



*Center for Policy
and Research*

INNOVATIONS in Medicaid Managed Care

Highlights of Health Plans' Programs
to Improve the Health and Well-Being
of Medicaid Beneficiaries



March 2013

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This publication is the latest in a series of AHIP *Innovations* reports highlighting trends in health care.

Previous volumes include:

- *Innovations in Patient Safety*
- *Innovations in Reducing Preventable Hospital Admissions, Readmissions, and Emergency Room Use*
- *Health Insurance Plans' Innovative Initiatives to Combat Cardiovascular Disease*
- *Health Literacy and America's Health Insurance Plans: Laying the Foundation and Beyond*
- *Trends and Innovations in Disability Income Insurance*
- *Innovations in Recognizing and Rewarding Quality*
- *Innovations in Prevention and Wellness*
- *Trends and Innovations in Health Information Technology*
- *Trends and Innovations in Chronic Disease Prevention & Treatment*
- *Innovations in Chronic Care*
- *Innovations in Health Information Technology*
- *Innovations in Medicaid Managed Care*
- *Reducing and Preventing Childhood Obesity: Health Insurance Plans Partnering in Communities*
- *Health Plan Innovations in Worksite Wellness*

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Overview: Rising to the Challenge in a Time of Transition

An Inside Look at Successful Programs

In this report—an update to AHIP’s 2005 *Innovations in Medicaid Managed Care* book—we provide details about 17 health plan initiatives dedicated to improving the health and well-being of Medicaid beneficiaries. The report is divided into three chapters:

- Working with Community Partners;
- Addressing Obesity; and
- Caring for People with Complex Needs.

Wherever possible, we have included comments from people who have participated in these programs. For the first time, we have produced an online version of this publication that includes videos featuring Medicaid beneficiaries and staff who are involved with the initiatives, as well as interviews with some of the people who run them.

As with our previous *Innovations* reports, we have provided contact information for people in the companies who are available to answer questions. This in-depth description of best practices is intended to foster discussion about lessons learned and replication of successful approaches.

Achieving a Smooth Transition to an Expanded Medicaid

It is our hope that a review of best practices will be especially productive in this time of transition

for Medicaid. The Affordable Care Act allows states to expand the program to all people with incomes at or below 138 percent of the poverty line beginning in 2014.¹ The Congressional Budget Office estimates that by 2014, an additional 7 million people will be enrolled in Medicaid and the Children’s Health Insurance Program (CHIP), and by 2022, an additional 11 million people will be covered by these programs.² At the same time, states and the federal government are facing major budget challenges, and policymakers will continue to look for ways to achieve additional savings in the Medicaid program.

A Long Track Record of Success in Medicaid Managed Care

For more than two decades, health plans have been partnering with states to develop Medicaid managed care programs tailored to their populations’ needs, ranging from prenatal care initiatives for pregnant women to home- and community-based long-term care and support for individuals with chronic conditions. Research has shown that these programs are improving the quality of care for Medicaid beneficiaries and achieving cost savings for taxpayers.^{3,4,5,6}

States are relying more and more on health plans to provide quality health coverage for their growing Medicaid populations. In 2011, approximately 29 million people—more than 50 percent of program beneficiaries—were enrolled

1 Congressional Budget Office. (July 2012). Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision. Washington, DC: Author. Available at: <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>.

2 Congressional Budget Office (July 2012).

3 Bindman, A., et al. (December 2007). Preventable Hospitalizations among Medi-Cal Beneficiaries and the Uninsured. Oakland, CA: The California HealthCare Foundation. Available at: <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20PreventableHospitalizationsInMediCal2007.pdf>.

4 Lloyd, R. (December 2010). MHCP Racial Disparities in Healthcare Utilization Monitoring Report. Saint Paul, MN: Minnesota Department of Human Services. Available at: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_160229.

5 Roohan, P. (2006). Quality measurement in Medicaid managed care and fee-for-service: The New York State experience. *American Journal of Medical Quality*, 21(3): 185-191. Available at: <http://ajm.sagepub.com/content/21/3/185.abstract>.

6 The Lewin Group (March 2009). Medicaid Managed Care Cost Savings – A Synthesis of 24 Studies. Washington, DC: America’s Health Insurance Plans. Available at: <http://www.ahip.org/MedicaidManagedCareCostSavings/>

Overview: Rising to the Challenge in a Time of Transition *(continued)*

in Medicaid health plans in 35 states plus Puerto Rico and the District of Columbia.⁷ From 2001-2011, the proportion of beneficiaries covered by health plans grew from 37 percent to 51 percent, and from 2010-2011, enrollment in Medicaid health plans grew at nearly twice the rate of total Medicaid enrollment (9 percent compared to 4.6 percent).⁸

Overcoming Life Challenges

The 337 health plans participating in Medicaid⁹ have learned that caring for the population well means addressing the tremendous challenges that beneficiaries face in their day-to-day lives. Many struggle to navigate health care, education, and social service systems that assume English as the primary language. Some are homeless or in temporary, unsafe living situations. Others don't have enough money to heat their homes, buy cars, or clothe their children. Still others are frail seniors with multiple chronic conditions who aren't getting the treatments they need, can't remember to take their medications, and have no family to help. Some have physical disabilities or mental health conditions that require coordination of a complex array of services.

Beneficiaries facing day-to-day challenges meeting their most basic needs have difficulty focusing on getting regular exercise or making appointments for check-ups. Many Medicaid beneficiaries don't have family doctors and rely on emergency rooms for care. The nearest clinic may be an hour away, and they may not have an easy way to get there.

Looking Beyond Health Care

In committing to serve the Medicaid population, health plans are rising to the challenge. They

know that to be effective, they have to do more than provide for quality care. In fact, before they can begin to bring about improvements in beneficiaries' health, they need to look beyond health care, to all of the factors that are affecting people's lives. To help people meet their basic needs, health plans are reaching beyond their own walls, to community partners that can provide affordable housing, home energy assistance, free or low-cost transportation, child care, and access to healthy food.

Health plans are doing more than just linking people with outside services; they are working on a daily basis with foster care agencies, emergency medical services departments, foundations, schools, community centers, American Indian tribal leaders, and even a local police department, on wide-ranging initiatives to improve patient care and help people lead healthier lives.

Meeting People Where They Are

Getting Medicaid beneficiaries the care they need takes a lot more than giving them a ride to the doctor. It means knowing where they come from, speaking their languages, being familiar with their family traditions, and understanding how they think about health and health care. It means meeting people where they are, whether it's at churches, schools, baby showers, family reunions, community festivals, bus stops, or home.

Health plans are providing this kind of personalized outreach in a variety of ways, in some cases training people in low-income neighborhoods to teach their friends and neighbors about staying healthy. Some health

7 America's Health Insurance Plans (December 2012). Medicaid Health Plan Enrollment and Participation Trends, December 2012. Washington, DC: Author. Available at: <http://www.ahip.org/MedicaidEnroll1212012/>.

8 America's Health Insurance Plans (December 2012).

9 America's Health Insurance Plans (December 2012).

Overview: Rising to the Challenge in a Time of Transition *(continued)*

plans provide care coordinators who stay in touch with members regularly, visit their homes, and facilitate arrangements for all of the health care, personal care assistance, behavioral health, and social services they need to live safely and independently in their communities. Some offer fun exercise and cooking classes in local YMCAs and community centers. One health plan sends a children's author to schools to read to children in low-income communities and get them excited about healthy living. Another brings dental care to people's neighborhoods in a specially equipped van.

Entering New Realms

To help people who have been reluctant to use the health care system on a regular basis, health plans have learned about traditions outside of Western medicine and have enabled people to access care in ways that are consistent with their values and beliefs. To help children whose health care is arranged through the foster care system, health plans have become well-versed in the language and rules of foster care and have built working relationships with caseworkers to make sure that foster children get all of their well visits, immunizations, chronic care, and behavioral health services in a timely way.

Improving health care for Medicaid beneficiaries is by definition a work in progress. As the Medicaid population continues to grow and change, health plans will adapt their programs and add new ones, as they partner with states to achieve a smooth and successful transition to an expanded Medicaid program in the years ahead.

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Chapter 1: Working With Community Partners

This chapter highlights health plans' partnerships with a variety of organizations to help beneficiaries achieve good health. Recognizing that people's health is determined by many factors outside the health care system, health plans are reaching out into their communities and forming new relationships. Improving the health of Medicaid members has meant being open to new ways of thinking, communicating regularly with different agencies and groups to build understanding and trust, and finding creative new ways to connect people with critically needed information and services.

The result is a set of programs as diverse as the people they serve. One health plan is working with American Indian tribal leaders to provide benefits for people to receive care from traditional healers, or medicine men, in addition to care from primary care physicians and specialists. Another helped its local emergency services department revamp its 911 system to handle calls more effectively. Two health plans have created extensive new support systems for foster children and their caseworkers—to make sure that the children receive high-quality primary, preventive, specialty, and behavioral health care in a timely manner. One health plan is coordinating with school systems in 18 states to offer a fun and engaging new way for children to learn about healthy living. And another is working with a local foundation to bring quality dental care to children in low-income neighborhoods.

We hope that sharing the details of these programs will inspire others to push beyond traditional boundaries as they seek new and better ways to help Medicaid beneficiaries live healthy lives.



Centene Corporation

Getting Kids Excited about Healthy Living

Introduction

As she struggled with the question of how to get kids in the Medicaid program excited about healthy living, Dr. Mary Mason of Centene Corporation stumbled on an idea close to home—books! Dr. Mason had experienced first-hand how engaging books are for children, and she knew that many children in low-income families have never had books of their own. After she was introduced to children’s author Michelle Bain and shared her thoughts, the idea for “Thumbs Up Johnnie” and the Adopt-a-School program was born.

The Adventures of Thumbs Up Johnnie and Darby Boingg

Since the program’s launch in 2009, thousands of students have read about Thumbs Up Johnnie, a cowboy whose adventures are described in comic-style books such as *Adventures through Fitropolis* (about healthy eating); *Smokey Yuckpak* (about the dangers of smoking); and *Adventures from Sugarland* (about diabetes). Because the series was so popular, Centene commissioned the creation of another character, Darby Boingg, a walloughby who wears a fanny pack to carry healthy snacks, medications, and exercise equipment. In 2013, Darby Boingg will explore the topic of bullying.

