. Prioritizing efforts around personal preference and cost-effectiveness, Anthem was able to reach a higher level of member engagement than with its previous model, which relied on phone calls and mailings only.

Outcome:

HEDIS measures for members who received reminder calls were 32% higher for Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life, 53% higher for Adults' Access to Preventive/Ambulatory Health Services and 74% higher for Breast Cancer Screening.

The QMORE team engaged roughly 40% of Anthem's hard-to-reach members. Anthem's tiered strategy reached 20% of members with texting, 20% with phone calls and roughly 25% with face-to-face outreach. There were over 2.5 million texts in 2019 and 99% of members were enrolled into the HNS (Health Needs Screening) campaign; 43% were actively engaged in Smoking Cessation; 32% in Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications; 78% in Human Papillomavirus for Adolescents; and 78% in Lead Screening in Children. By engaging more hard-to-reach members, Anthem helped build a relationship between many members and their primary care provider.

PATIENT AND FAMILY ENGAGEMENT

PROJECT TITLE: United Way of Greater Chattanooga Kiosk Initiative

Organization: BlueCare Tennessee

Topic: Patient and Family Engagement

Project Contact: Lauren Roberts, MBA, CPHQ, PAHM; LaurenL_Roberts@bcbst.com

Project Overview:

The United Way of Greater Chattanooga Kiosk Initiative was developed to support improving rates for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services in Hamilton County. Barriers to receiving these services are often related to social needs. Vulnerable populations frequently have challenges accessing resources due to limited knowledge about available services.

Kiosks are strategically located in schools based on high noncompliance with EPSDT. They offer social services information to school aged children and families. School staff and educators also have access to resources available in their schools to support students and families in real time. Members can connect to BlueCare as well, for extra support and assistance with scheduling appointments.

Innovation:

As a local Tennessee health plan, BlueCare Tennessee (BCT) recognizes the impact that social risk factors have on health. There is a much greater risk for poor health outcomes when members are faced with multiple disparities. By adding kiosks into the community, BCT supports members, parents and educators by providing tools to increase the probability of success. For members under the age of 18, kiosks provide an abundance of resources that members might not be aware of, such as food services, health care, utility payment assistance, employment services and BlueCare resources. When their social needs are addressed, members can focus on their health needs.

Outcome:

In March 2018, BlueCare initiated an advisory panel in Hamilton County, bringing together community voices, including social service agencies, provider partners and health plan leadership, to address how to better connect to members. The panel identified improving access to EPSDT services in Hamilton County as an objective. The United Way and BlueCare launched the Kiosk initiative in August 2018.

Through extensive planning and partnerships, BlueCare has expanded local resource services into the community, addressing the unique health challenges members face. To deepen the self-service kiosk offering, BlueCare partners with community agencies, schools and companies to successfully move forward in a changing technocentric community through mutual collaboration.

Partner:

Business (non-profit)

PATIENT AND FAMILY ENGAGEMENT

PROJECT TITLE: BlueCare Le Bonheur Member Resource Coordinator Initiative

Organization: BlueCare Tennessee

Topic: Patient and Family Engagement

Project Contact: Lauren Roberts, MBA, CPHQ, PAHM; LaurenL_Roberts@bcbst.com

Project Overview:

The Le Bonheur Member Resource Coordinator initiative was developed in response to the rising utilization of emergency services for nonurgent health needs in Shelby County. The majority of ED visits took place at Le Bonheur's Children's hospital. Through other programs, a collaborative working relationship with the pediatric primary care group, Le Bonheur Pediatrics, was established. This resulted in an embedded BlueCare Member Resource Coordinator (MRC) in the ED to assist with the initiative during peak hours identified by Le Bonheur.

The goal is to improve member outcome by facilitating movement across settings between the ED and primary care. By embedding an MRC in the ED, BlueCare hoped to decrease unnecessary ED visits, address SDOH and reconnect members with their PCPs for routine and nonurgent health needs. The initiative offers BlueCare the opportunity to expand cohort-driven outreach to members who are high ED utilizers, to address barriers, decrease ED utilization and guide members back to their PCP.

Innovation:

This initiative centered on addressing health literacy and barriers to care. The ED resource assists with member education, nonurgent SDOH needs and coordination of follow-up appointments using BlueCare's integrated appointment scheduling platform, which also allows automated transportation scheduling and appointment reminders to increase compliance.

Before members are discharged, members with urgent social needs are referred to social workers embedded in the ED. PCP staff are available to intake appointments scheduled through the platform and work to build a solid relationship of trust with members. PCPs also helped BlueCare develop a quick reference page to provide members with important contact information, hours of operation and after-hours resources.

Outcome:

The overall goals of the initiative are to reconnect members with their PCP, increase EPSDT rates and reduce SDOH barriers, as well as to connect with as many members as possible through in-person interaction with the MRC and phone calls with head nurses. The embedded MRC completed 1,081 in-person visits from May–December 2019 and scheduled 135 follow-up appointments. Scheduled follow-up appointments had a 60% show rate.

BlueCare found that many members declined an invitation to schedule a follow-up appointment, so it changed the scheduling strategy to be more direct by providing members a follow-up appointment in lieu of offering to schedule one. This increased the scheduling rate immediately. SDOH needs were also captured and addressed during the interaction.

Housing, utilities and transportation were the top three needs identified by members seen by the MRC. Outreach conducted by head nurses had a 71% connect rate.

Partner: Health System (ACO, Hospital)

PATIENT AND FAMILY ENGAGEMENT

PROJECT TITLE: Mobile Patient Engagement

Organization: CBHA

Topic: Patient and Family Engagement

Project Contact: Hayley Middleton, MPH; hayleym@cbha.org

Project Overview:

CBHA utilized IRIS (a digital kiosk employee) and SMS mobile surveys to add to its telephone patient satisfaction surveys and gather more patient feedback.

Innovation:

The Hologram Employee Kiosk lets CBHA ask patient satisfaction questions and backlog data into a platform for review. CBHA also started texting post-visit "thank-you" messages with a link to a patient survey for quick, focused feedback, and began using a third party to make telephone survey calls for more in-depth feedback.

Outcome:

CBHA now has data available to cross reference and evaluate across multiple platforms, to help it gauge referral intentions and overall patient satisfaction. The kiosk has allowed CBHA to gain feedback from a higher volume of patients and increase its confidence in the data.

Partner:

Primary Care Practice(s)

PATIENT AND FAMILY ENGAGEMENT

PROJECT TITLE: "Know More: HPV"—Improving vaccination uptake and closing health disparities with a digital, in-office patient intervention

Organization: CenCal Health

Topic: Patient and Family Engagement

Project Contact: Rachel Ponce; rponce@cencalhealth.org

Project Overview:

CenCal Health developed the Know More: HPV patient education program to increase the rate of HPV vaccination—around 31%—in south Santa Barbara County. After searching unsuccessfully for an existing intervention available in Spanish, 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 in the provider's office.

Partnering with a local Federally Qualified Health Center 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 nine months. CenCal Health's HPV vaccination rate is now 59.12%—higher than NCQA's established 95th percentile benchmark of 56.02%.

Innovation:

The use of a digital educational program given directly to parents via tablet, in the clinic setting where the child is already present, is not a widely used strategy to improve HPV vaccination. CenCal Health determined that there were very few programs appropriate for its target audience, and none were available in Spanish, one of CenCal Health's threshold languages.

CenCal Health created its own program and pilot tested it. This approach is successful and has also increased clinic workflow efficiency around HPV education. For parents who do not know about the HPV vaccine, the program educates them about the importance of HPV vaccination while they wait for their child's visit. Once they are seen by the provider, they are primed to discuss HPV vaccination and ask informed questions, saving time during the visit.

Outcome:

Success of the "Know More: HPV" program is measured through HPV vaccination rate data, parent/guardian satisfaction data and anecdotal provider satisfaction feedback. An in-house dashboard calculates measure rates through HEDIS-certified software and captures vaccination rate data and monitors program impact.

As of December 31, 2019, the HPV vaccination rate was 44%—a nearly 25 percentage point increase. HPV vaccination completion improved by 131% in nine months. An added value of the program is that it occupies parents, which reduces perceived wait times. Providers can offer patients a targeted, no-cost educational resource right in the clinic.

CenCal Health received the 2019 California Department of Healthcare Services' Innovation award. CenCal Health offers the program at no cost to providers and other health plans and it can be accessed on a cell phone, computer or tablet. Accessibility makes it especially useful during the current COVID-19 crisis.

