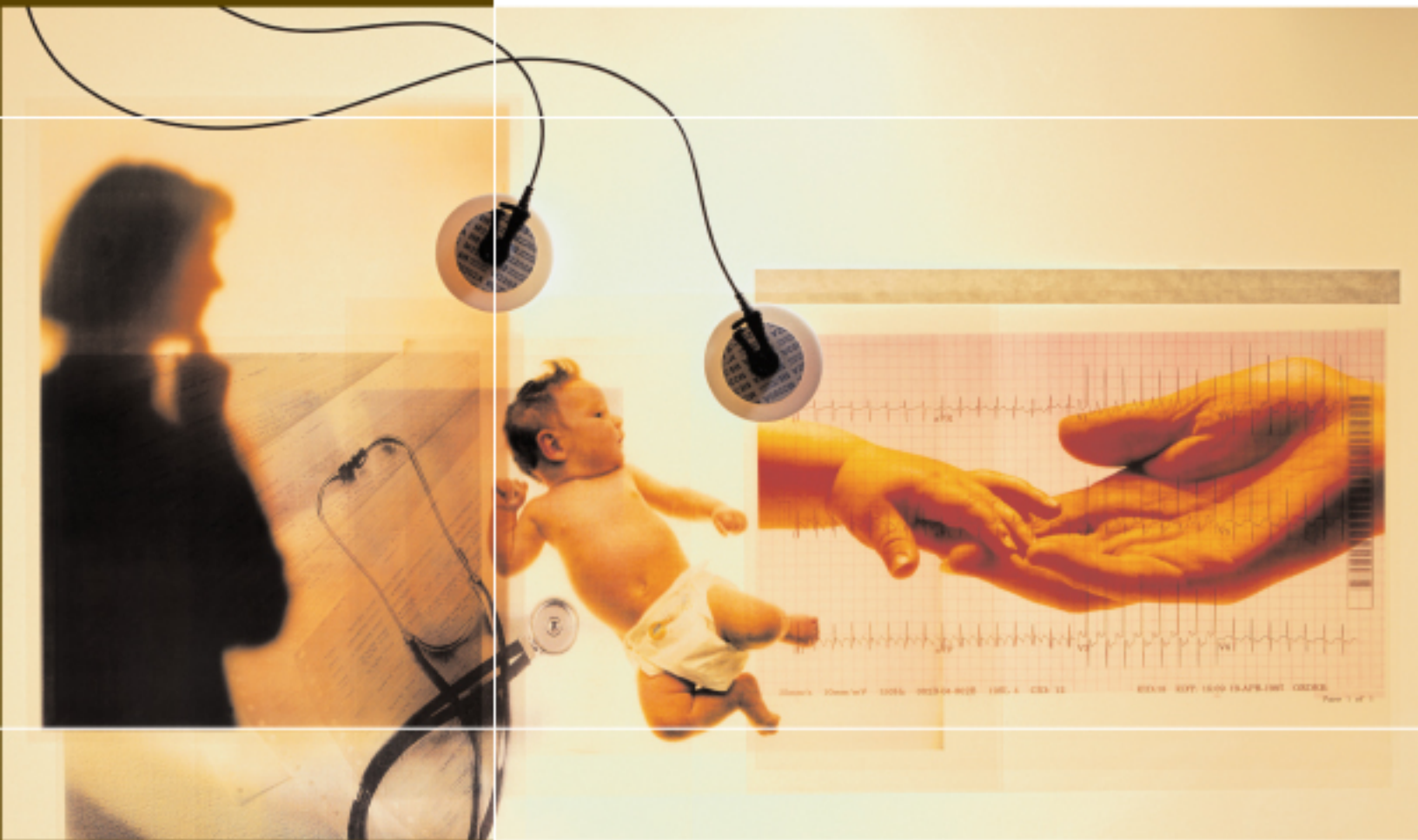


Innovations in Medicaid Managed Care



America's Health
Insurance Plans

Providing health
benefits to over
200 million Americans.

*Health Plan Programs to Improve
the Health and Well-Being of
Medicaid Beneficiaries*



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America's Health Insurance Plans is a national association representing nearly 1,300 members providing health benefits to more than 200 million Americans. AHIP and its predecessor organizations have advocated on behalf of health insurance plans for more than six decades.








As the voice of America's health insurers, our goal is to advance a vibrant, private-public health care system, one characterized by consumer choice, product flexibility, and innovation. We support empowering consumers with the information they need to make health care decisions, promoting health care quality in partnership with health care providers, and expanding access to affordable health care coverage to all Americans.

AHIP's mission is to effectively advocate for a workable legislative and regulatory environment at the federal and state levels, one in which our members can advance their vision of a health care system that meets the needs of consumers, employers, and public purchasers.

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AHIP staff who contributed to this report include:

Ellen Bayer, Project Manager
AHIP Center for Policy and Research

Review editors included:

Carmella Bocchino
Diana C. Dennett
Elyse Greenwald
Joni Hong
Jeff Lemieux
Bryan Ooley
Susan Pisano
Howard Weiss

Design: Ted Lamoreaux

Glenn Andis
Medica
Minnesota

Susan Beane
Affinity Health Plan
New York

Cathy Becker
CareSource Management Group
Ohio

Jill Bell
Passport Health Plan
Kentucky

Kathleen Bibo
Neighborhood Health Plan
Massachusetts

Lorraine Bisco
BlueCross BlueShield of Western New York
New York

Karen Bray
Optima Health
Virginia

Rick Buck
Keystone Mercy Health Plan
Pennsylvania

Kimberly Gower
Arizona Physicians IPA, Inc.
An AmeriChoice Health Plan
Arizona

Millie Havens
State Health Programs
Health Net of California, Inc.
California

Dianne Houston
AMERIGROUP
Maryland

Sheila Keith
BlueCross BlueShield of Tennessee
Tennessee

Anita Keneipp
Health Net of California, Inc.
California

Cynthia Lord
HealthPartners
Minnesota

Steven Matthews
AmeriChoice, a United Health Group Company
Virginia

Mary McGregor
Group Health Cooperative
Washington

John Monahan
WellPoint State Sponsored Programs
California

Michael Musci
AMERIGROUP
Virginia

Cynthia Nakasato
Kaiser Foundation Health Plan
Hawaii

Beth Nelson
BlueCross BlueShield of Minnesota
Minnesota

Stephen Robitaille
Santa Clara Family Health Plan
California

Karen Romero
Affinity Health Plan
New York

Beatriz Solis
L.A. Care Health Plan
California

Geri Soliz
State Health Programs,
Health Net of California, Inc.
California

Colleen Walsh
UPMC Health Plan
Pennsylvania

Ivona Wisniewski
Fallon Community Health Plan
Massachusetts

Ghita Worcester
UCare Minnesota
Minnesota

Introduction

Making Medicaid More Effective



By Karen Ignagni

President and CEO, America's Health Insurance Plans

When the federal-state Medicaid program makes headlines, the news is often bad: costs are up (63% in just five years, and currently running at more than \$300 billion annually), state budgets are reeling under the strain, and frustrated program administrators are warning of dire changes ahead, including possible benefit cuts and eligibility restrictions.