In *Fitropolis*, Johnny (and now Darby) learns lessons like “Only snack when you are hungry” and “Keeping fit is easy...You can walk your dog, throw a ball, do jumping jacks, run, jump rope, or play hopscotch.” The characters Skip Drive-Thru, Spike Armstrong, Constance Eatrite, Claire Springs, and Snack-King guide Johnnie and Darby on adventures in healthy eating and exercise.

In Smoky Yuckpak, a character named Dr. Von Wheezles asks, “Do you know what smoking does to you?” and he tells Johnnie, Darby and his friends that “Smoking causes breathing problems and is bad for your lungs,” and “Smoking can cause cancer of the mouth, tooth decay, gum disease, and really yucky yellow teeth!” At the end of the story, Smokey decides to quit and changes his name to “M.T. Yuckpak.”

All of the books include activities such as connect-the-dots, coloring pages, mazes, word-search puzzles, and stickers. On the front cover, kids answer questions about the topics to be covered, and at the end, they answer more questions based on what they learned. Each book also includes a guide for parents to talk about the book’s topics with their children.

Inspiring the Next Generation of Writers

In the past three years, Thumbs Up Johnnie and Darby Boingg have reached an estimated 7,500 students ages four to nine at over 25 schools in 18 states (WA, AZ, TX, AR, LA, MS, FL, GA, SC, WI, IL, IN, KY, OH, MO, MA, NH, and KS). As part of the program, author Michelle Bain visits an average of three schools in each state, in areas where a high percentage of students receive free and reduced-price lunches. In small group meetings with students by grade level, Bain talks about how she became a writer and how the children can be authors and junior editors too. She reads one of the books aloud, answers questions, and gives each child a free copy, along with a guide for parents and guardians. Students then attend a school-wide assembly in which Centene staff members lead group activities related to the topic, such as taking a fitness pledge. The book’s mascot always makes an appearance to build enthusiasm.





Centene Corporation *(continued)*

Getting Kids Excited about Healthy Living

“Despite this being the technology age, books are a phenomenal way to reach children... There’s nothing like having a book in their hand. Some kids don’t even own a single book.”

– Dr. Mary Mason, *Senior Vice President and Chief Medical Officer, Centene*

“If you don’t have the right nutrients, you won’t be able to have enough energy to play sports or run or anything you like to do.”

– Dakota, *fifth grader and participant in the Adopt-a-School program*

Kids have had an overwhelmingly positive response to the events, and many schools have asked to participate. Centene shares the books with its primary care physicians; health coaches; case managers; federally qualified health centers and other free clinics to distribute to their patients. All books are written in English and Spanish.

Children in foster care and those with asthma or diabetes receive copies of *Darby Boingg Helps a Friend on a Foster Care Journey*, *Adventures from Puffletown*, and *Adventures from Sugarland* from Centene’s nurse case managers. The books help children understand and talk about these topics, and they show them how to manage asthma and diabetes.

Also as part of the program, more than 1,000 Girl Scouts in 75 schools around the country have engaged in special activities tied to *Adventures Through Fitropolis* since 2010. In areas where more than 50 percent of students receive free or reduced-price lunches, Brownie troops received copies of the book, along with a guidebook for engaging in six to seven fitness-related activities, along with parent guides and supplies such as jump ropes, water bottles, index cards to write down ideas for healthy snacks, and posters to draw pictures of healthy foods. In 2013, a new Brownie badge based on the *Smokey Yukpack* book is being developed for troops in four states.

Teachers and Girl Scout leaders are asked to have children answer a series of questions before and after participating in the program’s activities to measure what they have learned. As an incentive for having their students answer the questions, teachers receive free books for their classrooms.

Teaming Up to Write a Cookbook

In 2010, students who participated in the Adopt-a-School program had the chance to enter a recipe contest for the best healthy snack. A panel of dietitians and Centene staff reviewed the recipes and scored them for nutritional value. A total of 15 children had their recipes published in the book. They all received \$50 gift cards to Subway, and the winner won a one-year family membership to the YMCA.

Besides recipes, the *Super Centeam 5 Cookbook* includes messages about good nutrition from Darby Boingg and his friends, along with stickers and a “cookin’ pledge.” The cookbooks are available from school nurses and free clinics in 18 states.

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Health Partners

Bringing Healthy Smiles to Kids in Low-Income Neighborhoods



Introduction

In some communities, finding quality dental care is a major challenge. The nearest dentist's office may be two bus rides away—not a good option for parents with small children. As a result, many parents take their children to the dentist only when it's an emergency. Health Partners is trying to change that with the Chopper Check program, launched in 2009. Chopper Check brings a fully-equipped mobile dental clinic—the Ronald McDonald Care Mobile van—to low-income communities so that children can have their teeth checked and treated right in their own neighborhoods.

Chopper Check

Health Partners' member families with children ages three to eight who have not been to the dentist in more than a year receive postcards inviting them to the Ronald McDonald Care Mobile Dental Program in their communities on days when children are not in school. Families who are interested call Health Partners to register for Chopper Check and schedule their appointments. People who are signed up receive appointment reminder calls, and Health Partners staff can provide directions and other information. Children can receive dental care on the van and continue to use the Care Mobile as their dental home, with emergency care available 24/7.

The van is staffed with two dentists and a dental hygienist. Children coming to the van can enjoy face painting and visits from Health Partners' friendly mascot along with their dental check-up. Dentists discuss the importance of avoiding nighttime bottles or Sippy cups of formula or juice, proper tooth brushing, and a healthy diet that promotes good dental health. Each child

receives a care plan for follow-up treatment and can continue coming to the van every six months for dental check-ups.

Resources for Parents

Parents who bring their children to the van receive gift cards for local supermarkets and retail stores. During their visits, parents can have their blood pressure and body mass index checked, and they can talk to a nutritionist about healthy eating. They can also take home brochures with information about dental care, nutrition, and exercise.

The program is run in partnership with the Saint Christopher's Foundation for Children, which receives grants and donations to operate the mobile dental clinic. Saint Christopher's Hospital for Children is part of Health Partners' network, and the health plan's Medicaid members can use the hospital's dental clinic for complex treatments.

Results

Each year, the Care Mobile van treats more than 2,000 children, half of whom are Health Partners members. The total includes those who use the van as a regular source of care and return for preventive visits and follow-up care. More than half of the children visiting the van need and receive treatment for tooth decay.

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Molina Healthcare

Reaching Out to American Indian Communities

Introduction

The key to improving the health of Molina Healthcare's low-income American Indian members in Utah and New Mexico can be summed up in one word: trust. American Indians often struggle to have faith in the Western health care system. They may not feel comfortable going to the doctor so generally go to traditional healers, or medicine men, for care. They have fewer doctor visits and receive fewer health services and prescriptions than any other population group. Yet American Indians have the lowest life expectancies of any U.S. population group, and they die at higher rates than other Americans from tuberculosis, alcoholism, diabetes, and unintentional injuries (including car accidents).¹⁰

Respecting Traditional Practices

When Molina set out to help, it first tackled the issue of trust. Molina reached out to Utah's Indian Health Advisory Board and New Mexico's tribal leaders, community members, and other health care representatives. Molina staff visited reservations in remote, rural areas and sat in on tribal leadership meetings. Initially, tribal leaders were wary. But over the course of many months, Molina staff listened to their concerns and built working relationships with them. During these meetings, Molina learned that many American Indians would not begin to even think about seeing a Western doctor unless they had their medicine men's blessing.

The result was Molina's Traditional Medicine Benefit, rolled out in New Mexico in 2007 and Utah in 2011. The benefit works like a grant: Molina's American Indian members with Medicaid coverage in Utah can apply for and

receive \$100 a year to spend on traditional care, such as herbal treatments from a medicine man or a purifying sweat lodge ceremony with a spiritual healer. In New Mexico, the grant is for \$200 a year if Medicaid members receive healing services at home and \$100 for services in a hospital setting. Members can visit healers as many times as they want and use the grant for as many visits as it covers.

Molina consulted with tribal leaders extensively about how to design the benefit and how to publicize it most effectively in their communities. During this process, Molina made it clear that it was not in any way trying to diminish the role of traditional healers. Rather, the goal was to encourage its American Indian Medicaid members to use traditional healing services in coordination with Western medicine and preventive care to improve their overall health and well-being.

One of tribal leaders' main concerns was that healers' traditional practices not be publicized or compromised in any way by the program. Molina respects the confidentiality of traditional healing practices and provides the grant with no questions asked about what happens during members' visits with healers.

Getting the Word Out

To publicize the benefit, Molina worked with tribal leaders to produce an engaging brochure with easy-to-read information about how to access the benefit. Molina provides the brochure along with sample applications to community organizations and health care centers serving a large number of low-income American Indians. Tribal leaders also help spread the word directly with members of their communities.



¹⁰ U.S. Department of Health and Human Services. Indian Health Service (2011). IHS Fact Sheets: Indian Health Disparities. Available at <http://www.ihs.gov/PublicAffairs/IHSBrochure/Disparities.asp>.



Molina Healthcare *(continued)*

Reaching Out to American Indian Communities

Taking Care of Unmet Needs

Each person who signs up for the benefit is paired with a care manager, generally a nurse or social worker. Care managers review members' medical histories and assess their needs. If members do not have primary care physicians, care managers can help them set up appointments. Because it is not unusual for Indian reservations to be more than an hour away from the nearest medical facility, Molina also may help with transportation. The health plan provides incentive gift cards to encourage members with diabetes to have preventive care exams, and it can enroll people in programs to help them stop smoking. Molina's care managers can help members find social workers and social service agencies, for example, to apply for other benefit programs, such as those to help pay for medications or energy bills.

Care managers can work with members on a one-time basis or for a longer period if needed. They follow up with members who use the Traditional Medicine Benefit to ask if they were satisfied with the benefit and whether they

would recommend it to others. Care managers encourage members to communicate with both their primary care physicians and their traditional healers. They do not ask about individuals' visits with healers, but they encourage patients to tell their primary care doctors about any herbal medicine or other traditional treatments that have been prescribed, to avoid dangerous interactions.