PATIENT AND FAMILY ENGAGEMENT

PROJECT TITLE: Building a Population Health Strategic Plan in a Value-Based World

Organization: Denver Health

Topic: Patient and Family Engagement

Project Contact: Maria Casaverde Marin, PCMH CCE; maria.casaverdemarin@dhha.org

Project Overview:

New payment models that include value-based components have prioritized the quality of care in recent years. Because health care systems must manage multiple contracts with multiple metrics, priorities and goals, a strategic population health plan that includes all of them has become a necessity. Denver Health is reorganizing how it provides care by emphasizing team-based care and maximizing limited resources as a safety-net medical home. It is using cutting-edge technology tools to focus clinic leadership on accountability metrics so quality of care happens with every patient, every visit, every time.

Innovation:

Quality improvement usually focuses on outcome metrics, but by then it might be too late to identify barriers that prevent delivery of high-quality care during an office visit. Denver Health uses process metrics down to the staff level to help it identify teams that might need more training and support.

Because not all patients engage with the health care system in the same way, Denver Health is developing a plan that includes multiple between-visit interventions and a mix of interventions—patient portal, letters, text messages and call—deployed during different times for different populations, to meet population engagement levels.

Outcome:

Denver Health has more specific, workable targets that could be measured on a daily basis by clinic leadership. Leadership can identify if teams are completing the daily work that supports quality metrics and can apply staff changes if needed.

Partner:

Health System (ACO, Hospital); Multiple payers, Specialty Practices

PATIENT AND FAMILY ENGAGEMENT

PROJECT TITLE: SHAPE: Stroke and Heart Attack Prevention Every Day for Members with Diabetes and Cardiovascular Disease

Organization: Health Net, LLC

Topic: Patient and Family Engagement

Project Contact: Jean Shahdadpuri, MD; Kay Judge, MD; Rosa Isela Calva-Songco, MPH

Project Overview:

Health Net is partnering with its providers to help reduce the number of heart attacks and strokes for patients with diabetes and heart disease. Past analysis found that slightly less than 27% of Health Net's population with diabetes received the recommended cardio-protective medication bundle (a combination of aspirin, ACE inhibitor and statins). This led to the implementation of Health Net's intervention project, Stroke and Heart Attack Prevention Every Day (SHAPE) for members with diabetes and cardiovascular disease.

The project's goals are educating members about their medication regimen and wellness and encouraging and educating health care providers to prescribe the recommended cardio-protective medication bundle. To support member compliance, SHAPE provide health care coaches (e.g., diabetes educators, nutritionists, dieticians, pharmacists) who engage with members to ensure adherence.

Initial results show that medication adherence rate to the cardio-protective bundle has increased by 43% for members with diabetes.

Innovation:

Health Net wants to ensure that eligible patients are on the cardio-protective medication bundle. The SHAPE project is member-centric and customized to the level of each member's acuity and willingness to engage in a conversation about understanding their medical condition. The goal is to promote and ensure medication compliance through health behavior modification.

Coaches available to members via telephonic outreach include pharmacists, nutritional counselors, wellness coaches and/or dieticians trained in motivational interviewing skills. Frequency of engagement is determined by the coach and is based on the member's acuity and risk.

Health Net conducted additional data analysis to identify cultural and/or language barriers to medication adherence. Health Net works to make the project the most effective "touch" and preferred outreach for members.

Outcome:

SHAPE is a multi-year project that began with phased implementation in mid-2017. Medication adherence to the cardio-protective bundle increased by 43% in the first year for members with diabetes who were not receiving the suggested cardio-protective medication bundle at the start of the project. HEDIS rates for reporting year 2019 across all products reached the 75th or 90th Quality Compass® percentile benchmarks for measures related to diabetes and cardiovascular health.

Preliminary ROI data show substantial cost-reduction. Early findings suggest that the SHAPE program has the potential to impact cardiovascular health outcomes and process measures through increased member and provider awareness, resulting in reduced ED usage and adverse cardiovascular events. SHAPE can be part of the solution to reduce the mortality rate for diabetes and cardiovascular disease due to comorbidities.

Partner:

Envolve People Care (EPC is a Centene-subsidiary); Neighborhood Network Be There San Diego; American Heart Association; American Diabetes Association; OPTUM (disease management program vendor)

Medical Affairs cross-collaborates with other divisions within the plan: Quality Improvement, Pharmacy, Data Analytics, Health Education, Provider Relations, Marketing/Provider Communications, Medical Management, Case Management, Culture & Linguistics department, Disease Management.

PATIENT AND FAMILY ENGAGEMENT

PROJECT TITLE: Oncology Home Based Infusion Model

Organization: Horizon Blue Cross Blue Shield of New Jersey

Topic: Patient and Family Engagement

Project Contact: ira Jan, MS, PharmD; saira_jan@horizonblue.com

Project Overview:

Horizon Blue Cross Blue Shield of New Jersey (Horizon) partnered with the Rutgers' Cancer Institute of New Jersey (CINJ)/RWJ Barnabas Health 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.

Innovation:

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. An existing collaborative relationship allowed Horizon to immediately create a solution: Oncologists and other providers identified treatments that under certain circumstances can safely be delivered in the home. Horizon implemented a payment model that allowed the cancer center to quickly divert care to the home setting. The compelling need to protect patients drove them to implement a solution in days, not months.

Outcome:

The program's goal is to redefine the existing oncology care delivery model and improve the patient experience while maintaining clinical outcomes. Proposed metrics and considerations for the project are:

- Cost of care.
- Patient satisfaction.
- Nurse satisfaction.
- Safety outcomes.
- Operational costs.
- Time to delivery of care.
- Regimen/drug plausibility.

Partner:

Qualitas (home infusion)

PATIENT AND FAMILY ENGAGEMENT

PROJECT TITLE: Screening Incentives

Organization: Kentucky Mountain Health Alliance, Inc.

Topic: Patient and Family Engagement

Project Contact: Vicky Harden; vicky@kymha.org

Project Overview:

Little Flower Clinic is a Federally Qualified Health Clinic in Perry County, Kentucky, serving a primarily homeless population. In September, it began offering patients a $10 gift card that can be used for gas or food when they return a Fecal Immunochemical Test (FIT) kit to the clinic. The clinic also started using a part-time patient navigator to discuss the FIT collection process and explain the incentive card with patients. The CRC screening rate at the practice has doubled since beginning the incentive card program.

Innovation:

The clinic serves patients who would normally fall through the cracks of health care prevention and treatment. Subsistence needs often take priority over health care that is not seen as urgent, such as preventive care. Providing small financial incentives helps moderate financial and transportation barriers to care. Working with the technical assistance team and participating in the learning collaborative helped identify a way to help the population meet this important preventive health care practice.

Outcome:

Between January and August 2017, the clinic screened an average of 48 patients per month. After the incentive was introduced, this increased to an average of 95 patients per month.

The annual UDS CRC screening rate goal is 80%. The screening rate was 65% in December 2019 after discovery of a data issue in the EHR, which has been corrected.

Partner:

Department of Public Health

PATIENT AND FAMILY ENGAGEMENT

PROJECT TITLE: Improving Health Outcomes in Pre-Diabetic Minority Patients

Organization: San Fernando Community Health Center

Topic: Patient and Family Engagement

Project Contact: Patrice Little, MBA; plittle@sfchealthcenter.org

Project Overview:

San Fernando Community Health Center (SFCHC) developed a diabetes prevention initiative to improve health outcomes and reduce rates of disease advancement in patients disproportionately impacted by diabetes. Racial and ethnic minorities have higher prevalence rates, worse diabetes control and higher rates of complications and diabetes-related mortality.

This pilot project considers cultural, environmental and social determinants of health that affect health outcomes and patients' ability to adhere to health goals and treatment plans. It resulted in significant improvements for pre-diabetic participants, demonstrating that patient engagement in preventive treatment plans improve health outcomes.

Innovation:

This project was piloted as part of the CDC Diabetes Prevention Program (Prevent T2 Lifestyle Change). It is unique because it focuses on preventing progression from pre-diabetes to diabetes through a holistic care plan and emphasizes patient involvement in treatment plans. It implements strategies to prevent progression and obtain better health outcomes.

Project objectives were to create evidence-based, customized interventions proven to reduce progression of pre-diabetes through program and community engagement, lifestyle change, healthy eating, and physical activity. Participant engagement is a key focus throughout the life cycle of the project, using motivational strategies to promote long-term participant commitment in one-on-one and group activities, cooking classes, and sessions with program specialists and community participants.

SFCHC is participating in the Los Angeles County Department of Public Health DAPS pilot project, whose goal is to track and monitor data and work toward developing a system in LA County that will meet the needs of National Diabetes Prevention Program providers in the region. All data collected for the project is also entered in the DAPS database.