But there is another—and much more positive—side to the Medicaid story. That side is the focus of this report.

With innovative programs and stubborn determination, health plans are working to make Medicaid more effective: reaching out to single parents and underserved children, to the elderly and disabled, to patients struggling with chronic illnesses who have never had ongoing relationships with caring health professionals—and offering them the advantages of comprehensive services and coordinated care.

These efforts, worthwhile in themselves, are paying off in improved quality of care *and* in more effective use of Medicaid funds than in the traditional fee-for-service program, as many studies have shown. For example:

- ▶ **Access to care:** Medicaid participants served by health plans in New York City report better access to care than patients in the fee-for-service program, and are more likely to have a regular source of care and to seek care at a doctor's office rather than in emergency rooms.
- ▶ **Prenatal care:** Infant mortality rates in Rhode Island have dropped dramatically—from 4.5 deaths per 1,000 births to 1.9 per 1,000—since health plans began providing care for pregnant women enrolled in the state Medicaid program.
- ▶ **Asthma:** Children with asthma enrolled in Medicaid health plans in Wisconsin are significantly less likely to require hospitalization than asthmatic children in the state's fee-for-service program.
- ▶ **Diabetes:** Among Medicaid participants with diabetes in North Carolina, those served by health plans are more than three times as likely to properly monitor and control their blood glucose levels.

- ▶ **Substance abuse treatment:** Since 1995, when Medicaid participants in Oregon with substance abuse problems began receiving care through health plans, participation in treatment programs has increased nearly 40%.
- ▶ **Reduced hospitalization rates:** A study of preventable hospitalizations among Medicaid participants in California found that those enrolled in health plans were up to 38% less likely to have been hospitalized for conditions amenable to timely outpatient treatment.
- ▶ **Preventive care:** Since 1997, when Kentucky began encouraging Medicaid participants to enroll in health plans, the percentage of Medicaid-covered children receiving early and periodic screening, diagnostic and treatment services has increased nearly 250%.

These are not isolated examples. A recent analysis of numerous studies found compelling evidence that health plans are improving access to care, continuity of care, quality of care and health status outcomes for millions of Medicaid participants—and at savings of up to 19% compared with Medicaid fee-for-service arrangements.

One way of looking at these findings, especially in light of all the headlines about Medicaid’s problems, is to consider how much more cost-burdened the program would be without the involvement of health plans. That, in turn, makes a strong case for extending access to health care to the more than 3 million adults and 6.5 million children who are eligible for, but not enrolled in, Medicaid or a State Children’s Health Insurance Program (SCHIP), and for encouraging more participants to receive their care through health plans.

The Medicaid program currently provides health coverage for about 42 million lower-income Americans who would otherwise be uninsured and unable to afford care. As of June 2003, according to data compiled by the federal Centers for Medicare and Medicaid Services (CMS), about 39% of all Medicaid participants were enrolled in health plans providing comprehensive health care services, and another 20% were covered by less comprehensive versions of managed care. Meanwhile the fee-for-service system, although covering less than half of the total Medicaid population, accounted for more than 80% of all Medicaid spending.

The scores of case studies summarized in this report (which updates and expands upon an earlier version published in 2002) showcase the many innovative ways in which health plans are contributing to improved care for Medicaid participants. These initiatives deserve recognition and should inspire replication. Increased awareness of exemplary initiatives and best practices will help ensure that what works will work for more people, at costs that are more broadly affordable and sustainable for hard-pressed state governments and Medicaid program administrators.

In these pages, for example, you will learn how a health plan uses the appeal of attending a full-day basketball camp as a way to reach out to children and their parents and teach them how to manage asthma. Results: healthier kids and a dramatic drop in emergency room visits. The same plan uses a similar outreach strategy—partnering with churches—to sponsor workshops for African American women on a range of health issues. In five years more than 30,000 women have participated, increasing their health awareness and their ability to self-manage chronic illnesses.

You will learn how another health plan places a “diabetes life coach” (a nurse trained in diabetes education) in physician offices to educate patients with diabetes about how to understand and manage their condition, with telephone follow-ups to provide support and assess progress. Result: effective hands-on outreach to more than 1,000 patients, with significant improvements in medication utilization and diabetes management.

You will learn how a health plan established 10 community resource centers throughout California to improve services to its multi-ethnic, multi-lingual Medicaid clients. Responding to community-specific needs, the centers have sponsored such initiatives as free English-as-a-second-language classes, a diabetes self-management class conducted in Vietnamese, in-school asthma education classes via telemedicine video conferencing, child immunization campaigns, and crisis counseling. Results: greatly improved health awareness, very high levels of patient satisfaction, and widespread enthusiasm about the effectiveness of the centers.

These are representative examples of the imagination and commitment at work among health plans serving Medicaid populations nationwide. They reflect plans' awareness that Medicaid patients often need an extra measure of help to address health problems exacerbated, in many cases, by a long history of being left out of the health care system. And they demonstrate that a combination of systematic outreach and focused follow-through can be a powerful way to improve the health status of previously underserved populations—while stretching Medicaid's finite resources.

Despite the abundant evidence in this report that Medicaid funds can be used more effectively, it is important to recognize that Medicaid's overall costs will inevitably continue to rise in the years ahead. As we noted in our 2002 report, the underlying factors driving Medicaid costs include the sheer number of Medicaid participants who have not had the benefits of adequate care, the disproportionate numbers of participants with multiple needs, the rapidly rising cost of pharmaceuticals, high rates of at-risk pregnancies, and continuing over-reliance on costly, episodic emergency-room care. To this list must be added the increasing burden of long-term care as the baby boom generation approaches old age and as more of the elderly, after exhausting their assets paying for such care, turn to Medicaid for help. All of these factors are contributing to Medicaid's increased costs. It would be understandable, perhaps, for lawmakers to believe that because health plans are delivering better care at more affordable cost, budget cutbacks can be justified—but such an outlook would be shortsighted. Underfunding innovative initiatives that are producing positive results would be a penny wise and a pound foolish.