The program has been well-received in American Indian communities. Soon after it was launched in New Mexico, the number of applications for the benefit increased by 78 percent. Molina continues to publicize the program and enroll members in both New Mexico and Utah.

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Passport Health Plan

Partnering with Emergency Medical Services to Transform 911



Introduction

The first of its kind in the nation, a public-private partnership between Passport Health Plan and Louisville, KY has led to a new and more effective way of helping people access urgent and emergency care. Over the years, it became clear to the leadership of Louisville Metro Emergency Medical Services (LMEMS) that many people were using the 911 call system for situations that could be handled faster and more effectively outside of the EMS system. As a result, the call system was overwhelmed, and its ability to provide immediate response to people with life-threatening needs was in jeopardy.

Therefore, the agency applied to Passport for a grant as part of the health plan's Improved Health Outcomes (iHOP) grant program, which provides one-year, \$50,000 annual grants for innovative programs that improve the health and well-being of Medicaid beneficiaries and people without health insurance in its 16-county service area. Passport awarded the grant at the end of 2008, and beginning in 2010, Louisville Metro EMS launched the Priority Solutions Integrated Access Management (PSIAM) initiative. The program serves the entire population of Louisville, regardless of individuals' insurance status.

A New Kind of Call Center

The program works as follows: When someone calls 911, a call center staffer asks a series of questions (based on nationally recognized clinical standards) to determine the severity of his or her condition. Based on this information, the caller is assigned a priority level of severity. People in life-threatening and emergency situations receive immediate service through the Louisville Metro EMS system, e.g., with response from a firefighter and/or ambulance.

People with conditions that do not constitute emergencies are transferred immediately to a PSIAM nurse, who serves as the hub of the system. He helps people remain calm, guides them to next steps, and helps them navigate the health care system. The nurse asks callers questions based on nationally recognized clinical standards to determine the most effective course of action. This could include, for example, seeing a physician within the next several hours or days.

If the patient has a primary care physician, the nurse can call the doctor to make an appointment on the patient's behalf. If the patient does not have a regular source of care, the nurse turns to the program's network of physicians, dental providers, urgent care centers, and federally qualified health centers to set up an appointment. The PSIAM nurse can help patients find primary care physicians and can arrange for transportation if necessary. And the nurse follows each case through to resolution—getting a contact phone number for each patient and calling back to ensure that he or she has received needed services.

Results

- In 2011, the program served more than 1,200 911 callers with non-emergency conditions, and it has served more than 2,000 callers since 2010. The program has been successful in identifying people whose needs do not require emergency care so that those with emergency needs continue to receive immediate assistance.
- From 2010 to 2011, the program saved patients an estimated 30 percent in medical transportation costs.



Passport Health Plan *(continued)*

Partnering with Emergency Medical Services to Transform 911

“Our triage nurses are not only medical professionals, but they’re care navigators, patient advocates, negotiators, transportation coordinators, salespeople—it’s a unique combination of skills. With a little guidance and confidence on our end of the line, most patients realize that it’s a tool that’s there to help them, not simply remove them from the 911 system.”

– Kristen Miller,
Chief of Staff, Louisville
Metro Emergency
Medical Services

- Based on the program’s success, Louisville Metro EMS made the program permanent at the end of Passport’s grant year. This year, Louisville was chosen as one of five cities across the country to receive a grant from the Bloomberg Foundation to fund innovative government projects that improve customer service. The grant will make it possible to expand the program, for example, by adding weekend hours; hiring a second full-time nurse; adding a phone line that people can call directly, rather than dialing 911; and adding case management for patients with chronic conditions who call 911 frequently.

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UPMC for You

Getting Children in Foster Care on Track for Good Health



Introduction

Organizing the health care of children in foster care is not easy. Foster children often have major unmet needs and are behind on immunizations and well-child visits. Their medical and dental records often are scattered among several clinics and doctors' offices. Their caseworkers from the county's Department of Children, Youth, and Families (CYF) are overburdened with the work they need to do just to keep children safe.

To improve the care of its 400 Medicaid members in Allegheny County, PA's foster care system, UPMC for You focused on two goals: (1) creating electronic health records (EHRs) for each child; and (2) providing county caseworkers with the information, support, and resources to make sure that children receive the care they need.

Developed and implemented by UPMC for You, the program received some initial support from the Annie E. Casey Foundation as part of a three-year project organized by the Center for Health Care Strategies (CHCS), a non-profit health policy resource center. The program was launched in 2008 and continues today.

Tracking Foster Care Placements in Real Time

UPMC for You's first step was to work with the county to speed up the process of notification when health plan members are placed in foster care. Previously, the health plan relied on information provided by the state Department of Public Welfare, which was not always timely. Under the pilot, UPMC for You reached an agreement with the Department of Children, Youth, and Families so that now CYF staff shares information with the health plan as soon as its members enter foster care. This allows UPMC for You and the county to begin immediately working together to coordinate children's care.

Using Electronic Health Records

Once children enter foster care, UPMC for You uses electronic records to keep close track of their health care. UPMC for You worked with its behavioral health division, Community Care, to develop electronic health records of each child's medical, dental, and behavioral health care. Once a month, UPMC for You sends EHRs for all children newly placed in foster care to the Allegheny County CYF. Every quarter, UPMC for You sends records for all of its Allegheny County members in foster care to CYF. These records become part of the children's agency files and provide a valuable reference for caseworkers, biological parents, foster parents, placement staff, and health care providers.

"Understanding Each Other's Worlds"

UPMC for You staff quickly recognized that to make the program successful, they would need not only regular electronic communication, but also regular conversations with caseworkers to build understanding and provide updates on children's health care needs. Caseworkers are the hub of the foster care system, but they have large caseloads which make it difficult to track the health care needs of individual children. The foster care world is completely different from health care, with different rules, priorities, and terminology. At the program's outset, UPMC for You set up a Foster Pilot Work Group that met with social service staff regularly so they could build strong working relationships.

UPMC for You staff also attended caseworkers' regional office staff meetings and distributed brochures to let them know about the program's goals and how UPMC for You could help. Health plan staff continues to hold bi-weekly troubleshooting meetings with the Allegheny County Department of Children, Youth, and Families to focus on addressing children's unmet needs.

UPMC for You (continued)

Getting Children in Foster Care on Track for Good Health

Ongoing Support and Help for Caseworkers

UPMC for You keeps in close touch with caseworkers, providing one-on-one support to help them arrange for children’s care. UPMC for You nurses and social workers (known as care managers) reach out to caseworkers at least weekly to let them know about needed well visits, chronic care, dental care, and behavioral health care for individual children. Care managers can help caseworkers find doctors, dentists, and behavioral health providers who accept their members, and they can set up transportation.

Caseworkers have responded positively to the outreach, often calling UPMC for You care managers to discuss cases and ask questions about the health plan’s network and benefits.

Engaging Birth Parents

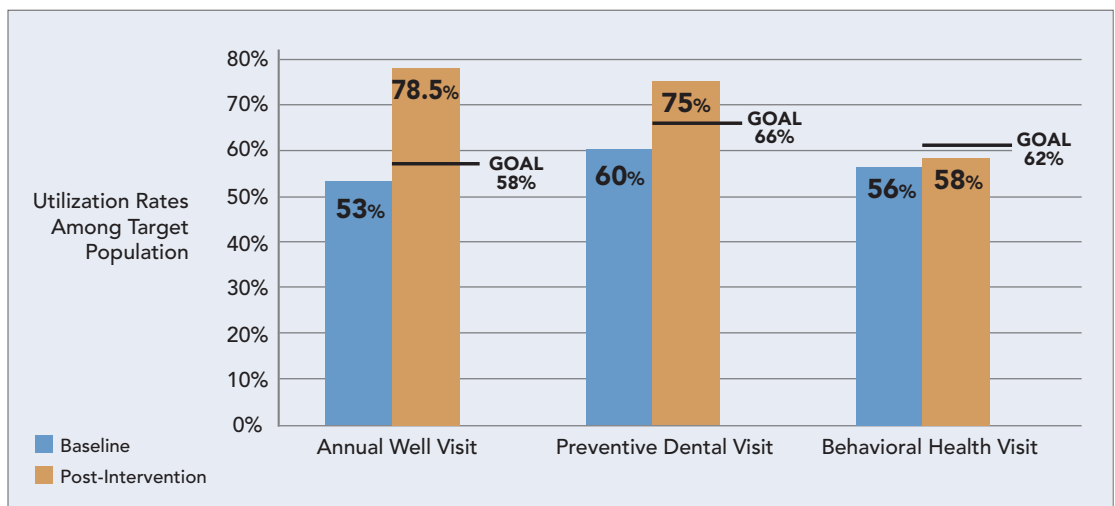
To get birth parents involved in children’s care, CYF caseworkers inform them about the

health plan’s benefits and services and can help with making appointments for well visits, behavioral health care, as well as treatments for conditions such as asthma and attention deficit hyperactivity disorder (ADHD). Caseworkers also can arrange transportation and go with families to appointments as needed.

Supporting Children Following Hospitalization for Behavioral Health

Based on the working relationship formed through the program, Community Care coordinates with CYF to access timely care for foster children following behavioral health hospitalizations. Within 24 hours of discharge, CYF notifies Community Care where children have been placed so that health plan care managers can quickly set up all of the outpatient care and community supports needed for a smooth transition and reduce additional hospitalizations.

Use of Health Services Among UPMC for You Members in Foster Care



Source: Allen, K.D. et al. (2012). *Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit*. Hamilton, NJ: Center for Health Care Strategies, Inc. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261349.

UPMC *for You* (continued)

Getting Children in Foster Care on Track for Good Health

Results

- UPMC *for You* has created EHRs for 100 percent of its Medicaid members in Allegheny County who are in foster care.
- From the year before the program was launched (2007-2008) to the year after (2009-2010):
 - The proportion of children in foster care with annual well-child visits grew from 53 percent to 78.5 percent—a 48 percent increase.
 - The proportion of children in foster care age 3 and older who had annual dental check-ups rose from 60 percent to 75 percent—a 25 percent increase.
 - The proportion of children newly placed in foster care age 5 and over who received needed behavioral health care within 60 days increased from 56 percent to 58 percent (a 3.6 percent increase). UPMC *for You* has since made a variety of changes to achieve greater improvement, including a change in the way it tracks needs for behavioral health care so that more children can access care in a timely manner.
- CYF caseworkers who previously had questioned the value of working with UPMC *for You* now collaborate regularly with the health plan's care managers and view them as a valuable resource in meeting foster children's needs.