Outcome:

Overall program goals include enrollment and retention of five or more participants, weight loss of 5%–7% and sustainable lowering of A1C and blood glucose levels. These goals were surpassed significantly during Year 1: 14 patients were enrolled and retained; the average weight loss was 13.2% at month 12; and there was an average A1C drop of .03% at month 12. At the conclusion of Year 1, 7 participants dropped to A1C levels within normal range (<5.7%) and all participants lowered baseline A1C levels.

Cohort 1 participants remain enrolled and are being monitored through Year 2. A second cohort of 15 participants is in the initial phase of the program and already demonstrates improvement. During COVID-19 isolation, patients in both cohorts have remained engaged in virtual and phone contact and report continued commitment to healthy eating habits, improvements in weight loss and physical activity increase.

The health educator and registered dietitian assist with medication management and compliance and discuss patient questions and concerns. Participants carry over program objectives to family members in their homes, promoting healthy eating and exercise habits throughout the household.

Partner:

CSUN Department of Kinesiology and 3WINS

PATIENT AND FAMILY ENGAGEMENT

PROJECT TITLE: Southside Medical Center/Georgia Department of Family and Children Services Health Services Access Program

Organization: Southside Medical Center

Topic: Patient and Family Engagement

Project Contact: David Williams, MD; dwilliams@smcmed.com

Project Overview:

Due to a shortage of both readily available community service options and Medicaid provider access, Southside Medical Center developed partnerships with Department of Family and Children's Services offices in three Georgia counties to provide evidence-based, standardized medical, dental and behavioral (trauma/psychological) screenings and assessments for children under the state's legal guardianship. Southside also provides well-child, sick-visits, ongoing follow-up services and recommendations/referrals for needed services, thus offering a medical home for each child.

Innovation:

Southside Medical Center initially reached out to Fulton County's Department of Family and Children Services (DFCS) to offer trauma assessments for children in their custody. It turned out that DFCS needed help obtaining medical and dental services within a court-mandated time frame. Their collaboration resulted in development and implementation of new processes and procedures to address backlogs of foster care children needing medical, dental and behavioral health services.

This program provides DFCS with a reliable single-source, multi-specialty Medicaid provider for high-quality services, capable of meeting deadlines for timely care, reducing inefficiencies and delays. The solution and results have suggested the need for the program's replication in other jurisdictions.

Outcome:

More than 1,180 children and adolescents under guardianship of the state have received the program's services. Since the initial collaboration with Fulton County DFCS, Southside has extended formal collaborations with both DeKalb, Gwinnett and other county DFCS.

The program has been a win-win for Southside, DFCS and the children served: Southside provides services and receives reimbursement, thus strengthening revenues to support costs of operation; DFCS has a ready, consistent Medicaid provider from which to obtain medical, dental and behavioral health services, thus maintaining its mandates and obligations; and children and adolescents receive high quality services to meet their needs.

Partner:

Government Agency

RESPONSE TO COVID-19

RESPONSE TO COVID-19

PROJECT TITLE: COVID-19: Expanding Access to Care in a Pandemic

Organization: Access Health Louisiana

Topic: Response to COVID-19

Project Contact: Chenier Reynolds-Montz; creynolds@accesshealthla.org

Project Overview:

Access Health Louisiana developed a COVID-19 Task Force to initiate and develop protocols to expand access to health care services in a pandemic, including ways to protect and educate high-risk, chronically ill patients. With "stay at home" orders in place, the organization had to respond quickly to help its uninsured population seek care. The Greater New Orleans region was hit hard by COVID-19. Access Health created access points for testing in rural parishes to help flatten the curve, using its mobile health unit to assist the Office of Public Health, National Guard and Homeland Security with COVID testing in nine parishes.

Access Health educated patients and the community on the safety of using telemedicine through Public Service Announcements in Spanish and English on television, radio and social media. It educated other Federally Qualified Health Centers on best practices for COVID-19 testing and created immunization drive-throughs for graduating seniors at school-based health centers.

The project resulted in 5,000 people being tested for COVID-19, increased overall health awareness among chronically ill patients and patient confidence in virtual visits.

Innovation:

Access Health Louisiana was the first Federally Qualified Health Center in southeast Louisiana to train and implement telemedicine throughout its entire organization during COVID-19. It met with school superintendents to create plans to give students and families access to testing, primary care, behavioral health and pharmacy services with free home delivery.

Access Health's infectious disease physician and task force continue to work with school systems to create best practice approaches for return-to-school protocols, as well as creating webpages that allow fillable consent-for-care forms for parents. Its physicians are educating outside communities and states about the impact of COVID-19 through op-eds in national publications such as USA Today, Forbes Magazine and online platforms, and host daily podcasts and Facebook Live shows for the public to write in and call with questions about COVID.

Health coaches outreach to chronically ill patients daily to ensure they are in the best possible health should they contract the virus. The mobile health unit continues to mobilize in rural areas to create access points for testing; patients are notified of their results and offered support if necessary.

Outcome:

Access Health Louisiana's epidemiology and data team compiles daily encounter reports on whether patients are seeing providers for scheduled appointments. Patient feedback has been positive; most feel comfortable with virtual visits once they get used to accessing the system. Patients can easily access the "waiting room" for their telemedicine appointment on the website.

Many employees enjoy working from home and are willing to see patients at later times during the day in order to better accommodate new schedules. School-based health center providers see children for appointments in the afternoon and evenings. Adolescents and teens embraced virtual group therapy as an outlet for their anxiety of being away from friends.

Telemedicine also allowed Access Health to save on PPE and to space out in-person visits, to allow thorough cleaning of exam rooms. Quality of care improved because patients saw the importance of taking care of themselves and felt more comfortable sharing information with providers in a home setting.

An organization of more than 300 employees was able to implement telemedicine throughout the state within a few days and test more than 5,000 people for COVID. School districts have also learned to rely on Access Health to help children continue health care when away from school campuses.

Partner:

National Guard, OPH & Homeland Security

RESPONSE TO COVID-19

PROJECT TITLE: Rapid Development of a Team to Address Workplace COVID-19 Illness and Exposures in Healthcare Centers and Pharmacies Providing HIV Primary and Support Services in 16 States

Organization: AIDS Healthcare Foundation

Topic: Response to COVID-19

Project Contact: Christine Uranaka, RN, BSN; christine.uranaka@aidshealth.org

Project Overview:

AIDS Healthcare Foundation (AHF) was challenged with rapid set-up of a program to protect patient and employee health and well-being during the COVID-19 pandemic. Domestic AHF has approximately 200 individual sites among multiple business lines throughout 16 states and Puerto Rico. Policies and action plans required detailed responses that could be applied effectively in a wide variety of service sites.

The goals were to minimize workplace transmission through establishing a COVID-19 Clinical Response Team (CCRT) to deploy and implement policies and procedures for a variety of worksite and service activities; to create an incident team (subordinate to the CCRT) to identify interventions, investigations and containment of ill and/or exposed employees; and to resource and distribute personal protective equipment (PPE).

Innovation:

The CCRT had to respond to a wide variety of internal and external needs. AHF has 64 health care centers across 17 jurisdictions and 3 time zones. Utilizing electronic media, LoopUp trainings, WebEx and a COVID-19 webpage on the company intranet allowed the CCRT to provide up-to-date information and continually adjust to the everchanging front in the war against the virus.
AHF recognized a need for a specialized team, dedicated to educating staff, preventing transmission and containing COVID positive employees. Some implementations that led to success in containing the spread of the virus in the company were:

- Early generation of the CCRT.
- Implementation of the COVID-19 intranet page as a resource for all.
- Utilizing electronic media to hold education sessions and formal updates across the United States throughout three time zones.
- Formation of a centralized site for ordering PPE, disinfecting solutions and wipes. All products are researched by a CCRT team member and meet FDA guidelines.

Outcome:

CCRT Outcomes: A dozen core policies and procedures were developed; 10 remained active through the first quarter of the pandemic. Communication and educational activities included 33 email advisories (1 every 3 days) and 6 LoopUp seminars were provided to address changing procedures. A dedicated website stored and archived printed and recorded resources.

Incident Management. During the first 14 weeks of the pandemic, approximately 480 (23%) domestic employees reported exposure to or illness from COVID-19. Diagnostic testing was not available in many instances and was complicated by (probably) false negatives from tests now known to be poorly sensitive. Daily information was submitted to the CCRT and weekly graphic summaries were prepared. An incident spreadsheet was maintained on a secure drive and shared daily via secure email with incident team members.