Medicaid's challenges are complex and of long duration. Thus, the health plan initiatives profiled in this report address a very wide range of needs. What they have in common is a strong and sustained commitment to the improved well-being of the populations they serve. In that sense they provide a model for the Medicaid program as a whole and for the challenges it faces in the years ahead. Only a program that is sustainable—adequately funded for the long run—and that encourages innovation along the lines described in these pages can meet the needs of the nearly one in five Americans who count on Medicaid for their health care.

Chapter 1

Caring for Members with Asthma



More than 20 million Americans report having chronic asthma, and 9 million children have been diagnosed with the disease. The National Heart, Lung, and Blood Institute estimated that the nation spent over \$11 billion on asthma-related health care in 2004. Because asthma disproportionately affects people living in poverty, health insurance plans serving Medicaid beneficiaries have made asthma care a top priority. They provide members with extensive information about asthma, help develop individualized asthma action plans to improve members' health, and encourage use of effective treatments based on sound medical evidence.

Medicaid beneficiaries who have participated in health insurance plans' asthma programs have learned to recognize their symptoms early, use effective medications, and seek care as needed to avoid emergencies. As a result, the quality of life for Medicaid patients with asthma is improving dramatically. In addition, these programs are providing significant savings for the Medicaid program. The U.S. Environmental Protection Agency estimated that implementation of asthma management plans can save an average of \$1,200 per year in health care costs for individuals with moderate to severe asthma. The programs summarized in this chapter illustrate the range of ongoing health insurance plan initiatives that improve the health and well-being of Medicaid beneficiaries with asthma.

The Asthma Health Management Program: A Three-Part Strategy

BlueCross BlueShield of Western New York (WNY) established its Asthma Health Management program in 1996 to improve the health care and quality of life for children and adults with asthma. The program was implemented for Medicaid members, members with coverage through New York's State Children's Health Insurance Program (SCHIP) (Family Health Plus and Child Health Plus), as well as BlueCross BlueShield of Western New York's commercial members.

The program uses a three-part strategy: (1) identifying individuals with asthma; (2) providing targeted information and interventions based on the severity of illness; and (3) working with health care practitioners to improve asthma care.

Identifying Members with Asthma

The program targets members with a diagnosis of asthma (ICD-9 code 493.0) who are ages 5 through 56. However, members of any age who have asthma may be referred and will be accepted into the program. Members are identified through:

- ▶ Analysis of office visit and pharmacy claims associated with asthma;
- ▶ Referrals from health care practitioners and member self-referrals;
- ▶ Claims data indicating a hospital admission for a primary diagnosis of asthma; and
- ▶ Results of a health risk assessment survey administered to all public program members.

Members remain in the program once they are identified as having an asthma diagnosis unless they choose to opt out.

Providing Targeted Interventions Based on Severity of Illness

BlueCross BlueShield of WNY provides different information and interventions to members with asthma depending on the severity of their condition, with Level IV representing the least severe symptoms and Level I representing the most severe.

Level IV - All members with an asthma diagnosis and at least four prescriptions for an asthma-related medication receive age-appropriate educational materials and reminders to have an annual flu shot. The educational materials include information on asthma symptoms and warning signs that an asthma episode may be on the way; strategies for controlling asthma; exercise and asthma; and how to use a spacer, peak flow meter, and inhaler.

Level III - Every six months, BlueCross BlueShield of WNY analyzes office visit and pharmacy claims to identify new members with asthma. These members receive a survey on quality-of-life issues, age-appropriate educational materials as described above, and a flu shot reminder. In six months, these members receive a follow-up quality-of-life survey to measure the impact of the educational materials they received.

Level II - Upon joining BlueCross BlueShield of WNY, public program members complete a health risk assessment that includes a question about asthma symptoms. Members identified through this survey receive educational materials about asthma and flu shot reminders; an Asthma Action Plan; information on how to obtain an Asthma Care Kit through their primary care physician; a resource book on community-based educational sessions; and the link to BlueCross BlueShield of WNY's Web site, which provides information about asthma.

The Asthma Action Plan is a written plan that health care practitioners develop for their patients on how to manage their asthma in different situations—when they are symptom-free, when they have signs of illness, when they are exposed to irritants that could cause problems, and when their prescribed medicines are not providing relief from asthma symptoms.

The Asthma Care Kit includes an educational video, as well as a spacer and an age-appropriate peak flow meter to help members manage their asthma. BlueCross BlueShield of WNY sends this kit to the member's primary care physician so that the physician can show patients how to use a peak flow meter and spacer to help manage their asthma.

Level I - Members who have an inpatient hospital admission for a primary diagnosis of asthma (as identified through claims data, referrals from hospitals, medical management nurses, and daily hospital census reports) receive the interventions provided under Level III (or Level II if the patient has not been previously identified as having asthma), and they are referred for case management. As part of the case management program, they participate in four educational sessions conducted by home health nurses who have been trained as asthma educators.

Working with Health Care Practitioners

BlueCross BlueShield of WNY recently adopted the New York Department of Health's Asthma Management Guidelines. The health plan provides these guidelines to its participating primary care practitioners, allergists, and pulmonologists and posts them on its practitioner Web site.

In addition, on a semi-annual basis, BlueCross BlueShield of WNY sends practitioners a summary of medication use by their patients with asthma. The summaries indicate whether patients have filled four or more prescriptions for "reliever" drugs (used when asthma symptoms have become severe) or one prescription for a "controller" medication (used on a regular basis to help manage asthma symptoms and avoid emergencies). The clinical guidelines sent to practitioners recommend a medication regimen based primarily on controller drugs.

BlueCross BlueShield of WNY encourages practitioners to work with patients to develop an Asthma Action Plan; to refer patients with asthma to smoking cessation classes as appropriate; and to provide referrals to specialists as needed. Practitioners also receive an Asthma Care Kit—with an age-appropriate peak flow meter, spacer, an educational video, and brochures—to distribute to patients with the most severe symptoms.