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Volunteer State Health Plan

Creating a Rapid Response Team for Children in Foster Care

Introduction

When Volunteer State Health Plan (VSHP) began caring for Medicaid members in foster care in 2001, one thing was clear: the children's needs were many, varied, and complex. Therefore the health plan had to create a solution that covered all the bases: strong collaboration with the Department of Children's Services; early contact with foster parents and ongoing support; medical homes for children; timely preventive, primary, and specialty care; comprehensive care management for children with chronic medical conditions and/or behavioral health needs; support for children aging out of foster care; and the ability to respond on a moment's notice to the full range of often unexpected needs at any hour of the day or night.

The first step was to create the *SelectKids* Unit, which serves as a one-stop shop to address the needs of the health plan's 9,500 Medicaid members in foster care. Foster parents, Department of Children's Services staff, and primary care providers can contact *SelectKids* staff at any time to help with any issue, from obtaining identification cards to making appointments and arranging transportation to needed services.

Providing for the Full Range of Care

More than 800 physicians and nurse practitioners participate in VSHP's Best Practice Network (BPN) and provide medical homes for foster children. BPN care teams deliver comprehensive primary care, coordinate specialty and behavioral health care, and work continuously to improve the quality of care that children receive. VSHP provides specialized training to BPN doctors and nurses on topics that are important in the care of foster children, such as addressing behavioral

health challenges. BPN providers receive additional payments for care coordination.

SelectKids staff keep track of whether children have had timely immunizations and other preventive care, and they can help make appointments for these visits as needed. When children need specialty or out-of-network care, *SelectKids* staff can help find specialists and coordinate out-of-network benefits. If children have chronic medical or complex behavioral health conditions, *SelectKids* helps them enroll and participate in disease management and/or case management programs. VSHP's care managers, who are nurses and licensed behavioral health clinicians, maintain close contact with children's health care teams to plan for and coordinate their ongoing care.

Enabling and Supporting Use of Electronic Health Records

To help the professionals working with foster children stay informed about all of the services they have received, VSHP worked with Shared Health, Tennessee's largest public/private information exchange, to increase the use of electronic health records (EHRs) that the exchange had created for each child. The records include all information on children's diagnoses, medications and allergies, as well as their health care services.

As soon as a VSHP member enters the foster care system, Shared Health sends the child's EHR to the Department of Children's Services and then to the child's primary care provider. VSHP's goal is to have primary care providers and the Department of Children's Services staff review the records prior to foster children's first medical exams, to identify issues needing immediate attention.





Volunteer State Health Plan *(continued)*

Creating a Rapid Response Team for Children in Foster Care

Helping Foster Parents Keep Children's Records Organized

At the request of the Governor's Office of Children's Care Coordination and the State's Department of Children's Services, VSHP created Personal Health and Wellness History Notebooks for foster parents. Foster parents are using the notebooks to keep records and documents related to children's health, wellness, growth, and development, as well as children's VSHP identification cards. The notebooks include additional information for parents on topics such as time frames for check-ups and immunizations as well as VSHP contact information. Children take the notebooks with them when they move to new homes.

Coordinating Hospital-to-Home Transitions

Whenever a VSHP member in foster care is admitted to or discharged from a psychiatric hospital or residential facility, the health plan notifies the State's Department of Children's Services so that the department's psychologists, nurses, and health advocates can mobilize to plan for the child's next placement and work with VSHP care managers to arrange for all needed health and social services. VSHP's care managers lead conference calls including social service staff, health care practitioners, and caregivers to discuss complex care issues on a regular basis.

Addressing Emergency Needs at a Moment's Notice

Sometimes children enter foster care in dire situations, for example, after violent incidents in the middle of the night that require emergency care. VSHP's behavioral health professionals and nurses in senior leadership are ready to help in these situations, working with social

service staff to arrange emergency "safety" admissions to hospitals until the Department of Children's Services can arrange for appropriate care, for example, in specialized foster homes for medically fragile children.

In one case, a child who needed home medical equipment was taken into state custody late at night. The child's grandmother agreed to become his legal caregiver, but she lived far away and did not know how to use his medical equipment. VSHP arranged for the child to be admitted to the hospital until the grandmother arrived and learned how to use the equipment to care for the child safely at home.

Helping Children Who Are Aging Out of Foster Care

VSHP is working with community partners to provide a safety net for youth aging out of foster care. When VSHP members in foster care are six months away from their 18th birthdays, a team of VSHP medical and behavioral health care managers meet with the Department of Children's Services to set up Supplemental Security Income (SSI) benefits and line up all of the behavioral health and medical services they need. Medical care case managers help the teens make informed choices about their health care as they transition from pediatricians to internal medicine specialists. Behavioral health case managers help teens with behavioral challenges find supportive housing for independent living.

Partnering with Centers of Excellence to Address Complex Needs

When children in foster care or those at risk of foster care have particularly complex needs—most often in the area of behavioral health—VSHP consults with experts at one of five academic medical centers it has designated



Volunteer State Health Plan *(continued)*

Creating a Rapid Response Team for Children in Foster Care

as Centers of Excellence for Children in State Custody (COE). Children are referred to COEs, for example, if they are not making progress with their existing treatment plans, or if they have complex challenges related to psychiatric symptoms or trauma. COE specialists conduct in-depth assessments, including in-person evaluations and thorough reviews of children's medical, school, and psychiatric records. COE psychologists and psychiatrists make recommendations and work with VSHP nurses and social workers to develop care plans for each child. COE professionals are available to consult with children's behavioral health care practitioners on an ongoing basis and do additional reviews as needed. COE staff also provide training for physicians on effective ways to address trauma among foster children.

Results

- For the past four years, VSHP's three health plans have far exceeded the federal standard for well-child screening. Two VSHP plans achieved 100 percent scores in 2011.¹¹
- In 2011, VSHP's TennCare Select health plan, which includes children in foster care as well as other children with Medicaid coverage, received the highest score possible on an assessment of patients' care experiences—the "Best Overall CAHPS Award"¹²—from the Bureau of TennCare's Quality Oversight Division.

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¹¹ In 2011, two VSHP plans (TennCare Select and BlueCare West) achieved 100 percent screening ratios for providing required Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services to Medicaid members, including those in foster care. The third plan (BlueCare East) received a score of 95.79 percent. All VSHP plans were above the federal standard (80 percent) four years in a row.

¹² The Best Overall CAHPS award is given to the health plan with the most CAHPS scores at least one standard deviation above the statewide average. CAHPS stands for Consumer Assessment of Healthcare Providers and Systems, an initiative of the federal Agency for Healthcare Research and Quality (AHRQ) to support and promote the assessment of consumers' experiences with health care. TennCareSelect had 10 CAHPS measures meeting the criteria for the award.

Chapter 2: Addressing Obesity

This chapter profiles health plan initiatives to help beneficiaries lose weight and pursue healthy lifestyles. Health plans are offering life coaching, personal training, and support from case managers to help people who are overweight or obese follow nutrition and exercise recommendations. They are partnering with local community centers, schools, Boys and Girls Clubs, and churches to provide fun group exercise classes like Zumba® and water aerobics, as well as hands-on cooking demos and supermarket tours. One health plan created an exercise and nutrition DVD that parents and children can follow together. The plan also worked with a local police department to offer a fitness and nutrition class for youth.

Family, fellowship and community are central to the success of health plans' obesity-related programs. Health plans have trained community health educators, or *promotores*, to reach out to friends, family, and neighbors with practical information to address health problems like diabetes, obesity, and high blood pressure. One plan offers fitness classes for parents and children to take together. Another invites families to attend special class celebrations. Members encourage and support each other in nutrition and weight loss classes and form lasting friendships. Many keep in touch with each other outside of class and continue to exercise together and socialize long after classes end.

In the pages that follow, we show how these programs have worked to yield positive results—with people exercising more each week, improving their diets, reading food labels, and achieving reductions in weight, body mass index, and blood sugar levels.



Health Net®

Health Net

Making Fitness a Family Event

Introduction

In over a decade of working with Medicaid members to overcome obesity, the most valuable lesson that Health Net learned was about family. Family relationships determine when and how people exercise and eat. Busy parents often don't have time to go to the gym regularly. They may not know how to read food labels or how to cook healthy meals.

Health Net used to offer Medicaid members weight loss classes and refer them to community groups for support. But they found that approach wasn't nearly enough to help busy parents and kids lose weight. The solution was Fit Families for Life, a family fitness program launched in 2006. Fit Families for Life reaches members in the places where they spend the most time: at home and in their neighborhoods, schools, youth groups, churches, and community centers. Health Net spreads the word through family doctors, community leaders, health educators, and even the local police department.

Fit Families for Life Home Edition

The core of the program is the Fit Families for Life Home Edition, which includes a family-centered DVD and workbook. The DVD, designed for parents and children to watch together, offers suggestions for good nutrition—such as reading food labels and adding fruits and vegetables to meals—and includes a series of 10-minute segments with easy-to-follow exercises. It includes a special section just for teens. The DVD is available in English and Spanish, as well as with closed captioning and sign language interpretation.

The Fit Families for Life workbook, also in English and Spanish, guides people through a process

of setting goals and taking steps to meet those goals. Each week, people are given a list of ideas for healthy eating and physical activity, and they check off activities that they plan to do that week (e.g., “Instead of lard, use a little corn or canola oil,” “Go out for a walk or run with your neighbors.”). At the end of the week, members indicate whether they did the things checked off on the list. If not, they write down the reasons why, and they list changes they will make the next week to be more successful.

Community Fitness Classes

Parents living in the communities where Health Net operates are invited to bring their children to the health plan's free fitness classes at community centers, schools, and doctor's offices. Based on information in the Fit Families for Life Home Edition, classes run for three weeks and include cooking demos, fun group exercise, and interactive learning about how to eat healthy, read food labels, and fit physical activity into busy schedules.