PPE resourcing and distribution. At onset, PPE stocks in many locations were virtually nonexistent. There was no national inventory and staff were inexperienced in evaluating products for purchase. A centralized process was implemented for the provision of adequate PPE at all sites. This was crucial to maintain patient services. CCRT leaders in nursing and operations used existing staff with logistical, data and purchasing knowledge to develop a central management process.

Development of a national PPE supply report took 3–4 weeks and a purchasing website required 2 months to implement. The Operations Department developed a centralized process for inventory reporting and purchasing. A daily web-based inventory report identified critical shortages. A central web-based purchasing software was used to list vetted alternative products, to allow local purchasing of supplies. Nursing and medical staff with skills in vetting purchases provided approval oversight for unskilled purchasers.

Partners:

Evelyn Byrd Quinlivan, BSN, MD, FIDSA, Department of Medicine, National Director of Infectious Diseases

RESPONSE TO COVID-19

PROJECT TITLE: Innovating for a Healthier COVID-19 World

Organization: Anthem, Inc.

Topic: Response to COVID-19

Project Contact: Ryan Chizum, MPH; ryan.chizum@anthem.com

Project Overview:

Against the backdrop of the global COVID-19 pandemic, Anthem worked quickly and seamlessly with local, state and federal officials, care providers, members and community partners to develop a coordinated response.

Part of that response involved focusing on the 10% of Anthem members at greatest risk. Anthem directly contacted more than 200,000 people and offered support. Its program directly assisted roughly 68% to obtain adequate food, support through isolation, medication management and refill needs, medical attention and telehealth. Anthem associates engaged members in open discussions around COVID-19 and their concerns.

Innovation:

Technology & Telemedicine: An online Self-Assessment for COVID-19, based on CDC guidelines, was released on Anthem's site and its mobile application, to give members and caregivers assistance at their fingertips, including seeing a provider from home via telemedicine, assessing symptoms, finding a COVID-19 testing center and getting advice. Anthem also collaborated with partners to create the C19 Explorer webpage, which geographically demonstrates current COVID-19 infection rates across the nation and gives users the ability to drill down into each local market.

Top 10% at-risk: Leveraging the CDC's guidelines for individuals most at risk for serious COVID-19 complications, Anthem created an algorithm to identify the top 10% of its Medicare, Medicaid and commercial members. Anthem associates who traditionally contact members for other reasons received additional training and focused on the most vulnerable members to offer information and support.

Outcome:

As of June 30, 2020, Anthem had contacted over 200,000 members. Roughly 68% were managing well. The remaining members in this group needed help with obtaining adequate food, medication, social supports and other issues.

There were also unique circumstances, such as members who needed help buying pet food and food insecurity of a pregnant member who did not have access to food and meal resources. Case management called the member's county and school district to set up participation in meal delivery; the family started receiving meals the same day.

Partner: All of the above are critical partners in the battle against COVID-19.

RESPONSE TO COVID-19

PROJECT TITLE: Addressing Community Needs in the Face of Covid-19: A Comprehensive Plan by CareFirst

State: CareFirst, Blue Cross and Blue Shield of Maryland

Topic: Response to COVID-19

Project Contact: Stacia Cohen, RN, MBA; stacia.cohen@carefirst.com

Project Overview:

CareFirst implemented a multi-faceted strategy to address the immediate needs of the pandemic, along with an ongoing, long-term plan to focus on issues that could arise after the initial outbreak.

For providers:

- Enhanced coverage and reimbursement for virtual visits and telephone consultations.
- Elimination of prior authorizations for tests or treatments for members with COVID-19.
- Donations of PPE to community-based organizations, primary care practices, health centers, community clinics and related entities.
- An accelerated payment program to health care providers experiencing financial strain due to the coronavirus.

For members and community:

- A public-private partnership with Baltimore City and local hospitals to expand response to COVID-19.
- Outreach to at-risk populations.
- Premium deferment program.
- $2 million of immediate aid in health, social and economic needs for communities.
- Cafeteria staff at CareFirst prepared meals for affected organizations.
- Waived cost sharing for visits to a provider's office, lab fees or treatments related to COVID-19.

Innovation:

CareFirst offers a comprehensive portfolio of health insurance products and administrative services to 3.3 million members. In addition to meeting the immediate needs of members and providers for access, testing, equipment and financial support, CareFirst crafted a plan to address the health, social and economic needs caused by the pandemic. It developed a data tool to support local health departments and hospitals in identification and analysis of populations at higher risk, as well as ongoing surge readiness and management. It analyzed health indicators and utilization trends to develop an interactive web-based resource and made it available to every hospital and health department in the region.

Outcome:

CareFirst/providers/partners:

- Expanded telehealth program.
- Ability to keep offices open and staff employed through accelerated payments and telehealth options.

Members:

- Better health access.
- No loss of coverage through premium deferments and allowing new enrollments.

Associates: On March 13, CareFirst transitioned to 95% telework. Future plans will likely involve phased working conditions where office buildings are not at full capacity to ensure proper social distancing. Associates also have ongoing access to a phone-based employee assistance program to help cope with additional stressors of COVID-19.

Community: With CareFirst's support, Baltimore/Washington area hospitals have been able to meet demand despite capacity surges.

RESPONSE TO COVID-19

PROJECT TITLE: Drive Up Clinic/Services

State: CBHA

Topic: Response to COVID-19

Project Contact: Hayley Middleton, MPH; hayleym@cbha.org

Project Overview:

CBHA developed a Drive Up clinic to provide access to necessary services during the COVID-19 pandemic. This project resulted in communitywide access to health care and clinic-wide improvements in communication, workflows, safety and use of technology.

Innovation:

CBHA developed, built and implemented a process that uses appointment reminder text messages to confirm appointments and send a detailed photo map with instructions on where to go upon arrival. When patients arrive, they park in a numbered parking spot and respond to the text message with the number of their parking spot. This checks them in and allows them to get needed care from clinical staff while remaining in their car.

This service has been seen a lot in the grocery and retail market, but CBHA is excited to see the "art of the possible" and how it crosses over into the health care industry.

Outcome:

CBHA increased access by scheduling one 15-minute appointment per provider. Numbered parking spots allow efficiency and organization, increase safety through limited exposure for patients and staff and limit possible exposure through calculated scheduling.

The program decreases PPE waste through self swabbing, social distancing, limiting Drive Up services and scheduling longer blocks of staff (less need to switch PPE from room to room). CBHA also uses reusable PPE in the Drive Up clinic, which allows better control of stock.

Partner: Primary Care Practice(s)

RESPONSE TO COVID-19

PROJECT TITLE: Covid-19 Response: Cross-Discipline Collaboration and Virtual Care

State: Dignity Health Medical Foundation/Mercy Medical Group

Topic: Response to COVID-19

Project Overview:

In response to the COVID-19 pandemic, Mercy Medical Group rapidly implemented virtual visit care and cross-discipline collaborative practices to recover and sustain patient care operations. Primary care physicians, specialist physicians, hospital staff and members of the extended care team all collaborated to improve access, target high-risk patients and plan for a possible surge. Access to care was maintained for patients with immediate needs, and high-risk, vulnerable patients received additional outreach and attention.

Innovation:

Innovative aspects of this project included intense cross-discipline collaboration that led to rapid-cycle implementation of virtual visits, "Sick Clinics" and parking lot testing. Through virtual visits, limited in-person visits and outreach, core services continued during the crisis and the group was quickly able to return to normalized operations—largely due to strong collaboration between primary care clinicians, specialists, hospitalists, ER physicians and all other members of the extended care teams.

Mercy Medical Group rapidly and drastically transformed its video visit practices to continue providing timely care to its patient population, and accelerated into intense cross-discipline collaboration among primary care physicians, specialist physicians and the extended care team to serve its most vulnerable patients during this sensitive time.

Outcome:

Criteria for success—intended to ensure that timely care was not compromised and that attention was given to higher-risk patients—included establishing "sick clinics," increasing virtual visit capacity and total visits, performing outreach to vulnerable patients and maintaining performance thresholds on selected clinical quality measures. Four "Sick Clinics" were established before the end of March. Clinician visits for patients in need of immediate care were maintained through virtual visits, which were operational by the end of March and totaled 52K between March and June.

Partner: Health System (ACO, Hospital)

RESPONSE TO COVID-19

PROJECT TITLE: Rapid Implementation of Telehealth in Response to the COVID-19 Pandemic

Organization: Greater Portland Health

Topic: Response to COVID-19

Project Contact: Ann Tucker, SHRM-SCP atucker@greaterportlandhealth.org

Project Overview:

In response to the spread of the COVID-19 virus in its community, Portland Community Health Center dba Greater Portland Health (GPH) quickly created and implemented a telehealth program despite never having offered telehealth services before.