Results

BlueCross BlueShield of WNY measures the effectiveness of its asthma program through: results of its annual HEDIS® analysis and quality-of-life survey; rates of flu immunization; inpatient admissions; and emergency room visits. Results are as follows:

- ▶ Use of appropriate (controller) medications for asthma among Medicaid members increased from 55.5% in 2001 to nearly 70% in 2004.
- ▶ Use of appropriate (controller) medications for asthma among Family Health Plus and Child Health Plus increased from 65% in 2001 to 74% in 2004.
- ▶ The percentage of members who follow recommendations for daily medication use (as reported on the 2003 quality-of-life survey) increased among children, from 18% in the pre-survey to 54% in the post-survey, and held steady at 67% for adults during the same time period.

BlueCross BlueShield of Western New York (cont'd)

New York

- ▶ The percentage of members with asthma who had a flu shot increased from 28% in 2001 to 31% in 2003.
- ▶ The rate of inpatient admissions among asthma members decreased from 4% in 2002 to 3.5% in 2003.
- ▶ The rate of emergency room visits for asthma fell from 23% in 2002 to 15.5% in 2003.

BlueCross BlueShield of WNY attributes the reductions in inpatient admissions and emergency room use to better member compliance with recommended asthma treatments and to the education that participating health care practitioners have provided to members with asthma.

For more information, contact:

Lorraine Bisco, BSN, CPHQ
Asthma Coordinator
BlueCross BlueShield of Western New York
1901 Main Street
P.O. Box 159
Buffalo, NY 14240
(716) 887-6983
bisco.lorraine@bcbswny.com

Asthma - *Be in Charge!*sm Program

More than 11,000 of Health Net's Medicaid members have asthma and related pulmonary conditions that either require medication or have resulted in inpatient hospitalization or emergency room visits. Because of the profound impact this disease has on its members and because asthma is a condition for which prevention, intensive therapy, and effective case coordination can prevent both short- and long-term complications, Health Net developed Asthma - *Be in Charge!*sm in February 2004 to help members manage asthma on an ongoing basis. Based on the Center for Health Care Strategies' (CHCS) Best Clinical and Administrative Practices (BCAP) program, the initiative is designed for Medicaid members ages 5 through 56 who have persistent asthma symptoms and who have been continuously enrolled in Health Net for at least one year.

Information and One-on-One Coaching

The program uses claims data to identify members with persistent asthma who have had any of the following in the prior year:

- ▶ Four prescriptions for asthma medication;
- ▶ At least one emergency room encounter for asthma (as primary diagnosis);
- ▶ At least one inpatient admission for asthma (as primary diagnosis); or
- ▶ At least four outpatient asthma visits and at least two prescriptions for asthma medication.

Members are divided into three groups based on the severity of their condition.

- ▶ Members in the "green group," those with asthma who are relatively stable, receive information to increase their knowledge of the condition, make them aware of Health Net's educational materials on asthma and its toll-free Health Education Information Line, and encourage them to work with their primary care physician to develop an ongoing plan of care.
- ▶ Those in the "yellow group," members considered to have a moderate risk of hospitalization, receive the information described above, and they have access to a registered nurse who is the asthma coordinator. The coordinator can work with members at their option to develop an individualized care plan and help coordinate services as needed.
- ▶ Members who have had one or more inpatient admissions for asthma in the past year or two emergency room visits for asthma in the last six months are considered to be at high risk of hospitalization and are placed in the "red group." In addition to receiving the information and services described above, these members have ongoing contact with the Asthma - *Be in Charge!*sm nurse coordinator, who helps them manage their condition along with their physician. The coordinator works with them over the phone to develop an individualized care plan. In addition, the coordinator contacts the member's primary care physician to collect clinical information related to the care plan. The coordinator also encourages physicians to work with red group members to manage their asthma. The coordinator is in regular telephone contact with members and their physicians to help them achieve goals related to their care, such as ensuring that the member can describe the differences between rescue and controller medications.
- ▶ All members in each group above receive a DVD or VHS video on asthma self-management, which is available in nine languages.

Health Net of California, Inc. (cont'd)

California

Information for Physicians

Health Net provides participating physicians with information about Asthma - *Be in Charge!*sm, as well as the National Asthma Education and Prevention Program's Clinical Practice Guidelines. To increase physicians' awareness of which of their patients are enrolled in the Asthma - *Be in Charge!*sm program, physicians receive a list of their patients with asthma that notes the severity of their condition.

Results

Health Net evaluates Asthma - *Be in Charge!*sm on an annual basis. Results for 2004 are as follows:

- ▶ Emergency room visits per 1,000 Medicaid members with asthma decreased from 233 in 2003 to 114 in 2004.
- ▶ Inpatient days per 1,000 Medicaid members with asthma dropped from 87 in 2003 to 76 in 2004.
- ▶ Inpatient admissions per 1,000 Medicaid members with asthma declined from 37 in 2003 to 28 in 2004.

For more information, contact:

Geri Soliz, RN
Asthma Disease Management Coordinator
State Health Programs
Health Net of California, Inc.
21281 Burbank Boulevard, LNR-B5
Woodland Hills, CA 91367
(818) 676-6811
geralyn.l.soliz@healthnet.com

Keystone Mercy Health Plan

Pennsylvania

The Healthy Hoops Asthma Management Program

In 2003, after finding a high incidence of asthma among children in West Philadelphia, Keystone Mercy Health Plan partnered with the Healthy Hoops Coalition, comprising basketball coaches, area health organizations, and asthma health educators. Together, the health plan and the Coalition created the Healthy Hoops Asthma Management Program for Keystone Mercy's Medicaid members and other low-income children with asthma in Philadelphia.

A Four-Part Strategy

Using basketball as a platform, Healthy Hoops teaches children ages 7 through 15 and their parents how to manage asthma through effective medication use, proper nutrition, monitored exercise, and recreational activities. Healthy Hoops uses four main strategies to achieve its goals: outreach, program events, asthma disease management education, and member incentives.

Outreach

To enroll members in the program, Keystone Mercy identified three zip codes in West Philadelphia where there were high rates of asthma among the plan's members and in the community at large. The health plan sent a Healthy Hoops brochure and enrollment form to member families who had children between ages 7 and 15 with asthma. Keystone Mercy outreach staff and case managers made follow-up phone calls to everyone who received the brochure to answer questions and encourage enrollment in Healthy Hoops.

In addition, to increase awareness of the program and encourage enrollment, Keystone Mercy sent a Healthy Hoops brochure and enrollment form to families who had children with asthma and were referred to the program by community and health care organizations. The health plan also relied on school nurses and the Asthma Center of Excellence (ACE), a partnership between Keystone Mercy and the Greater Philadelphia Health Action, Inc.'s, Woodland Avenue Health Center, to identify children with asthma from the community at large. Both the school nurses and ACE are often on the "front lines" of asthma treatment and management for children.