Fit Families for Life Coaching

Health Net offers extra support for children and adults who are obese (members age 6-20 with a body mass index (BMI) at or above the 95th percentile). With a doctor's recommendation, these members (along with parents or guardians if they are under 18) can have five scheduled phone calls with health coaches. Coaches listen to members' concerns and challenges. They offer counseling, provide advice, and help members follow the steps outlined in the Fit Families for Life Home Edition materials to eat healthy and exercise more. They also can help members find other support in their communities, such as ongoing behavioral health counseling.





Health Net®

Health Net *(continued)*

Making Fitness a Family Event

“What I like about the Health Net Fitness Club is it is fun and helps you get in shape. You get rewards [for good achievement] in the program and you get to do a lot of activities with all the teachers.”

– Sergio, a participant in Health Net’s Club Fitness

Club Fitness

This four-week interactive educational program is designed for youth ages 9-13 who want to learn healthier habits or who are at risk for being overweight or obese. Club Fitness is conducted in partnership with schools, local Boys and Girls Clubs, and faith-based communities in Sacramento and Stanislaus Counties. Club Fitness engages families in a series of after-school activities twice a week that include interactive nutrition games and cooking demos, as well as physical activities such as Zumba^{®13}, jump rope, soccer, and kickboxing. Parents are required to attend two presentations to learn about the program’s goals, talk with motivational coaches, and participate in bilingual cooking demos. The program ends with a graduation ceremony attended by parents and school principals. In 2011, the graduation also featured a healthy food celebration and a special guest appearance by a member of the Sacramento Kings basketball team.

Fit Families for Life in the Community

Promotores

Health Net’s community health educators, or *promotores*, are teaching their friends and neighbors about Fit Families for Life. *Promotores*, who are often Medicaid beneficiaries themselves, have special training on health topics and community outreach. They reach out to people at school meetings, churches, neighborhood gatherings, health fairs, and one-on-one casual conversations and tell them where they can find help for health problems such as obesity, diabetes, and high blood pressure and how to sign up for Fit Families for Life.

The Los Angeles Police Department

In 2011, the Los Angeles Police Department’s Hollenbeck Police Activities League (PAL) worked with Health Net to offer a 12-week Fit Families for Life class for youth members of the PAL. Families were encouraged to attend the classes, which covered topics such as portion control, tips for eating out, adding fruits and vegetables to everyday meals, exercise, and strength training. With funding from Health Net, the PAL program is producing an hour-long documentary about child obesity from the perspective of low-income youths in an East Los Angeles neighborhood. The documentary follows youths in their efforts to understand the causes of child obesity, and it describes community programs, including Fit Families for Life, that can help.

Results

Fit Families for Life Home Edition

In 2011, 510 Medicaid members were enrolled in the Fit Families for Life Home Edition. After completing the program:

- Eighty-four percent said they improved how often they read nutrition labels.
- One hundred percent said they ate more fruits and vegetables each day.
- Sixty-one percent said they exercised more.
- One hundred percent said they increased how often they ate meals together as a family.

Community Fitness Classes

Health Net held 65 three-week family fitness class sessions in 2011.

- The proportion of people who answered questions about food labels correctly increased from 35 percent before completing the classes to 69 percent after.

¹³ Zumba Fitness[®] combines dance, exercise, and international music to create a fun “fitness party” experience.



Health Net *(continued)*

Making Fitness a Family Event

“I feel more energetic, healthier, happier, and even younger!”

“My eldest sister died of diabetes. I can’t even think about it because it’s so painful. I don’t want that to happen to me... Thank you Health Net because they are here in our community.”

– From two participants in Fit Families for Life who were featured in LAPD Hollenbeck PAL’s *Happy Planet* documentary

- The proportion of people who said they exercised a half-hour or more each day rose from 47 percent before taking the classes to 64 percent after.

Fit Families for Life Coaching

In 2011, 221 Medicaid members participated in the Fit Families for Life Coaching program. Of these:

- Seventy-eight percent of participants increased their levels of physical activity and reduced screen time.
- An estimated 73 percent improved their ability to read nutrition labels.
- Seventy-five percent learned how to make healthier breakfasts with fruits and vegetables.

Club Fitness

A 2010 survey of Club Fitness participants in Stanislaus County found that:

- Ninety-five percent increased their knowledge of nutrition and fitness activities that best fit their lifestyles.

- Eighty-two percent said they could identify false perceptions of beauty in the media and had improved their self-images.

The Promotores Network

- Since 2009, Health Net has trained more than 250 *promotores*.
- *Promotores* have reached out to more than 400 friends and neighbors with information about health and support programs available in their communities.
- In 2011, *promotores* coordinated a community event where more than 200 people received blood pressure screenings.

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Health Partners

Giving People the Tools for Healthy Living



“We have been given a valuable tool that has ignited and enriched our lives. This program has made us all knowledgeable of the importance of life, health, and the pursuit of happiness. We are now determined to live by choices, not chances.”

– Thelma Wilson,
participant in Health
Partners’ Biggest
Winner program

Introduction

Dealing with major life challenges like drugs, violence, and unsafe living conditions, many of Health Partners’ members have little time to think about taking care of themselves, eating healthy, and watching their weight. Often they do not have easy access to healthy foods or safe places to exercise. Many find themselves overweight and at risk for diabetes, high blood pressure and heart disease. The Health Partners Biggest Winner nutrition program, launched in 2009, is giving these members the tools to live healthier lives and lose weight.

Giving People the Tools for a Healthy Weight

The 13-week session—conducted in Spanish and English—meets once a week for 2½ hours in several locations in the Philadelphia area. During the classes, members learn how to read food labels and pay attention to calorie counts and salt content. They participate in weekly cooking demos and prepare food for each other. They tour supermarkets and learn to replace unhealthy food items on their shopping lists with healthy yet tasty options. Participants learn exercise routines they can do at home, and they tour a local fitness center that they can join at no cost once they have completed the class’s initial requirements.

Making New Friends

Meetings are held in an open discussion format so that people can share their struggles and challenges. Members offer each other support and encouragement both during and after class sessions. Many class participants keep

connected by phone, e-mail, and text. Many form such strong bonds that they don’t want the sessions to end. Members often join Weight Watchers and fitness centers together following the class sessions.

Results

The number of people signed up for The Biggest Winner program grew from 19 in 2009 to 62 in 2011. Of the 62 people enrolled in the program in 2011, 46 completed it.

Most people who finished the program lost weight and reduced their triglyceride and/or blood sugar levels.

- Among people who lost weight, the average weight loss was six pounds. The greatest weight loss was 22 pounds.
- Among those who lowered their triglyceride levels, the average reduction was 38 points.
- Of those who reduced their blood sugar levels, the average reduction was more than five-tenths.

The program is continuing to grow. More than 100 people participated in the Spring 2012 session of the Biggest Winner.

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Keystone Mercy Health Plan

Empowering People with Type 2 Diabetes to Lose Weight



“I’ve lost weight. I got my sugars down...I’ve met some great people, and it’s just been a great experience, it really has.”

– Rose, “Lose to Win” participant

Introduction

There are certain tried-and-true tools to help people with obesity and diabetes lose weight: personal action plans; health coaching; exercise classes; nutrition demos; and supermarket tours. But in Keystone Mercy Health Plan’s Lose to Win program for Medicaid members, it all came down to one thing: relationships. Close friendships that formed with their fellow classmates. Relationships that program participants had with health plan staff. And support from their families and friends.

The challenges were daunting. Thousands of the health plan’s Medicaid members were overweight and suffered from diabetes that was out of control. They didn’t have money to join fancy gyms or sign up for weight loss programs. Many didn’t know how to read food labels or make healthy meals for their families. And they lived in inner-city Philadelphia, far from safe parks and other recreation areas.

To address these challenges, Keystone Mercy launched the Lose to Win program, a 12-week health education and awareness program for adult Medicaid members with Type 2 diabetes and obesity. The program ran from September 2009-March 2010, and Keystone Mercy is seeking funding to offer it again in 2013. The program’s goals were to teach members healthy habits and strategies to manage their diabetes; increase people’s physical activity so they could lose weight; reduce members’ LDL (“bad”) cholesterol levels and body mass index (BMI); and reduce the need for emergency room use and hospital admissions.

Finding People Ready to Change

To have the greatest possible impact, the health plan decided to focus on Medicaid members with diabetes that was out of control (with HbA1c levels above 9), who were more than 30

pounds overweight, and who were ready to make the lifestyle changes needed to improve their health. Keystone Mercy’s outreach staff called more than 4,000 people who met the health and weight criteria and asked questions to evaluate their readiness to change. Of these, the health plan identified 200 members and offered them the opportunity to sign up. A total of 137 people enrolled in the program, and 115 completed it.

Building Enthusiasm from the Start

Keystone Mercy set the tone for the program with a fun kick-off event at a local park. People were invited to attend with their families. They participated in fitness activities and got to know their fellow participants. At the same time, Keystone Mercy took initial measures of people’s weight, blood sugar levels, cholesterol, and BMI.

One-on-One Support

After the kick-off event, each person received a call from a nurse case manager, who talked about managing diabetes and developing a care plan. Case managers worked closely with members’ primary care doctors in designing personalized care plans. Additionally, case managers touched base with program participants at least once a week to talk about their progress. If people had missed one of the programs’s meetings, case managers called to find out why, offer encouragement, and provide any support they needed to attend the sessions, for example, by setting up transportation or child care.

Building Fellowship

Lose to Win participants were encouraged to visit their local Philadelphia-area YMCA three times a week. During these sessions, participants worked with personal trainers to develop and follow personal fitness regimens. During other meetings, they engaged in fun exercise activities such as Zumba, water aerobics, and

Keystone Mercy Health Plan *(continued)*

Empowering People with Type 2 Diabetes to Lose Weight

*“I feel good.
I feel energized.
I feel stronger
than I have ever
felt in years.”*

– Ida, “Lose to Win”
participant

*“It was all
about human
relationships.
HbA1c levels
are measurable,
but really seeing
people develop
relationships
among
themselves, with
the wellness
coaches, with
case managers,
really allowed
them to develop
a sense of
empowerment.”*

– Dr. Glenn Hamilton,
Senior Medical
Director, Keystone
Mercy Health Plan

line dancing. Group sessions were also offered to help members share their feelings, talk about their challenges, and offer emotional support. Members also had the opportunity to participate in “special activities,” including supermarket tours and cooking demos. Special activities were voluntary but strongly encouraged. Throughout the program, Keystone Mercy monitored participants’ blood sugar levels and sent copies of lab reports to their primary care doctors.