Innovation:

GPH quickly developed a telehealth program in only a few days through significant effort, collaboration and staff flexibility, using telehealth equipment and video-conferencing technology that had never been used by the organization before.

A great amount of teamwork was required to get the telehealth program up and running. Providers quickly adapted to the new technology and the challenges of providing services remotely. Administrative staff and the billing team provided significant support to develop billing and EHR processes, adjust schedules, and create educational materials for staff and patients. The success of the telehealth program evidenced by the return of patient visits to near pre-outbreak levels was due in a large part to the collaboration and dedication of GPH staff.

Outcome:

GPH staff conducted 5,695 telehealth appointments in April and May, greatly reducing the number of patients and staff members physically coming into its sites and lowering the risk of spreading COVID-19 among patients, staff, family members and the community. Fewer individuals in the health center created a safer environment for patients who required in-person visits.

GPH providers and clinical staff serve some of the most vulnerable in the greater Portland community, including individuals experiencing homelessness, with substance use issues and with mental health needs. Its health centers saw 8,558 patients in April and May, both in person and via telehealth. By transitioning care from in-person to virtual telehealth visits, GPH continued supporting patients and safely provide essential primary medical and behavioral health services.

Partner: Primary Care Practice(s)

RESPONSE TO COVID-19

PROJECT TITLE: COVID-19 High Risk Member Outreach

Organization: Medica

Topic: Response to COVID-19

Project Contact: Jean Hutchinson Legler; jean.hutchinsonlegler@medica.com

Project Overview:

At the pandemic's onset, Medica worked quickly and collaboratively to develop and launch an outreach effort that focused on members at the greatest risk of developing complications from COVID-19. Through outreach, Medica evaluated members' physical, social and emotional needs, and assisted with connections to community and health plan services members needed.

Using the CDC risk factors as a guide, Medica identified members through a combination of claims and enrollment data. Staff used a social needs assessment to help identify specific areas of member concern and used the results to provide members with information and community resources. Through outreach, Medica talked with more than 33,000 high risk-members and helped them obtain needed medications, provided resources for food delivery and offered referrals to behavioral health and medical providers for additional support.

Innovation:

Medica used a combination of claims and enrollment data to develop an algorithm to identify and prioritize at-risk members based on medical complexity and age. All populations of Medica members were included in the analysis. Once members were prioritized, clinical customer and service teams at Medica contacted telephoned them to conduct a social needs assessment. Members were connected to health plan and community resources or, if their health conditions were complex, were referred to Medica's case management programs.

This project allowed Medica to restructure workflows and repurpose employees from its clinical and call center teams to lead and manage the project execution, reducing the need for employee furloughs. The team included clinical staff members from Medica's nurse practitioner, case management and utilization management programs, in addition to customer service agents from its commercial, individual and family business and government business segments. Medica delivered at-risk member lists to its network ACOs, provided timely data to health systems already distracted by pandemic readiness and helped identify at-risk members to complement health system outreach efforts.

Outcome:

Medica member challenges fell into three categories: SDOH, mental health and medical symptoms. The areas of greatest social need included medication, food, housing and utilities.

- Medica provided resources to members through the use of Aunt Bertha's dedicated COVID-19 website.
- Medica staff members made connections to its dedicated COVID-19 prescription assistance program.
- In partnership with Optum Behavioral Health, Medica offered a Crisis Line to support members struggling with their mental health.
- Referrals were made to help members access primary care, ensuring that reported medical symptoms could be treated in a timely manner.
- Members with ongoing medical needs were referred to the appropriate case management program.

Partner Type: Health System (ACO, Hospital)

RESPONSE TO COVID-19

PROJECT TITLE: Combining Technology and Tents: New Strategies to Promote Safe Access to Pediatric Care During the COVID-19 Pandemic

State: Nemours duPont Pediatrics

Topic: Response to COVID-19

Project Contact: Michelle Karten, MD; Michelle.Karten@nemours.org

Project Overview:

In response to the COVID-19 pandemic, Nemours duPont Pediatrics developed a unique care delivery model by forming regional hubs within primary care for office visits while also rapidly embracing telehealth services. Hubs allowed consolidation of visit types. Telehealth visits were used for well-visits (tele-well); these were paired with focused exams at outdoor immunization tents to ensure comprehensive well-child care.

At some sites, Suspected COVID Assessment Teams (SCAT) were established in outdoor tents for patients with symptoms consistent with COVID-19. Other sites provided exams for newborn infants and patients who screened negative for COVID-19 and were in need of hands-on evaluations. The rationale for this initiative was to provide access to essential preventive care, leverage telehealth capabilities to reach families hesitant to seek services, ensure high-quality pediatric care and ultimately limit the risk of COVID-19 infection. Teams of clinicians, nurses, office partners and operational stakeholders throughout Nemours identified barriers to determine solutions from a systems perspective. From March–June 2020, the initiative resulted in over 18,000 telehealth appointments, 7,000 vaccine visits, 1,361 newborn examinations and 535 SCAT assessments.

Innovation:

Multidisciplinary teams were led by clinicians and included stakeholders from primary care leadership, coding integrity, managed care/payer relations, population health management, data analytics and medical management/care coordination. Teams worked in alignment to create and implement pathways and workflows to transform care delivery. They generated consensus in real time by leveraging existing technology platforms to facilitate high-priority decision making, and utilized rapid PDSA cycles in daily huddles and weekly team meetings.

For preventive services, population health registries were utilized to develop a phased approach to address gaps in care, first focusing on infants and expanding to the remaining age groups. Through this process, the teams implemented an effective and efficient care delivery model that included a shift to telehealth for well-child and sick visits; outdoor immunization hubs and SCAT tents for visit types unable to be managed via telehealth alone; consolidation of newborn care to well child hubs; and pairing of tele-well visits with focused physical exams at the immunization hubs to ensure comprehensive care.

Outcome:

The COVID-19 pandemic response necessitated rapid implementation of telehealth services in Nemours duPont Pediatrics. This resulted in an exponential increase in telehealth visits—from 5 in 2019 to over 18,000 by June 2020. From March–June 2020:

- Tele-well visits represented nearly 40% of total telehealth visits overall.
- Over 7,000 children received vaccines during this time period via immunization hubs.
- 535 patients were seen at SCAT hubs. 140 were tested for COVID-19; nearly 1 in 10 were positive.
- 1,361 infants were seen across Nemours duPont Pediatrics.
- There was an 8% increase in well child visit completion rates across all patient demographics and insurance types when tele-well was offered, compared to in-office visit data from 2019.
- Medicaid well-child visits increased over 13%; Black/African American visits increased nearly 14%; Hispanic visits increased over 7%.

The demonstrated impact of telehealth services on visit completion numbers of at-risk/marginalized populations is a testament to the need for a more robust tele-well delivery model beyond the pandemic to address health disparities in underserved populations.

Partner: Health System (ACO, Hospital)

RESPONSE TO COVID-19

PROJECT TITLE: Coronavirus Relief Plan

Organization: Network Health

Topic: Response to COVID-19

Project Contact: Elizabeth Benz; ebenz@networkhealth.com

Project Overview:

Network Health implemented a Coronavirus Relief program to provide more than 110,000 members with financial assistance and expanded benefits. The program focused on benefit changes for members at highest risk for COVID-19, including members with chronic conditions, Medicare and Individual and Family Health Plan members. Its objective was to provide new, safe ways to access, improve and maintain members' health and positively influence their overall experience with Network Health and provider owners. Guiding principles for this project included supporting "return to normal" member health services utilization; emphasizing sustainable benefit changes, where possible; investing in benefits to drive member satisfaction and quality outcomes; investing in care management tools to help members.

Innovation:

Network Health implemented financial relief and enhanced benefits for commercial and Medicare members less than a month after the crisis began. In March, it expanded telehealth visits to include virtual face-to-face visits at no cost. In June, it added five benefit enhancements for Medicare Advantage members.

Network Health began offering transportation to medical appointments for all Medicare members and meals post-inpatient stay, and expanded the hearing aid discount program. It began offering weekly virtual "yoga on the lawn" classes to all members and expanded its fitness offering through contracting with two new YMCA facilities.

It partnered with a local company to implement a $200 benefits card program for Medicare and individual health plan members and their families. The benefits card provides funds for members to pay for Medicare-covered medical services, prescription drugs, over the counter items and supplemental benefits such as dental, vision and hearing. It gives members the ability to leverage services the way they need to and not through a prescribed benefit that may not be meaningful for them.

Outcome:

The financial relief and expanded benefit changes resulted in a 300% increase in member engagement through Network Health's call center and case managers, and a significant positive member experience and perception.