Program Events

The Healthy Hoops program is conducted over a six-month period. Each year's program features a kick-off event, health screenings, and a full-day basketball camp. In the second year of the program, Healthy Hoops expanded to include a professional development component to educate area sports coaches and physical education teachers in Philadelphia public schools. All participants from the program's first year were invited to continue the program in 2004.

Healthy Hoops Kick-Off

Keystone Mercy held the 2004 kick-off event at the Franklin Institute to inform Healthy Hoops participants and their parents about the program. At this event, Healthy Hoops participants registered for health screenings, a mandatory part of the program. In a fun and festive environment, professional basketball coaches and celebrity players conducted basketball drills with program participants, and asthma educators provided program participants with strategies on how to manage their asthma.

Keystone Mercy Health Plan (cont'd)

Pennsylvania

Health Screenings

All Healthy Hoops participants must undergo a health screening and spirometry screening to partake in the program's culminating event, the full-day basketball camp. Screenings take place at two Greater Philadelphia Health Action sites and St. Christopher Hospital. The objective of the spirometry screening is to measure lung strength and capacity. The objectives of the health screening are to assess each child's health status, measure lung capacity, and establish a personalized asthma treatment plan.

Healthy Hoops Challenge (full-day camp)

The culminating event of the Healthy Hoops Program each year is the Healthy Hoops Challenge (the full-day basketball camp). The Challenge is the event where participants are able to see the progress they have made during the program. As a reward, they can enjoy a day of basketball drills and games supervised by coaches. At this event, Healthy Hoops participants undergo another round of spirometry screenings to ensure they are healthy enough to participate in the day's basketball drills and to ensure that they have been managing their asthma (as shown through improved lung strength and capacity scores). During this time, parents participate in a workshop about living with and managing their child's asthma.

Asthma Disease Management Education

Asthma disease management education is the most important component of Healthy Hoops. At each program event, Healthy Hoops Coalition members, including doctors, nurses, and asthma educators, provide information to children and parents about asthma and asthma management, with a major emphasis on appropriate medication use. Each session reinforces and reviews information from the previous sessions. In addition, at each session, program leaders assess parents' progress in understanding and managing their child's asthma.

Incentives

The main incentive of Healthy Hoops is the opportunity to participate in the full-day basketball camp. Participants must attend the program's screening events, receive a health assessment, and have a treatment plan developed in order to attend the camp.

Results

In 2003, 130 children with asthma and 155 parents participated in the 2003 Healthy Hoops Program. Among participating children:

- ▶ The percentage of children with an emergency room visit for asthma fell from 40% to 6%.
- ▶ The percentage of children using controller medications appropriately increased from 48% to 77%.
- ▶ The percentage of children with a hospital admission for asthma fell from 10% six months prior to the program to 2% at the program's conclusion.
- ▶ The percentage of children with sleep disturbances due to asthma decreased from 36% to 32%.
- ▶ On average, the Healthy Hoops children's forced vital capacities, which measures lung strength, improved from 93% before the camp to 96% after the camp.

-
- ▶ Parental knowledge of the significance of sleep disturbances improved by 10%.
 - ▶ Parental knowledge of the need for regular medical follow-up and for taking medications before exercise increased by 10%.

In 2004, 184 children participated in the program (an increase of 38%). Preliminary findings for 2004 are as follows:

- ▶ In six months, the rate of emergency room visits among program participants dropped from 41% to 15%.
- ▶ Participants' lung capacity (as measured by forced vital capacities) improved 11%.

For more information, contact:

Rick Buck
Vice President, Communications
Keystone Mercy Health Plan
200 Stevens Drive
Philadelphia, PA 19113
(215) 863-5102
rick.buck@kmhp.com

Neighborhood Health Plan

Massachusetts

Working with Physicians to Promote Effective Asthma Care

In 1993, Neighborhood Health Plan recognized asthma as the most frequent diagnosis among Medicaid and commercial members, and therefore, began a program to help members care for asthma effectively on an ongoing basis, to avoid emergencies. On a quarterly basis, the health plan provides participating primary care physicians with information on their patients with asthma, including a summary of their hospitalizations, emergency room visits, asthma specialist visits, and medication use. On a bi-weekly basis, the health plan sends reports to physicians to help them identify members who have exceeded a threshold number of prescriptions for rescue medications (bronchodilators and systemic steroids). Extensive use of these medications indicates that asthma symptoms have worsened and that the condition is not being treated effectively. The health plan also sends a letter to physicians when members have high use of rescue medications and have not filled a prescription for a controller drug (such as inhaled steroids), which controls asthma effectively and helps prevent emergencies.

One-on-One Case Management

Neighborhood Health Plan case managers support primary care physicians' efforts to provide effective asthma care. Case managers contact members who are using rescue medications extensively or who have had an asthma-related hospitalization or emergency room visit to assess their needs, provide information about asthma care, help them follow the physician's recommended care plan, and ensure that they have access to needed services.

Home Visits

Respiratory therapists, nurses, and health educators conduct home visits with members as recommended by their physician. During these visits, members receive information about asthma, triggers that irritate the condition, and effective medications. Members also receive an assessment of the home environment and learn about proper use of asthma control equipment. Health professionals conducting these visits also evaluate the frequency and severity of the member's asthma symptoms, use of reliever medications, and their activity limitations caused by asthma.

Neighborhood Health Plan recently began offering a community-based program in which a bilingual asthma educator works with children and their families to promote effective asthma care.

Results

From December 1999 to June 2004:

- ▶ The percentage of members with asthma who received at least one prescription for a controller medication increased from 49% to 58%. Among members receiving a controller medication, the percentage that received an inhaled steroid (the most effective medication for persistent asthma) increased from 78% to 89%.
- ▶ The ratio of controller to symptom-relieving medication use increased from 0.42 to 0.69. As controller medication use increases, asthma symptoms decrease, and the need for reliever medications is reduced.

-
- ▶ The percentage of members receiving eight or more prescriptions for bronchodilators to relieve asthma (an indication of worsening symptoms) decreased from 8% to 6%.
 - ▶ The percentage of members with an asthma-related hospitalization fell from 3.1% to 2.6%.

For more information, contact:

Kathleen Bibo RN, BSN, MBA
Director of Clinical Operations
Neighborhood Health Plan
253 Summer Street
Boston, MA 02210
(617) 204-1435
Kathleen_Bibo@NHP.org

Passport Health Plan

Kentucky

Helping Members Treat Asthma Effectively

In 2000, Passport Health Plan (PHP) established an asthma disease management program for adults and children (ages 2 to 56) to improve members' health and quality of life, and reduce unnecessary asthma-related hospitalization and emergency room use. The program is based on the National Institutes of Health (NIH) guidelines for asthma care.