In the beginning of the program, Keystone Mercy’s case managers made a lot of phone calls to remind people to attend sessions. But according to Keystone Mercy’s Senior Medical Director, Glenn Hamilton, after a few weeks, “they were hooked” on the program and didn’t need more reminders.

Dr. Hamilton noted that one of the most encouraging parts of the program was the high level of camaraderie that developed. People supported and encouraged each other to exercise and lose weight. They exchanged contact information and walked together to some of the program’s activities. People made friends through the program and began bringing their families to the gym. Their motivation and commitment continued to grow.

Members also formed strong bonds with Keystone Mercy staff. One man invited Dr. Hamilton to speak at his church about fitness. Other members encouraged the program’s coordinator, Tonya Moody, to work out at the gym with them, and she did.

A Celebration of Success

The program’s final activity, filmed by a local TV station, was a celebration and group Zumba session at a local community center. Families were invited, and members had the opportunity to talk about their experiences.

People were praised for their accomplishments, and all participants received a free one-year membership to the YMCA. People who lost the most weight received awards.

Staying in Touch

Energized by the experience, several members volunteered to be leaders and role models for new participants when the program starts again in 2013. Keystone Mercy staff stay in touch with these leaders, several of whom now serve on the health plan’s Education Outreach and Advisory Committee. The committee gives members a voice in designing the health plan’s community-based outreach programs.

Results

Among the 115 people who completed the program in 2010:

- The average weight loss was 10-15 pounds.
- BMI levels improved by an average of 3.78 percent.
- HDL (“good”) cholesterol levels rose by an average of 5.5 percent.
- The total cost of diabetes care fell by 12.1 percent.

A Keystone Mercy survey following the program found that members’ knowledge about nutrition and healthy food had increased. Additionally, most members reported an increase in regular exercise and an overall commitment to a healthier lifestyle.

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L.A. Care Health Plan

Engaging Community Members to Improve Their Health



"I...took the [Zumba] classes because I wanted to lose weight, and since I started, I lost 30 pounds. So now I... started training and learned the Zumba steps, and now I'm teaching the classes."

– Wendy Ruiz,
participant in
L.A. Care's
Nutrition and
Zumba class series

Introduction

"Meeting people where they are" is the guiding principle behind L.A. Care's grass roots education initiative, called the Community Health Improvement Project (CHIP). The program, established in 2009, is helping L.A. Care members and others in their communities lose weight, manage their asthma and diabetes, take action to prevent breast cancer, deliver healthy babies, and live healthier lives. All of L.A. Care's members have low incomes, and most are Medicaid beneficiaries.

Given the cultural and geographic diversity of the Los Angeles County service area, the leadership of L.A. Care Health Plan realized that a very personalized, community-based approach was needed. That meant giving members a voice in setting up programs and listening to their advice on how to continuously improve. It meant making health education engaging and accessible. And it meant doing outreach in a new and highly personal way, with peer-to-peer health educators, who talk to their friends and neighbors about how to stay healthy and manage chronic disease.

Eyes and Ears and Zumba!

L.A. Care's Regional Community Advisory Committees (RCACs)—comprised of L.A. Care's Medicaid members, as well as doctors, nurses, other health care providers, and community representatives—serve as the plan's "eyes and ears." The committees meet every other month to tell health plan leadership what it is doing right, what needs improvement, and which additional services or programs would be helpful. RCAC members receive training on health topics such as pre- and post-natal care and adolescent well care. And they do outreach and health education to their peers on these topics at bus

stops, school events, family reunions, community festivals, baby showers, and their friends' homes. They encourage people to see their doctors, hand out information sheets on community resources, and help members find care at local clinics.

At the suggestion of L.A. Care members, in 2011 the RCACs piloted a popular *Nutrition and Zumba Series*, to help members and others in the community get fit and manage their diabetes and heart disease. Certified fitness instructors led the Zumba class, and dieticians did food preparation demos and discussed good nutrition. Classes—which met for 2½ hours a week for six weeks—were interactive, high-energy, and engaging. The response was overwhelming, with many members calling to find out when the next series would be offered. L.A. Care has expanded the program and now offers a series of 16 classes in each of its 11 regions.

Free Classes in the Community

L.A. Care offers members free health education classes in recreation centers, community centers, and senior centers on topics such as asthma, hypertension, cholesterol, prenatal care, cancer screening, and what to do when a child is sick.

Reaching Out to Friends and Neighbors

More than 40 L.A. Care members serve as Health Promoters, reaching out to friends and neighbors with actionable information and helpful hints on topics as wide-ranging as managing diabetes, healthy eating, finding a doctor, and understanding health care reform. Health Promoters receive 40-80 hours of training on each topic, and they offer one-on-one and group education to their peers in the community on an ongoing basis. Health Promoters are well-versed in the health and social services available in



L.A. Care Health Plan *(continued)*

Engaging Community Members to Improve Their Health

“...I was a person that couldn’t get out of bed without help. I had to call my children so that they could help me turn over... and put my feet down in order to get up! But now, the little exercise I do here...and the changes I have made in how I cook my meals are really helping a lot...”

– Unidentified participant, Nutrition and Zumba class series

their communities, and they can guide members to clinics, local agencies, and other sources of assistance. Members have a special bond with Health Promoters, who speak their native languages,¹⁴ live in their neighborhoods, and share their cultural backgrounds, perspectives, and concerns.

Results

Grass Roots Education

- The Community Health Improvement Project has reached more than 79,000 Los Angeles community members since 2009.

Nutrition and Zumba Class Pilot

- More than 415 people participated in the Nutrition and Zumba pilot program at a total of 11 Los Angeles County locations. Sixty percent of participants completed the entire program.
- Average weight loss for participants in the class ranged from 0.2 to 12.6 pounds, with an overall average of 4.2 pounds in six weeks.

- Test scores demonstrating participants’ knowledge about nutrition and physical activity increased by nine percentage points (from 76 percent to 85 percent) after completing the program.
- Ninety-eight percent of participants in the series rated their experiences as good or excellent, and 93 percent said they would recommend the class to others.

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¹⁴ L.A. Care provides interpreter services in more than 180 languages and a complete range of patient information in the 10 threshold languages spoken by members: English; Spanish; Armenian; Chinese; Vietnamese; Korean; Tagalog; Khmer (Cambodian); Russian; and Farsi. L.A. Care’s member and health education materials are also available in Braille and audio format.

Chapter 3: Caring for People with Complex Needs

In this chapter, we describe health plans' strategies to help beneficiaries manage a wide array of complex needs at all stages in life. One health plan provides extensive information and support to women and their families during high-risk pregnancies, in neonatal intensive care units, and at home caring for babies with serious health conditions and disabilities. Another health plan is helping adults make smooth transitions from psychiatric hospitals to home. A third offers intensive care management to help people set goals for their health; organize their care; and find access to resources such as affordable housing, alcohol and substance abuse treatment, community support groups, and child care. Another is coordinating with the State of Tennessee to help seniors and members with disabilities set up the long-term care arrangements and support services that work best for them.

Several health plans offer frail seniors one-on-one, personalized guidance from nurses and social workers, who do whatever it takes so that people can live safely in their homes. This ranges from explaining complex care instructions to having area rugs removed to prevent falls. It means arranging for home-delivered meals; coordinating personal care assistants to help with bathing, dressing, and cooking; making sure people can get doctors' appointments quickly and setting up no-cost transportation; scheduling consultations with nutritionists; and even finding people to mow lawns and shovel driveways.

These programs are making it possible for millions of people to remain healthy in their homes and communities while avoiding unnecessary hospital admissions, readmissions, and nursing home stays.



Aetna

Reaching Out to Medicaid Members with Support to Match Their Needs



Introduction

Aetna's Integrated Care Management program for Medicaid members means different things to different people. For people who have relied mainly on emergency rooms for care and who have multiple chronic medical and behavioral health conditions, the program is a life line to licensed (nurse or behavioral health) care managers who can help them organize their care and work one-on-one to help them live healthier lives. For people in good health who have not had check-ups or annual flu shots, the program can be as simple as a few phone calls to help set up appointments and arrange rides. For people with diabetes or other chronic illnesses, it can mean help with finding doctors and periodic phone calls to check on their needs.

When Medicaid members join Aetna, the health plan reviews their health histories and past use of hospital and emergency room care. Aetna nurses, social workers, and other professionals reach out early to people based on their identified level of need. People with the most extensive needs—who may, for example, be homeless and have substance abuse problems besides having heart and lung conditions—are paired immediately with professionals who can help.

Intensive Care Management

Through Aetna's Intensive Care Management program, nurses and licensed social workers serving as care managers seek first to understand the full range of challenges people are facing and identify the root causes of their health problems. For example, a care manager

could explore the reasons why someone was not going to the doctor for diabetes-related care and find out it was because he was afraid to leave his apartment.

Care managers help people work through challenges—such as overcoming fears that interfere with healthy living, or finding safe housing, food pantries and rehabilitation programs for alcohol and substance abuse—so that they can begin to address their medical conditions. Care managers often come from the same communities and share the same cultural backgrounds as the people they serve, and this common ground helps build mutual understanding and trust.

Nurses and licensed social workers in the Intensive Care Management Program do in-depth interviews with people to find out their health-related goals, priorities and motivations, and they work closely with members to achieve these goals. Care managers serve as Medicaid members' single point of contact to all of the health care, social services, and behavioral health care they need and can guide people to a broad range of resources in their communities, such as church-based support groups, low-cost transportation, affordable child care, Alcoholics Anonymous meetings, community mental health centers, and more.

Care managers interact with people in person and by phone. Medicaid members in nursing homes and those receiving long-term care in community settings meet face-to-face with care managers.



Aetna *(continued)*

Reaching Out to Medicaid Members with Support to Match Their Needs

“A pregnant woman...was prescribed bed rest and didn’t do it, because she needed to walk her children to the bus every day. Instead of making her feel bad for not following the doctor’s treatment plan, the case manager listened to her and found out that she didn’t feel safe having her boyfriend do it... She was risking a preterm delivery by walking her kids to the bus. The case manager helped her to find a neighbor to walk her children to the bus.”