8% of Medicare members used the benefits card to purchase health services or health-related items within five days of receiving it. 69% of transactions were at pharmacy locations. Telehealth claims through provider health systems increased more than 1,000% since expanding telehealth visits at $0.

Partner: Accredited Health Plan

RESPONSE TO COVID-19

PROJECT TITLE: Off-Site Pediatric Well Child and Vaccination Clinic

Organization: Norton Sound Regional Hospital

Topic: Response to COVID-19

Project Contact: Robyn Goff, PharmD; robynkylea@gmail.com

Project Overview:

Norton Sound Health quickly developed an offsite pediatric well child and vaccine clinic to allow routine health care to continue. The team's focus is pediatric vaccines and child wellness. The project resulted in the relative maintenance of well-child rates in Nome, Alaska. The off-site clinic has completed 129 well-child visits via telehealth and provided 556 vaccinations, with a goal to continue throughout COVID-19.

Innovation:

The Norton Sound Health Corporation health system encompasses all aspects of health. Its one building houses an ED, acute care unit, long term care facility, pharmacy, primary care center, cafeteria, lab, eye care, audiology, physical therapy, dental and administrative office that keeps the corporation and 15 outlying village clinics operating. Having everyone located in one building during a global pandemic was problematic during the pandemic, so the team sought a training facility owned by the corporation that was set up similar to a clinic. It had the resources necessary to allow Norton Sound Health to provide well-child exams to healthy children in an environment that put parents at ease. Only one patient at a time is seen and all appropriate social distancing measures are in place.

Outcome:

As of June 30, 2020, 30.77% of children under 6 years of age in Nome were up to date with their well child visit. Norton Sound Health had completed 129 well child visits, provided 409 vaccinations at these visits and also provided an additional 147 vaccines in vaccine-only visits.
Parents are grateful to have an offsite area, away from the hospital, where they can bring their children.
The building is smaller and offers a family-friendly atmosphere. To eliminate unnecessary contact, only the pediatrician, CMA and case manager are there.

Partner: Health System (ACO, Hospital)

RESPONSE TO COVID-19

PROJECT TITLE:

Ensuring the Continuity of Care for High-Risk Senior Populations Amid a Pandemic

Organization: Orlando Family Physicians/Premier Health Network

Topic: Response to COVID-19

Project Contact: Marcella Ramirez, MPH; mramirez@premierhealthnetwork.net

Project Overview:

At the onset of the coronavirus pandemic, Orlando Family Physicians (OFP) quickly implemented new initiatives: expanded education and access to telehealth; wellness checks; drive-through services; food and medication deliveries; expanded provider coverage and hours; remote monitoring for certain chronic conditions. This rapid transition to telehealth resulted in an average of more than 1,200 visits per week, accounting for more than 75% of all primary care and specialist appointments, with some locations seeing up to 90% of patients via telehealth.

By quickly redeploying resources and staff to focus on implementing new services and models of care under strict protocols, OFP successfully manages the health of its at-risk population and identifies new strategies for delivering care going forward.

Innovation:

OFP predominantly serves seniors, many with preexisting chronic conditions that make them particularly vulnerable to COVID-19. The team implemented a comprehensive telehealth platform to almost immediately reconnect with and conduct appointments for patients. Through this process, it increased patient communication and education through a dedicated webpage, instructional videos and phone calls to ease the transition and use of virtual care. OFP knew that access to telehealth visits was not enough for most at-risk patients, who needed higher coordination of services.

By quickly realigning resources and repurposing staff members whose positions were not directly related to patient care, OFP was able to implement food deliveries, expand transportation assistance and add staff at its call center, which averages more than 3,000 calls a week. OFP partnered with local vendors to transition chronic care management services to in-home, coordinate mental health resources and to launch telemonitoring capabilities for the highest-risk patient populations with comorbidities.

Outcome:

OFP's expansion of telehealth services resulted in more than 1,200 televisits per week on average, accounting for over 75% of all appointments. Some locations have seen up to 90% of patients through telehealth. Because of the demand for services, OFP increased provider coverage and expanded clinic hours. Medication and food deliveries have reached hundreds of patients. Expanded call center staffing and hours support an average of 3,000 patients a week with scheduling, wellness checks, referrals and more.

Despite challenging circumstances, OFP maintains low admission and readmission rates for Medicare patients, with a YTD average of 133/1000 admissions and a 12% 30-day readmission rate. Patient satisfaction is an overall 94%, with nearly 80% of respondents rating their experience as excellent. This unique experience presented the opportunity to refine OFP's provision of care going forward, including introduction of telemonitoring services for certain complex conditions. OFP is exploring the opportunity to provide more home-based services for patients who risk exposure to the virus.

RESPONSE TO COVID-19

PROJECT TITLE: COVID-19 Workflows and Protocols Through the Pandemic

State: Rainbow Kids Clinic

Topic: Response to COVID-19

Project Contact: Jennifer Marchisio, CMA; jmarchisio@rainbowkidsclinic.com

Project Overview:

Rainbow Kids Clinic (RKC) developed and continuously updated workflows to match new information and recommendations by the Tennessee Health Department, the CDC, OSHA and state guidance. Its project resulted in improved safety protocols and inventive ways to evaluate and treat patients, monitor their health and answer questions, as well as help keep the community, hospitals and the health department from being overwhelmed.

Innovation:

RKC needed to develop a way to provide the best care safely during the pandemic. It contacted its main lab companies to provide COVID-19 testing early on. To be able to see patients and stretch the supply of PPEs, it initiated telehealth through its EMR. RKC posted information to social media, on its website, in its patient portal and in EMR messages to keep parents and caregivers informed. The IT department set up phones and computers so staff could work from home. The patient portal ensured a no-contact approach to the check-in process and paperwork. As recommendations change, RKC's strategies adjust.

Outcome:

RKC wanted to continue to treat patients, reduce the surge to hospitals and not refer patients to the health department. Through its efforts, hospital/ED events dropped by 46% from March–May. RKC utilized HEDIS reports, reports provided by its MCOs and GAP reports from VHAN to call patients by age group and measure to get them seen either by televisit or in the office. Staff made calls to parents of patients who were past due for well-child checkups. RKC posts regularly about the importance of vaccinations—on social media, on its website and on the office sign. From March–April, well visits declined by 32%; in May they increased by 115% and in June by another 60%—for an all-time practice high.

Partner: VHAN-Clinically Integrated Network (CIN), THCII (Tennessee Health Care Innovation Initiative), TNAAP (non-profit)

RESPONSE TO COVID-19

PROJECT TITLE: Primary Care Limited PPE Resource Care Delivery Model

Organization: Southwest Orlando Family Medicine

Topic: Response to COVID-19

Project Contact: Bryan Roy, APRN; bryan.royarnp@swofm.com

Project Overview:

Within 48 hours, Southwest Orlando Family Medicine implemented a full telehealth suite of services and an educational call center.

The project included automation of a screening questionnaire, a call center campaign initiative, a screening tent/concierge service, a parking lot exam room and system for testing, car waiting rooms, mandatory masks and no to minimal contact patient flows.

Baseline encounters average 3,400–3,800 a month. Implemented procedures yielded full return in laboratory services demand to near baseline and a 40% increase in patient visit demand over the first 30 days.

Innovation:

Southwest Orlando Family Medicine created an advisory page as a single-source COVID-19 communication reference. It leveraged a mandatory screening questionnaire to promote patient and clinician safety during infection peaks to help weed out high-risk patients. It identified patients who required different care delivery models vs. in office visits and added an external office "triage tent" that enabled wireless check-in with minimal safety impact to staff.

To accommodate fearful patients, Southwest Orlando provided minimal-contact services for check-in, office visits and laboratory services that further reduced stress in maintaining continuity of care.

Outcome:

Southwest Orlando Family Medicine recovered 40% of lost encounters in the first 30 days of its project. It continues to maintain aggressive testing protocols through efficient testing blocks and structured communication. Through telehealth, it maintains continuity of care for patients who otherwise would have disengaged, treating every visit as opportunity for care gap closure and risk identification.

It continues to minimize improved patient access to services through aggressive outreach, with a subsequent reduction in ER utilization. Many patients previously sought COVID testing via the hospital; Southwest Orlando offers an alternative to that high-risk environment.

Partners: eClinicalWorks software solutions, Luma

RESPONSE TO COVID-19

PROJECT TITLE: COVID + RN Care Management Follow-up

State: UW Valley Medical Center

Topic: Response to COVID-19

Project Contact: Judith Puzon, RN, MSN; judith_puzon@valleymed.org

Project Overview:

At a time when access to health care was limited and preventing hospital surge was the focal point, the COVID+ Registered Nurse Care Management Follow-Up program was developed with the intent to provide safe, home-based support for symptom management and early referral to the right site of care.