Based on claims data as well as hospital and prescription drug use, PHP divides members with asthma into five groups based on the severity of their illness and the types of services they have used (e.g., inpatient admissions, emergency room visits). Members receive materials and services tailored to their needs.

All newly identified members with asthma receive a welcome packet with educational materials about the physiology of asthma, signs and symptoms, environmental factors that exacerbate asthma, and effective medications. All members with asthma also receive a peak flow meter to check their lung function and monthly mailings with educational materials targeted to their needs.

PHP asthma program coordinators contact members by phone to evaluate the severity of their asthma, identify their needs, and determine their level of knowledge about asthma. Based on this information, program coordinators work with members and their physicians to develop an asthma action plan that includes goals for improved health. Coordinators conduct home visits as needed.

Support for Health Care Practitioners

On a quarterly basis, PHP sends participating health care practitioners customized reports listing the pharmacy use, emergency room visits, and inpatient admissions for their Passport Medicaid patients with asthma. Asthma program coordinators conduct on-site visits to health care practitioners' offices to provide physicians and their office staff with suggestions for teaching members about effective asthma care.

Physician and Nurse Advisory Group

Passport receives regular feedback and suggestions for the program from an Asthma Advisory Group comprising physicians and nurse practitioners. The Advisory Group meets three times a year, and the health plan evaluates and refines the program based on their input.

Results

More than 27,000 members have participated in the PHP Asthma Disease Management program since 2001. From 2000 through 2003, the percentage of Medicaid members with asthma receiving controller medications increased on average from 51% to 77%.

The percentage of Medicaid members with an emergency room visit for asthma declined from 32.3% to 31.8% during this period. Admissions to a hospital intensive care unit for asthma declined from 0.6% to 0.5% of Medicaid members with asthma. At the same time, the percentage of Medicaid members with asthma who visited a specialist for their condition increased from 13% to 14%.

In recognition of these improvements, the Robert Wood Johnson Foundation's Center for Health Care Strategies chose PHP's Asthma Disease Management for its Best Clinical and Administrative Practices award in 2002.

For more information, contact:

Jill Bell
Vice President of Public Affairs
Passport Health Plan
305 W. Broadway
Louisville, KY 40202
(502) 585-7079
Jill.Bell@amerihealthmercy.org

LifeCoaching for Behavior Change

In 1997, Optima established an asthma disease management program to improve the health and quality of life of patients with asthma. The program is available to members of Optima's Medicaid and commercial health plans, and more than 60% of program participants are Medicaid beneficiaries. The program focuses on education and coaching for behavior change.

Identifying Patients at Risk of Hospitalization

Optima uses claims data to identify members with asthma. Once identified, each member receives a risk screening survey to measure the severity of his or her asthma. All members with asthma receive educational mailings on a regular basis. Members with moderate asthma receive at least one phone call from a registered nurse (RN) or registered respiratory therapist (RRT) case manager, and an information packet on recommended asthma care. Members with severe asthma who are at high risk of hospitalization receive home care services. Criteria used to identify members at risk for asthma-related hospitalization include use of "rescue" medications (e.g., short-acting inhaled beta2-agonists) for severe symptoms, emergency room visits, and inpatient admissions for asthma.

Home Care Services

Home care services are provided by an RN or RRT who visits and calls on a regular basis to function as a LifeCoach. The LifeCoach visits the member at home to conduct an environmental assessment and educates members and families on effective asthma management. The LifeCoach supports behavior changes that will positively impact the disease process, such as smoking cessation, removal of exacerbation triggers, proper use of asthma medications, and coordination of care with providers.

Care Coordination

The case manager coordinates members' medical care and provides regular written updates to their physicians. These updates include information about patient adherence to the asthma treatment plan, documentation of medication usage, and details on exacerbations of asthma symptoms. Often, primary care physicians are not aware of how often patients are using rescue medications, failing to fill preventive medications, or even experiencing exacerbations that lead to emergency room visits. As a result, the case manager updates play an important role in keeping the physician informed so that the treatment plan can be modified as needed.

Results

Optima found that among 451 members continuously enrolled over a five-year period, \$2.10 was saved for every dollar spent on the asthma program. In addition, on a yearly basis, for every 1.6 prescriptions for asthma "rescue" medications, at least one prescription for an anti-inflammatory asthma medicine was filled. Anti-inflammatory medications are used to manage asthma on an ongoing basis to prevent symptoms from becoming severe; use of these drugs is an indicator of appropriate asthma care.

For more information, contact:

Karen Bray, RN, CDE
Disease Management Program Director
Optima Health
4417 Corporation Lane
Virginia Beach, VA 23462
(757) 552-7198
KJBRA@sentara.com

The Asthma Action Program

In 1999, UCare Minnesota established the Asthma Action Program to help children and adult Medicaid and MinnesotaCare members manage their asthma. The program helps members manage symptoms on an ongoing basis so they do not need to rely on the emergency room and hospital for care. UCare Minnesota uses data from claims and emergency room reports to identify members with asthma. Members are then stratified based on risk level. UCare's asthma nurses provide patient education and encourage shared decision-making on asthma action plans and goals. Each asthma action plan includes information designed to help the patient manage his/her own asthma and avoid exacerbations. The type of information contained in the asthma action plan includes what medication to take, when to take it, and what to do when breathing becomes difficult. The goals of the program are to decrease emergency room utilization and inpatient stays for asthma, and increase use of controller medication among members with persistent asthma. As part of the Asthma Action Program, all members receive educational mailings and telephonic asthma management, and those with persistent asthma receive more intensive case management.

A Partnership with Hospitals, Emergency Rooms and Clinics

UCare has identified contacts at 14 metropolitan hospitals. The hospitals fax UCare a daily report indicating which members have accessed the emergency room for asthma-related care or treatment. UCare links information from the report with member-specific pharmacy data to create a personalized member report that is faxed to the member's primary care clinic. The clinic and the asthma nurse will both try to contact members to encourage them to see their doctor for a follow-up visit and medication review.

Results

From 1999 to 2004, the number of asthma-related inpatient admissions fell from 121 per 1,000 members to 90 per 1,000 members. The percentage of members taking controller medications as recommended increased by 12% between 2001 and 2004. Ninety-five percent of members responding to UCare's patient satisfaction survey said they were highly satisfied with the program.