– Dr. Judith Chamberlain, Senior Medical Director, Aetna, giving an example of the types of issues Aetna case managers address through the Integrated Care Management program

Nurses and social workers in the Intensive Care Management program coordinate with a team of professionals, such as primary care doctors, psychiatrists, nutritionists, pharmacists, and others, to address a variety of member needs. Care managers regularly consult with team members and a physician medical director to get advice on handling the most difficult challenges and share information about strategies that have worked to improve people’s well-being.

Supportive Care Management

For Medicaid members with more limited needs—for example, people who have not had annual check-ups or individuals with diabetes who are not having their blood sugar monitored regularly—Aetna’s outreach staff provides Supportive Case Management. Through this program, licensed professionals can help members find and make appointments with primary care physicians, link members to disease management services, and make sure that they receive the care they need. Aetna staff call members periodically to check in and can help members access Intensive Care Management if their needs change.

Aetna continuously monitors Medicaid members’ hospital admissions, readmissions, and the use of emergency rooms to find additional people who could benefit from either Intensive or Supportive Care Management, and outreach staff offer them the opportunity to enroll. Doctors and social workers can refer Medicaid beneficiaries to the program, and members can self-refer.

Results

- As of March 2012, 3,500 Medicaid beneficiaries in five states (AZ, DE, IL, TX, and VA) participated in Intensive Care Management.
- By mid-2013, Aetna will offer Intensive and Supportive Care Management to Medicaid members in 10 states (AZ, DE, MD, FL, VA, TX, CA, IL, MO, and OH).

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Affinity Health Plan

Easing Transitions from Psychiatric Hospitals to Home



Introduction

Medicaid beneficiaries who are discharged from psychiatric hospitals often have ongoing needs and don't know where to turn for help. They may not have transportation to follow-up doctor visits. They may not know how to take their medications or what to do about potential side effects. They may not know about the support services available in their communities. The Home-Based Therapy Program (HBTP) run by Affinity Health Plan's behavioral health partner, Beacon Health Strategies (Beacon), provides a safety net during this time of uncertainty. Social workers and psychiatrists reach out to people early and provide the help they need to live safely and independently at home.

Checking in with Patients in the Hospital and at Home

When a Medicaid member is admitted to a psychiatric hospital, he or she receives a letter from Beacon that describes the Home-Based Therapy Program and offers the opportunity to enroll. Members who agree to participate in the program can meet with HBTP social workers or psychiatrists in the hospital to talk about plans following discharge, ask questions, and discuss how to get any help they may need at home. Patients who do not enroll in the program while in the hospital receive letters at home offering the chance to participate.

As part of the program, HBTP social workers or psychiatrists meet with members at home to check on their safety and determine how they are functioning on their own. During their visits, they go over members' discharge instructions, encourage them to follow treatment plans, and make sure that they have 30-day supplies of their medications.

Meeting a Variety of Needs

HBTP social workers and psychiatrists work with Affinity to set up transportation to doctor visits as needed, and they are prepared to find solutions to many different kinds of problems—even helping a recent immigrant find a crib for her twin babies. Program staff coordinate with Affinity pharmacists and doctors' offices to help patients resolve any difficulties in filling prescriptions, taking medications, and keeping follow-up appointments.

People with continuing needs can receive additional support through Beacon's intensive case management program. Case managers provide ongoing guidance and help with any aspect of members' care, which could include, for example, helping members access food from local food banks, treatment for alcohol or substance abuse, as well as community support groups. Medicaid members can call Beacon's toll-free number at any time, and Beacon's clinicians are available 24/7 to help with any issue, whether it's resolving a crisis (for example, sending help immediately if a member feels at risk of harming himself or others), answering questions about coverage, or helping patients find doctors close to home. From 2009-2011, the number of people referred to the program rose from 207 to 805.

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Amerigroup Corporation

Creating More Choice for Seniors and People with Disabilities

Introduction

Ask seniors and people with disabilities in the Medicaid program what they want most, and the answer typically comes down to one thing: choice. The choice to live at home. The option to hire assistants or use a home care agency. And the freedom to go out anytime, anywhere. Yet these options generally have not been available to people in the Medicaid program who need long-term care.

Tennessee's Medicaid long-term care CHOICES program has changed all that. Launched in 2010, the program allows elderly beneficiaries and individuals with disabilities to make the decisions about how to live their lives and at the same time improves access to long-term care services.

Finding What Works Best

Amerigroup Corporation, one of three health plans participating in the Medicaid long-term care CHOICES program,¹⁵ works closely with seniors and members with disabilities to find the living options and support services that work best for them. Amerigroup's care coordinators—nurses and social workers—meet with beneficiaries to evaluate their needs, functional abilities, and preferences for care.

To get help with daily activities like bathing, cooking, and dressing, seniors and people with disabilities can work with home care agencies or hire personal care aides directly, through the program's Consumer Direction option.

Consumer Direction

Prior to 2010, Medicaid budget rules generally required everyone needing 24/7 care to live in nursing homes. Consumer Direction now allows them to get the help they need while living at home.¹⁶ Seniors and people with disabilities participating in Consumer Direction interview, hire, and supervise their personal care aides, while a fiscal intermediary working with Amerigroup handles the actual payments. Total costs are far less than that of nursing home care. The fiscal intermediary also provides support staff to help people advertise, set up and participate in interviews, and manage workers. People also can appoint representatives, such as family members, to help.

Whereas home health aides hired through agencies generally do not take people outside their homes, personal care aides hired through the Consumer Direction option can help people go out whenever they want. Consumer Direction enables people like Lorri, an Amerigroup member born with cerebral palsy, to lead an active lifestyle that includes going to work and competing in bowling tournaments.

Ongoing Support

Amerigroup's care coordinators keep in touch with members regularly to make sure they can access all of the medical, behavioral health, and long-term care services they need. They help members follow care plans, and they re-evaluate members' needs at least once a year but also whenever there are changes in health or functional abilities. People can contact care coordinators for help any time.



¹⁵ UnitedHealthcare and BlueCross BlueShield of Tennessee also participate in the program.

¹⁶ Under Tennessee Medicaid's home- and community-based waiver, Medicaid covers home- and community-based care as long as the cost is equal to or less than the cost of nursing home care. The cost of 24/7 care provided through a home care agency exceeds the cost of nursing home care. But when people hire workers directly, they avoid the overhead costs of agency care, and total costs are lower.



Amerigroup Corporation *(continued)*

Creating More Choice for Seniors and People with Disabilities

"It gives me more freedom."

– Lorri, an Amerigroup member with cerebral palsy who participates in the Consumer Direction component of Tennessee's long-term care CHOICES program

"Lorri is very active. She has a lot of energy. She loves bowling..."

– Eryn, Lorri's personal care aide

Results

- From March 2010 through April 2012, the number of Amerigroup members in Tennessee's long-term care CHOICES program grew from approximately 4,000 to 5,100, and the proportion of its CHOICES members living in the community grew from 18 percent to 35 percent.
- In 2012, about seven percent (120) of Amerigroup's 1,700 CHOICES members who were living in the community managed their own services through the Consumer Direction option.
- The average monthly cost for each member in a nursing facility is \$4,000-\$5,000 per month, almost double the average cost of providing services for members in the community. Because Tennessee Medicaid has been able to provide long-term care at a much lower cost in community settings, it covers more people than ever before and has eliminated the waiting list for long-term care services.

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CareMore

Teaming Up to Care for Frail Seniors



Introduction

Caring for frail people with chronic illnesses is anything but simple, but CareMore's¹⁷ one-stop shopping approach makes it as simple as possible. CareMore has developed a comprehensive model of care for eligible Medicare Advantage members, including those also covered by Medicaid, who have multiple chronic conditions.

Recognizing that effective care for people with chronic conditions takes more than visiting a doctor regularly, CareMore developed care centers where members can participate in disease management programs and gather educational materials in addition to receiving primary and preventive care. Nurse practitioners at the centers work to develop personalized care plans to address members' medical, functional, behavioral health, and social service needs early, to prevent greater health problems in the future. Patients receive care from teams of professionals that include nurse practitioners, social workers, nurse care managers, and medical assistants. Electronic health records make it possible for doctors, nurses, and other members of patients' care teams to view the most updated information on patients' care. Each center also includes a gym where individuals can participate in exercise routines specific to their functional status and disease.

Closing the Communication Gap

Team members communicate regularly, and if problems come up (e.g., if patients' symptoms get worse), patients see their doctors right away. Nurse care managers can help patients get appointments with specialists within an hour, and when patients are seeing multiple doctors, nurses coordinate care.

Helping Patients Make Lifestyle Changes

Members of CareMore-affiliated plans participate in intensive programs to help them manage chronic conditions such as heart failure, end-stage renal disease, chronic kidney disease, chronic obstructive pulmonary disease, high blood pressure, and diabetes. Nurses give patients detailed information about their conditions and help them make lifestyle changes, like quitting smoking, increasing exercise and eating healthier diets, to improve their health. Each member is encouraged to develop and follow a personal nutritional plan with a CareMore nutritionist. Nurses check in with patients regularly about their progress and help them overcome challenges in following care plans.

Being There to Handle Any Need

CareMore nurse practitioners provide extensive and ongoing support to help patients and their caregivers handle any need that arises. For example, they can arrange for no-cost transportation to doctor appointments. They can have foot doctors trim toenails. When patients have urgent medical needs but can't leave home, CareMore's nurses arrange for house calls by doctors and nurse practitioners.

Tracking Patients' Health at Home

Patients with high blood pressure, heart failure, and diabetes use electronic scales at home to check their weight and vital signs every day. Results are transmitted in real time to CareMore's nurse practitioners. If patients gain weight or experience other changes suggesting that their health has declined, nurses alert their doctors so they can take immediate action.

¹⁷ CareMore is a subsidiary of WellPoint, Inc.



CareMore *(continued)*

Teaming Up to Care for Frail Seniors

“John’s doctors sent someone from the clinic to analyze his home and made sure his vintage carpets from the 1980s were replaced with low rugs. And now John also regularly visits the clinic for light muscle-strengthening sessions and toenail clippings. CareMore helps make sure the seemingly little things in life don’t become big challenges to our members’ health and quality of life.”