Innovation:

In March 2020, Washington State experienced communitywide spread of COVID-19. Community members were fearful and triage phone volumes tripled. RNs were exposed to patients who needed to access urgent and emergency care. Testing was limited and the risk of hospital surge was imminent. It became clear that appropriate use of telephone triage could help prevent hospital surge and ensure safe management of self-care in the home.

UW Valley Medical Center presented a plan to hospital leadership: Use RN care managers to patients who tested positive. Patients in days 5–12 of symptom onset would receive a daily phone call from an RN, who would evaluate symptoms and, utilizing symptom-based algorithms, formulate an assessment and plan. Patients who were improving would graduate from daily phone calls on day 13 to a phone call every 2–3 days until day 21. The program offered patients the opportunity to have RN follow-up during the highest-risk period (days 5–14).

Outcome:

UW Valley Medical Center enrolled 427 patients; 324 graduated. March hospital readmission rates were the lowest in months. Though the hospital did experience a surge, the partnership between the inpatient teams and RN Care Managers facilitated knowledge to help guide patients to "earlier entry," likely preventing known complications associated with rapid deterioration and the need for ventilation. The role of the COVID+ RN Care Management workflow was to prevent surge, guide patients to the right level of care and provide safe, in-home care.

Partner: Health System (ACO, Hospital)

USE OF TECHNOLOGY

USE OF TECHNOLOGY

PROJECT TITLE: Population Health at the Local Level

Organization: BlueCare Tennessee

Topic: Use of Technology

Project Contact: Lauren Roberts, MBA, CPHQ, PAHM; laurenl_roberts@bcbst.com

Project Overview:

To improve data infrastructure and population identification, BlueCare customized an identification/stratification (IDStrat) process that includes 85 algorithms and predictive models to allow continuous monitoring of population health. BlueCare integrated 12 technology-driven tools to identify members and match them with the appropriate interventions. BlueCare's Population Health Management model was developed to address member needs in five areas:

- Keeping members healthy.
- Managing members with emerging risk.
- Patient safety or outcomes across settings.
- Managing multiple chronic illnesses.
- Member experience.

With this proprietary technology, BlueCare was able to create unique, regionally aligned Integrated Care Teams (ICT) across the state with specialized local knowledge to serve members, support providers and engage community stakeholders. There are 96 ICTs across the state, each composed of clinical and health navigation staff with specialized skills who play specific roles in member outreach and care management.

Innovation:

BlueCare designed an integrated system of data, predictive models and complex algorithms to assess a variety of factors that may impact health outcomes from SDOH to current comorbidities and health care utilization patterns. Systems provide Case Managers with information at their immediate disposal to:

- Create a 360-degree view of a member's health status.
- Identify disease-specific member patterns and clusters.
- Leverage artificial intelligence/natural language processing to make intervention recommendations.

Case managers can conduct deep-dive analyses to identify spend and utilization trends, identify members with needs and initiate triage to the appropriate program.

Analyzing all available data sources allows BCT to compile a snapshot of each member's total health care journey.

Outcome:

BlueCare created dedicated, regionally aligned ICTs to provide holistic member care and help foster deep local relationships. Regions were designed to meet needs of members residing in specific locations. Systems and technology allowed tailored care and continuous monitoring of the population's.

Over the course of a year, BCT committed significant system and data infrastructure investment to support the design of 12 technology driven tools. Data metrics included types of health care visits by region, regional baseline comparisons to cohorts, targeted members within subpopulation groups and culturally impacted member and provider availability and outcomes. With this information, BlueCare is seeing decreased inpatient admission, decreased emergency room and inpatient PMPM and targeted opportunities for continued reduction by location, member-type and cohort-specific interventions.

Data also provides the opportunity to monitor and limit negative trends. A key dashboard improvement is a heat mapping capability that allows BlueCare to utilize regional information and cross-reference items such as cohorts, SVI, population densities and age demographics.

Partner: Health System (ACO, Hospital)

USE OF TECHNOLOGY

PROJECT TITLE: Azara + MCO Payer Integration

Organization: CBHA

Topic: Use of Technology

Project Contact: Hayley Middleton, MPH; hayleym@cbha.org

Project Overview:

CBHA utilizes Azara Healthcare as a Quality Power BI platform to provide visuals into its quality performance for HEDIS and UDS. It recently integrated MCO contracts for quality performance into the tool, to track and manage care gaps based on insurance. This allowed CBHA to expand its Quality Program, improve internal performance and overall give a higher quality of care with better outcomes.

Innovation:

This project integrated CBHA's long-standing quality reporting for UDS and Azara's capability to build HEDIS Quality Measures to improve quality of care and patient outcomes across various arms of quality. The technology allows CBHA to not only filter by payer/insurance, but also to build and create benchmarks unique to each contract, to track performance throughout the year.

Outcome:

The main outcome of this project is measuring compliance on the various MCO contracts in place surrounding pay for performance. This has added value, efficiency and effectiveness to quality data, training and outcomes. CBHA keeps a detailed scorecard with measure details, numerator, denominator and compliance percentage that it uses to track trends and performance.

Partner: Primary Care Practice(s)

USE OF TECHNOLOGY

PROJECT TITLE: Clinical Library Combines Insight, Action to Drive Safe, High-Quality Care

Organization: Kaiser Permanente

Topic: Use of Technology

Project Contact: Anna Jarrard; anna.c.jarrard@kp.org

Project Overview:

Kaiser Permanente created the Clinical Library, a robust electronic platform that quickly and easily connects health care providers, physicians and care teams to more than 30,000 curated clinical guidance aids, clinical calculators and decision support tools backed by research and vetted by clinical experts, as well as thousands of journals, textbooks and more. Kaiser Permanente clinicians can access the Clinical Library at the point of care via computer or mobile device to form treatment plans based on the latest evidence and their patient's health record and care preferences. The Clinical Library is used over 2.8 million times per year, an average of 10,000 times each weekday.

Innovation:

Kaiser Permanente's Clinical Library provides a trusted clinical knowledge-sharing platform for its clinicians and care teams. Clinicians across the nation can access more than 31,000 clinical guidance aids, member handouts and other clinical resources; 10,600 full text journals; and 8,300 textbooks through an easy-to-use web portal that is integrated with the organization's EHR. The Clinical Library features navigation through search, browse or filter; regional customization; online personalization; and the ability to share content with colleagues and members. It combines these digital capabilities with human expertise, including chat and email access to librarians.

The Clinical Library is also tightly integrated with Kaiser Permanente's EHR through algorithmic calculators and automated data sharing. This innovative approach enables Kaiser Permanente to accelerate the identification and implementation of new evidence-based practices; expedite the spread of high-quality clinical and operational practices; and fast-track decision making.

Outcome:

Providers benefit from a national pool of information and the ability to quickly learn from the latest research, curated clinical guidance aids and each other. The Clinical Library has contributed to lower mortality rates from conditions like heart attack, stroke, cancer and sepsis. It is a key method for disseminating information about changes in practice, particularly when safety concerns are raised by ongoing scientific trials.

The Clinical Library supports affordability by eliminating additional expenditures for local site, tool and content development; consolidating subscription contracts; and decreasing duplication. It also significantly reduces the time that clinicians spend searching for resources and manually entering data into clinical calculators. The providers working to keep Clinical Library accessible and relevant have continued to make it more user friendly and streamlined with improvements such as the ability to add items to a Favorites List and an enhanced home browser page."

USE OF TECHNOLOGY

PROJECT TITLE: Improving Health Outcomes for Our Pediatric Population through an Integrated Model of Care Approach

Organization: Nemours Children's Health System

Topic: Use of Technology

Project Contact: Sara Gray, MSM, HCA, PCMH CCE; sara.gray@nemours.org

Project Overview:

Nemours Children's Health System developed a process to ensure completion of well-child visits and immunizations for patients in its primary care network through the use of a well-developed reliable method, a robust population health management tool and an integrated model of care delivery. Care Coordinators follow up on gaps in care utilizing the population health management tool; community health workers (CHW) contact hard-to-reach patients and Care Managers address gaps in care for higher-risk patients through a risk stratification tool.

Innovation:

Through the innovative technology of EPIC's Healthy Planet platform, The Nemours Children's Health System analytics department developed registries, metrics and reports that enabled the Care Coordination team to stratify and run reports on gaps in care. This helped the team identify patients who were either overdue or due soon for well-child visits and immunizations.

CHWs assisted in this process by addressing hard-to-reach patients using various methods, including home visits, if applicable. Patients identified as higher risk during the stratification process were referred to Care Management for additional services.