For more information, contact:

Ghita Worcester
Vice President, Public Affairs and Development
UCare Minnesota
P.O. Box 52
Minneapolis, MN 55440
(612) 676-3634
gworcester@ucare.org

Blue Cross of California State Sponsored Programs

California

A Point-of-Service Pharmacy Consultation Program

Since 1998, Blue Cross of California State Sponsored Programs has provided its Medicaid and State Children's Health Insurance Program (SCHIP) members with asthma the opportunity to make an appointment with their local pharmacist to learn about effective asthma medications and asthma management. To address the problem of missed appointments, the health plan began offering point-of-service consultations in 2003 to members with asthma whose medication usage indicates over-reliance on relief medications.

When a Medicaid or SCHIP member fills a prescription for asthma medication at any network pharmacy, the health plan's pharmacy system reviews his or her claims for the previous six months. A pop-up screen informs the pharmacist that the member is eligible for an educational consultation if the member has received three or more quick-relief medications and two or fewer long-term control medications in the past six months. Members are eligible for a consultation every six months as long as they are identified as having an over-reliance on relief medications.

As part of these consultations, pharmacists emphasize the importance of controller medications for managing asthma on an ongoing basis, and they demonstrate how to use spacers and inhalers. They encourage members to meet with their physician to develop an asthma action plan and note that Blue Cross of California State Sponsored Programs offers a choice of incentive gifts (e.g., clip-on inhaler case, dust mite pillow cover, or children's asthma storybook) to members whose primary care physicians verify that they completed the plan.

The health plan offers training for participating pharmacists to conduct the program, using the Asthma Continuing Medical Education program from Johns Hopkins University. The one-hour online educational program reviews recommended therapy and results of recent clinical trials for asthma management.

Results

During the first seven months of the program, approximately 7,000 Medicaid and SCHIP members with asthma received a pharmacy consultation. A study of members who received asthma education consultations from their local pharmacists found that the percentage of members using three or more controller medications increased five-fold in the six months following the consultation.

For more information, contact:

John P. Monahan
Senior Vice President
WellPoint State Sponsored Programs
5151-A Camino Ruiz
Camarillo, CA 93012
(805) 384-3511
john.monahan@wellpoint.com

Chapter 2

Caring for Members with Diabetes



More than 18 million people in the United States have diabetes, and diabetes causes more than 200,000 deaths each year. According to the American Diabetes Association, direct and indirect costs associated with diabetes were approximately \$132 billion in 2002. The number of adults with diabetes has increased 61% since 1991 and is projected to more than double by 2050. African American, Hispanic, American Indian, and Alaska Native adults are two to three times more likely than white adults to have diabetes, and diabetes disproportionately affects women and the elderly.

The American Diabetes Association estimates that complications of diabetes cost \$24.6 billion in 2002. Many complications and deaths from diabetes can be avoided through early detection, coordinated care, and ongoing use of effective screening tests and treatments. For example, effective blood pressure control can reduce heart disease and stroke by approximately 33%. In addition, the National Committee for Quality Assurance reports that 14,000 heart attacks, strokes, or amputations could be avoided if hemoglobin A1C levels for individuals with diabetes were controlled, saving approximately \$573 million per year.

Health insurance plans serving Medicaid beneficiaries with diabetes are providing them with information about the disease and are offering assistance through nurses who can answer questions, help them develop and meet goals in healthy living, remind them about important screening tests, and foster effective communication with physicians. The programs summarized in this chapter illustrate a range of initiatives to improve the quality of life for Medicaid beneficiaries with diabetes.

Diabetes - *Be in Charge!*sm Program

More than 10,000 of Health Net's Medicaid members have diabetes that either requires medication or has resulted in inpatient hospitalization or emergency room visits. Because of the profound impact this disease has on its members and because diabetes is a condition for which regular screening, intensive therapy, and effective care coordination can prevent both short- and long-term complications, Health Net implemented Diabetes - *Be in Charge!*sm in November 2003. Based on the Center for Health Care Strategies' (CHCS) Best Clinical and Administrative Practices (BCAP) program, the initiative is designed for Medicaid members ages 21 and older who have a diagnosis of diabetes and who have been continuously enrolled in Health Net for at least one year.

Patient Screening and Grouping Based on Severity of Illness

The program uses claims data to identify members with diabetes who have had any of the following in the prior year:

- ▶ Prescriptions for diabetes medication (e.g., insulin and oral antidiabetics);
- ▶ At least two outpatient diabetes visits; or
- ▶ At least one inpatient admission or emergency room visit for diabetes or any complications of diabetes.

Members Are Divided into Three Groups Based on the Severity of Their Condition:

- ▶ Members in the "green group," those with diabetes that is relatively stable, receive information by mail to increase their knowledge of the condition, make them aware of Health Net's educational materials on diabetes and its toll-free Health Education Information Line, and encourage them to work with their primary care physician to develop an ongoing plan of care.
- ▶ Those in the "yellow group," members considered to be at moderate risk, receive the materials described above, plus call-in telephone access via a toll-free member line to a nurse program coordinator who specializes in diabetes care. Members can call the nurse when they have concerns about their diabetes, medications, blood sugar, or any other self-care issues. The coordinator attempts to answer questions and encourage members to become more involved in their care.
- ▶ Health Net places members whose diabetes is most severe in the "red group." These members receive the information and services described above, including ongoing contact with the Diabetes - *Be in Charge!*sm nurse program coordinator, who helps them manage their condition along with their physician. The coordinator works with them over the phone to develop an individualized care plan. In addition, the coordinator contacts the member's primary care physician to collect specific clinical information, for example, the A1C blood level, which measures whether the member's diabetes is being managed effectively. The coordinator is in regular telephone contact with the member and physician to help members achieve specific clinical goals, such as an A1C level of 7 or less. The coordinator also encourages physicians to work with members to manage their diabetes.

Information for Physicians

Health Net provides participating physicians with information about the Diabetes - *Be in Charge!*sm program, the American Diabetes Association's most recent evidence-based practice guidelines, and a list of

their patients with diabetes that notes the severity of their condition. The health plan also mails primary care physicians a pocket-sized brochure titled *Diabetes and Culture - A Guide for Physicians*, which describes cultural issues that may affect the process of developing an individual care plan. The brochure includes suggestions on effective ways to address these issues.