– Dr. Sam Nussbaum,
Executive Vice President
for Clinical Health Policy
and Chief Medical
Officer, WellPoint, Inc.

Taking Care of Patients During and After Hospital Stays

When a member is hospitalized, a CareMore physician, called an extensivist, works with other specialists in the hospital to coordinate care. Extensivists visit patients at home or in nursing homes after they are discharged to help them understand and follow care plans. They also work with care managers to ensure that patients have their follow-up doctor visits within a week of being discharged. Extensivists and nurses check regularly to make sure that patients are taking their medications correctly.

Results

- CareMore provides care to 76,000 Medicare Advantage members in CA, AZ, and NV. Additionally, Anthem Blue Cross Blue Shield offers the CareMore model in some Richmond, VA Medicare Advantage plans, and Empire BlueCross BlueShield offers it for some Medicare Advantage members in Brooklyn, NY. Sixty percent of CareMore members have chronic conditions or are in frail health, and 20 percent are covered by both Medicare and Medicaid.
- The hospital admission rate for CareMore members is 24 percent below the national average, and hospital lengths of stay are 38 percent shorter.
- The 30-day hospital readmission rate for CareMore members is 13 percent (10 percent when measured on a risk-adjusted basis), compared with 20 percent in the overall Medicare population.

- The amputation rate for CareMore members with diabetes who have wounds is 60 percent less than the national average.
- CareMore’s most recent patient satisfaction survey found that 97 percent of patients are very satisfied or somewhat satisfied with their health plans, and more than 80 percent have recommended the company to friends.
- On the 2009 Annual Consumer Assessment of Healthcare Providers and Systems (the Agency for Healthcare Research & Quality’s survey on patients’ experiences with health care), CareMore scored 8.81 out of 10. The national average is 8.47, and the California average is 8.57.
- CareMore’s California and Arizona plans have achieved a Four-Star rating from the Centers for Medicare & Medicaid Services (CMS).¹⁸

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¹⁸ CMS rates Medicare health plans on their performance in five categories: (1) preventive care such as screenings, tests, and vaccines; (2) managing chronic conditions; (3) member experiences; (4) member complaints; and (5) customer service. Health plans can earn between one and five stars, with five representing “excellent.”



CareSource

Supporting Families through High-Risk Pregnancies and Beyond



Introduction

In working with Medicaid members with high-risk pregnancies, CareSource has found that the key to achieving good health for the whole family is to reach out early and often. As soon as CareSource learns of a Medicaid member with a high-risk pregnancy, a prenatal nurse case manager gets in touch to help her find a pediatrician. Nurses then coordinate with pharmacists, social workers, and others on CareSource's case management team to help women access all of the treatments and services they need.

In two Ohio counties, community health workers under contract with CareSource meet with Medicaid members with high-risk pregnancies to tell them about other public programs—such as home energy assistance, WIC (the Special Supplemental Nutrition Program for Women, Infants and Children), and safe, affordable housing—and help them access those needed services. Community health workers also can help families access food from local food banks.

Providing Support in the NICU

When a baby is admitted to the neonatal intensive care unit (NICU) following a high-risk pregnancy, the nurse case manager contacts the mother in the hospital to let her know about the benefits and support services available. If the baby is in the NICU for a long time, the case manager checks in with the mother periodically to offer help.

When babies are born with complex health conditions or disabilities, nurse case managers help keep the lines of communication open between families and their doctors. They can

explain complicated care instructions and make sure that families have all of their questions answered. Case managers also can set up appointments with social workers and other behavioral health professionals and arrange for transportation as needed.

Enabling Smooth Transitions

When babies are about to be discharged from NICUs, nurse case managers help families prepare to care for them at home. For example, they make sure families understand how to use oxygen, monitors, suction equipment, and other medical devices. They go over discharge instructions and medications with parents, check whether they have follow-up appointments with pediatricians and specialists, and help them access transportation.

CareSource coordinates with community social service agencies such as the YMCA and United Way to help families find other resources, such as child care and after-school activities for siblings. Families can call CareSource's 24-hour nurse line at any time to ask questions or request help from nurses who have access to their records.

Staying in Touch for Years

Besides providing support immediately following discharge, nurse case managers follow up with families six months to a year later and may stay in touch for many years. Families often form strong bonds with their case managers, and it is not unusual for nurses to be invited to birthday parties of 21 year-olds whom they had supported in NICUs.



CareSource *(continued)*

Supporting Families through High-Risk Pregnancies and Beyond

“Whenever a barrier is there, it’s our job to take care of it. It’s about collaboration, finding the right partners, coordinating and collaborating.”

– Cheryl Slagle,
Vice President,
Clinical Operations,
CareSource, describing
the health plan’s
Neonatal Intensive
Care Unit Care
Transitions Program

Results

- From 2011-2012, the number of NICU readmissions among CareSource’s Medicaid members fell by 10 percent, and the rate of readmissions per thousand dropped by 2 percent.
-

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Medica

Helping Seniors Make Connections for Good Health



“The best part of my role as a care coordinator is when I am able to provide a service to a member that will allow them to remain independent in the community.”

– Dee-Ana Farness, LSW, Care Coordinator, Medica

Introduction

Enabling low-income seniors to live independently at home means making the right connections. That’s why nurses and social workers serving as care coordinators connect immediately with Medica members who enroll in Minnesota’s Senior Health Options (MSHO) program for dual eligibles (people with both Medicare and Medicaid coverage) and link them with all of the medical, social, and behavioral health services needed to maintain good health. Based on their initial assessments, care coordinators work with doctors to develop care plans, and they give seniors all of the support they need to follow them.

Bringing It All Together

Care coordinators can help seniors access home care, adult day care, transportation assistance, home-delivered meals, and even services to mow the lawn and shovel the driveway. They can have podiatrists come to seniors’ homes to trim toenails. At least once a month and more often if needed, program participants have home visits with doctors and nurse practitioners. Care coordinators also can go with seniors to doctors’ visits, explain care instructions and medications, and make sure that all of their questions are answered.

When beneficiaries are struggling to follow special diets or learning to cook for themselves for the first time, care coordinators arrange for nutritional counselors to visit them at home. Seniors can meet with counselors up to six times, depending on their needs, and develop meal plans and shopping lists. Counselors offer practical suggestions and share healthy recipes.

Seniors able to live active lifestyles are linked with Medica’s Silver Sneakers fitness program.

They can access free transportation to the gym and participate in exercise classes at no charge.

Care coordinators check in with program participants regularly by phone and in person. They continue to work with beneficiaries throughout their enrollment in MSHO, whether they are at home, in hospitals, assisted living, or nursing homes. Seniors can call their care coordinators at any time for help.

Results

- From 2006 to 2012, the proportion of Medica members in the MSHO program who lived on their own in the community grew from 39.4 percent to 71 percent.
- Evaluating seniors’ functional status and reviewing their medications for potential duplication or adverse interactions are two key activities that the National Committee for Quality Assurance (NCQA) measures as indicators of health care quality. From 2011-2012:
 - The proportion of Medica members in the MSHO program who received evaluations of their functional status rose from 68.9 percent to 93 percent.
 - The proportion of members in the program who had their medications reviewed by care coordinators grew from 87.8 percent to 93 percent.

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UCare

Enabling Low-Income Seniors to Live Safely at Home



Introduction

Enabling low-income seniors to live safely on their own at home takes a lot of organization and support, but it all comes down to two things: personal connections and teamwork. UCare's nurses and social workers serving as care coordinators form strong bonds with the seniors they serve through Minnesota's Senior Health Options (MSHO) program for people covered by Medicare and Medicaid (dual eligibles). Seniors are paired with care coordinators who speak their native languages and share their cultural backgrounds. Care coordinators work closely with seniors to help them meet their goals for living independently at home. Care coordinators translate and explain complicated care instructions, answer questions, and arrange for services according to people's needs and preferences. For example, they can arrange for people to receive foods that are traditional in their cultures.

When discussing care options, care coordinators make suggestions based on what they know are important cultural priorities. For example, knowing that Somali and Hmong families often do not feel comfortable placing family members in nursing homes or assisted living communities, they would suggest the option of adult day care for seniors who need more support than they can get at home.

Mobilizing Care Teams

Care coordinators mobilize care teams to meet the individual needs of each person participating in the program. Care teams include doctors, social workers, pharmacists, meal and transportation providers, home care workers, and others, to provide all of the services and support that seniors need to maintain their independence at home.

Care coordinators communicate with doctors to ensure that each person in the program has a care plan. They arrange for services such as transportation to doctor visits and home-delivered meals. They can set up home care visits to help with bathing, dressing, and cooking. They can help seniors apply for financial assistance to pay for medications or home heating.

Care coordinators make sure that seniors receive all recommended preventive and chronic care services, and they communicate with other team members to resolve any outstanding questions, concerns, or needs. For example, they may put doctors in touch with pharmacists to discuss side effects or other difficulties with medications. They let doctors know right away about any changes in patients' health so that doctors can take prompt action.

Caring for the Whole Person

The MSHO program receives combined Medicare and Medicaid funding through a simplified payment system. As a result, patients' care teams can focus on bringing together all of the services that beneficiaries need—instead of having to spend time navigating complex rules that previously made it difficult to coordinate services covered separately by the two programs.

Results

The program has helped seniors achieve their goals for living independently in their own homes. From 2005-2009:

- The monthly nursing home admission rate for people in MSHO and UCare's Minnesota Senior Care Plus (Medicaid Managed Care for Seniors) consistently was about 50 percent lower than for beneficiaries in Medicare's fee-for-service (FFS) program.



UCare *(continued)*

Enabling Low-Income Seniors to Live Safely at Home

“I believe that my case manager [is] helping me a lot. One thing she [does] is make me happy, make me understand about the system, make me understand so I can take my medicine and talk to me so I can go see my doctor, I can get my care.”

– Ying Xiong, a UCare member who participates in Minnesota’s Senior Health Options program

- The average nursing home length of stay among MSHO and Minnesota Senior Care Plus members was between 2 and 10 percent lower than among those with Medicare FFS coverage.

From 2007-2011, the proportion of MSHO and Minnesota Senior Care Plus members age 65-84 with heart disease and/or diabetes who took aspirin every day as recommended rose from 25.9 percent to 41.8 percent.

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