Outcome:

Results showed an overall improvement of ≥5.36% over baseline data for well-child visits, HPV and flu immunizations. Success was measured in achieving stated goals: reducing costs to the organization by lowering ED/admission utilization, improving quality of health outcomes for patients and ultimately lowering the cost of care.

Nemours has earned millions of dollars in incentive payments since the process went live. Well-validated data allowed it to appeal over a dozen measures where payers initially evaluated it lower than internally generated scores. All but one appeal has been successful, resulting in over $1.2 million in additional performance-based revenue.

Partner: Primary Care Practice(s)

USE OF TECHNOLOGY

PROJECT TITLE: Reconnecting the Patient Centered Medical Home with their Hospitalized Patients: A Technology Enabled Delivery System Redesign

Organization: QMC Cares Hospitalist Group

Topic: Use of Technology

Project Contact: Marc Rivo, MD, MPH, FAAFP; marcleerivo@gmail.com

Project Overview:

A dangerous juncture in medical care occurs when patients enter and leave the hospital. The QMC Cares (QMC) Transition of Care (TOC) portal enables PCPs and admitting physicians to effectively manage this process. The TOC portal sends Florida's Encounter Notification Service (ENS) alerts by email, text or through the app to the hospitalist and the patient's PCP when their patients register in the ED.

PCPs can flag high-risk patients and provide patient records through the portal to QMC's area-hospital admitting physicians, replacing the antiquated medical record request form and error-prone fax process. This secure, multi-directional cloud platform helps hospitals minimize evaluation and treatment delays, medical errors and medically unnecessary testing.

The TOC portal can be leveraged to improve post-discharge follow-up visit rates, minimize community treatment delays, reduce hospital readmission rates, improve HEDIS scores and help meet NCQA Recognition and Accreditation requirements—and it is free to collaborating PCP practices. The cost is borne by QMC, hospitals and health plans who value the technology to enhance patient-centered care.

Innovation:

QMC began hosting and continuously innovating its TOC portal and reporting database on Amazon web services, giving hospitals, health plans and clinicians remote access and multi-directional sharing of patient records across their local hospital market.

Creative user-friendly features include:

- Automated alerts to hospitalists and PCPs when their patient enters the ED.
- Secure direct/Group private TOC messaging to community practices indexed by specific patient ID and date.
- Remote clinician access to the hospital face sheet and concurrent patient records through the TOC portal.
- Automated and customized health plan, hospital, hospitalist and PCP performance reports.

The TOC platform is free of charge to PCP, behavioral health and other community clinician users.

Outcome:

QMC's TOC portal is helping drive better integration across the delivery system through person-centered, PCP-connected hospital care. This scalable technology can be affordably built and deployed across the United States through aligned partnerships among large hospitalist organizations, medical groups and health plans committed to the PCMH model of patient-centered care.

Partner: MDFlow Hospitalist Management System; 500 medical and psychiatric admitting physician-owners of QMC; 100 collaborating hospitals; 82 collaborating skilled nursing facilities; 20 health plans in Florida that contract with QMC for hospitalist services and collaborate in the hospital TOC process; 36 collaborating NCQA-Recognized PCMHs; 30 collaborating ACOs, FQHCs, CMHCs and medical centers.

USE OF TECHNOLOGY

PROJECT TITLE: Preventing Diabetic Complications: An FQHC approach

Organization: Swope Health Services

Topic: Use of Technology

Project Contact: Naiomi Jamal, MD, MPH; njamal@swopehealth.org

Project Overview:

Swope Health Services serves a vulnerable underserved patient population that has many high-risk factors for complications of diabetes. Using PCMH principles, it built an EMR (e clinical works) tool for effective previsit planning—even in an open access setting—and linked it to other electronic tools, such as in-office retinal exam devices, to improve diabetes outcomes and focus on tertiary prevention.

Innovation:

Swope developed a previsit planning tool within its EMR that can be used for all patients, including "unscheduled " patients, to ensure that diabetes management measures (e.g., HgA1c screening, nephropathy and retinopathy screening, pneumonia immunization) are being met.

Retinopathy screening was linked to the use of a handheld retinal camera that created a flowsheet. This approach significantly improved diabetes-related outcomes for this high-risk population. The flowsheet and retinal camera use were piloted at a single site and are now being adopted throughout the organization.

Outcome:

The initiative yielded significant improvement in measures over the duration of the program. After use of the retinopathy camera, performance rates increased from 4% to 49.3% at the end of the measurement period. When an abnormality was found, patients were more motivated to follow up with an optometrist/ophthalmologist.

The uncontrolled HgA1c rate (>9.0) remained stagnant at 24%. This inspired Swope to regularly screen all patients for SDOH, including food insecurity. Preliminary outcomes indicated that diabetics with food insecurity were twice as likely to have uncontrolled levels than those without food insecurity. The outcomes prompted the organization to spread the initiative across all clinical sites and focus on SDOH (particularly food insecurity) in diabetic patients.

OTHER

OTHER

PROJECT TITLE: Cigna's Diabetes Prevention Program in Collaboration with Omada Health

Organization: Cigna

Project Contact: Rob Silverman, MBA; robert.silverman2@cigna.com

Project Overview:

Cigna's Diabetes Prevention Program (DPP), in Collaboration with Omada Health, is a digital intensive behavioral counseling program for people with prediabetes. Participants work with an Omada virtual coach and learn how to apply meaningful changes around eating, activity, sleep and stress, and then focus on sustaining changes over time. On average, participants experienced weight loss of 3.3%a–5%b during the initial pilots, resulting in net medical cost savings of $424a–$972b per participant.

83 percent of participants said they would recommend the program to a friend.

(a) 2016 Omada Diabetes Prevention Program Pilot Study based on four clients. National account customer survey results who completed the first phase of the Omada program. Individual client/customer results will vary and are not guaranteed. Marketed population defined as the number of people who saw Omada marketing materials during the pilot program.

(b) Omada Diabetes Prevention Program Pilot Program Results 2016 based on one client.

Innovation:

Diabetes prevention programs are considered a covered preventive benefit; most participants pay nothing because the health plan picks up the cost. The challenge for employers is how to promote and make this type of benefit available in a consistent and scalable way that works for all participants, especially for employers with geographically dispersed populations.

Cigna partnered with Omada to formally launch the Cigna DPP program in 2019, which allowed more of Cigna's employer clients to deploy a digital program platform to their entire employee populations, expanding reach, accessibility and measurability by driving volume and enrollment, behavior change, consistent tracking of success though weight loss and reducing the risk of diabetes in their populations.

Outcome:

Prior to the full program launch in 2019, Cigna worked with Omada on a pilot. Cigna will have an updated study in late 2020 that will be based on clients who started the program after the pilot. Post-pilot, for participants who lost weight using the program, the average weight loss is over 10 pounds; approximately 30% of participants achieve at least 5% weight loss, as measured over 2 years.

Customer satisfaction with the program is approximately 90%. Other metrics considered important include level of engagement, client adoption of the program and how well Cigna and Omada partner together. After 4 months in the program, 74% of participants continue to engage with Omada at least once a week. Client adoption of the program has been strong, with membership climbing consistently over time.

OTHER

PROJECT TITLE: Treating Oncology Patients During the COVID19 Pandemic

Organization: New York Cancer & Blood Specialists

Project Contact: Lynn Kay Winters, MBA, CMPE, CPHQ; lwinters@nycancer.com

Project Overview:

New York Cancer & Blood Specialists developed a multi-pronged, creative approach to treating oncology and hematology patients in New York during the COVID-19 pandemic. The project resulted in continued access to care during a time of crisis, in a way that felt safe.

Using remote technology and outdoor lab draws and shot administration, patients were able to stay in touch with their providers and receive the advice, assessments and treatment they needed, while minimizing exposure to patients and staff.

Innovation:

Development and execution of this novel process of outdoor visits, along with access to remote visits, improved patient access at a time that would otherwise have found patients opting out of care.

The project scope was laid out by an executive/administrative team that included nursing and physician leadership to include outreach to all 40 locations and 3 specialties. Patient options included a scheduled remote check-in with their physician and drive-through lab draws and injections. The mission was to capture as many visits as possible so as not disrupt any patient's care.

Outcome:

To date, the out-of-doors effort provided a successful outcome. Data as of April 7, 2020, shows that of the 421 patients who would otherwise have cancelled their appointments for care, 371 (88%) elected to receive care in a drive-through location. New York Cancer & Blood Specialists utilized the same staff members who normally provide care at those sites, to promote continuity and mitigate the feeling of the "unknown" for patients.

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