Results

Health Net evaluates Diabetes - *Be in Charge!*sm on an annual basis. Results for 2004 are as follows:

- ▶ Emergency room visits per 1,000 Medicaid members with diabetes decreased from 43 in 2003 to 38 in 2004.
- ▶ Inpatient days per 1,000 Medicaid members with diabetes were reduced from 90 in 2003 to 86 in 2004.
- ▶ Inpatient admissions per 1,000 Medicaid members with diabetes declined from 30 in 2003 to 26 in 2004.

For more information, contact:

Millie Havens, RN
Diabetes Disease Management Coordinator
State Health Programs
Health Net of California, Inc.
1055 E. Colorado Boulevard, Suite 300
Pasadena, CA 91106
(626) 683-6258
Millie.x.havens@healthnet.com

Passport Health Plan

Kentucky

Diabetes Education and Reminders

To reduce complications among adult Medicaid members with diabetes and improve their overall health, Passport Health Plan (PHP) established the Diabetes Disease Management Program in 2000. The program uses clinical practice guidelines based on the American Diabetes Association's Standards of Care.

PHP uses claims and pharmacy data to identify adult Medicaid members with diabetes. All newly identified Medicaid members with diabetes receive a welcome letter that introduces them to the program and provides information on how to contact a diabetes program coordinator. On a quarterly basis, all program participants receive educational materials, including dietary recommendations. Passport sends reminders for eye exams and other diabetes-related testing twice a year.

Diabetes program coordinators contact Medicaid members who have had an emergency room visit or hospital admission for diabetes and who are not receiving ongoing diabetes care. During these discussions, they assess members' needs and provide information about the disease.

PHP divides members with diabetes into groups based on their response to the plan's mailings and the level of services they are receiving, and the health plan provides additional information and services tailored to their needs.

Collaboration with Health Care Practitioners

Passport sends health care practitioners quarterly reports on the extent to which their Medicaid patients with diabetes are using services critical to their health, such as eye exams, prescription drugs, and regular health screenings (i.e., micro albumin, hemoglobin A1C, lipid panel, and dilated retinal exam). The reports also indicate whether these patients have other conditions (e.g., asthma or pregnancy) that can cause complications of diabetes.

PHP encourages practitioners to compare the information in the quarterly reports to their patient records and to help patients with diabetes obtain effective tests and screenings. PHP's diabetes program coordinators conduct visits to practitioners' offices to emphasize the importance of these tests, and to explain PHP's diabetes programs and services.

Results

In 2003, the National Committee for Quality Assurance chose Passport's diabetes disease management program for a Best Practices award. The award recognized PHP's support of effective physician practice patterns and members' use of effective care.

For more information, contact:

Jill Bell
Vice President of Public Affairs
Passport Health Plan
305 W. Broadway
Louisville, KY 40202
(502) 585-7079
Jill.Bell@amerihealthmercy.org

The LifeCoach Model

In 1998, Optima Health established a disease management program for members with diabetes in its Medicaid and commercial health plans. The health plan identifies members with diabetes by using a combination of claims, lab, and pharmacy data. The diabetes program uses a “LifeCoach Model” based in offices of participating primary care physicians with a high number of patients with diabetes.

Optima places a diabetes LifeCoach (a nurse trained in diabetes education) in physician offices for one-half day per week to educate patients with diabetes about appropriate care, blood glucose self-monitoring, medication utilization, self-management skills, and prevention of long-term complications. LifeCoaches also help patients develop and adhere to goals for meal planning and physical activity. LifeCoaches follow up regularly by telephone with members to evaluate day-to-day management issues, offer support, interface with the physician to develop treatment plan updates, and coordinate care with multiple providers. LifeCoaches also support patients in communication with their physicians, as patients often require assistance understanding the complex treatment plan common in diabetes management.

Educating Patients

Diabetes is a disease in which positive outcomes depend heavily on the patient’s ability to modify lifestyle and behavior, such as meal planning, physical activity, self-blood glucose testing, and even adjustment of medication based on those factors. In addition, national guidelines recommend that people with diabetes have regular evaluations such as cholesterol testing, dilated eye exams, urine protein testing, and glucose testing. However, numerous studies have shown that most persons with diabetes do not receive the recommended tests. As part of the Optima program, members with diabetes receive educational materials on a regular basis. LifeCoaches also periodically lead supermarket tours and cooking classes for program participants to highlight the types of foods most appropriate for managing diabetes effectively. This program is quite popular as it teaches and reinforces the skill sets needed to make and sustain behavior changes related to meal planning, one of the cornerstones of diabetes management. Participating physicians receive quarterly reports on patients’ medication use, diabetes testing, blood glucose levels, and progress in behavioral management of the disease.

Enhancing Communication with Physicians

The LifeCoach communicates with members’ physicians to help them identify which patients are in need of routine diabetes care and testing, so that the physician can encourage the appropriate follow up care. This also helps “close the loop” on communication among the patient, the physician, and the LifeCoach. If, for example, the LifeCoach notes that the patient is in a smoking cessation program, the physician can reinforce the value of such a program during the office follow-up.

Results

Approximately 1,000 members participated in the LifeCoach diabetes program from May 2002 to April 2004. The baseline year was measured from May 1, 2002, and through April 30, 2003, and the intervention period was from May 1, 2003 through April 30, 2004. Data were collected on a number of indicators from the physician office medical record, claims data within the health plan, as well as lab and pharmacy data.

Optima Health (cont'd)

Virginia

At the end of the study, the following clinical results were obtained:

- ▶ 21% improvement in patients achieving an A1C level less than 7%*
- ▶ 22% improvement in patients achieving a blood pressure level below 130/80*
- ▶ 13% improvement in patients achieving a low-density lipoprotein (LDL) level less than 100*

*American Diabetes Association Standards of Care

The following improvements in recommended screening and testing were obtained:

- ▶ 2% improvement in patients having two A1C tests within the period*
- ▶ 5% improvement in patients having an LDL test within the period*
- ▶ 2% improvement in patients having a urine protein test within the period*
- ▶ 8% improvement in patients having a dilated eye exam within the period*

*American Diabetes Association Standards of Care

The following improvements in other preventive care activities were obtained:

- ▶ 41% improvement in patients having a documented foot exam
- ▶ 58% improvement in patients undergoing nutrition counseling
- ▶ 78% improvement in patients undergoing activity planning counseling
- ▶ 18% improvement in patients having an annual flu shot
- ▶ 36% improvement in patients having documented smoking cessation counseling

The following improvements in appropriate medication utilization were obtained:

- ▶ 7% improvement in patients taking ACE/ARB (improves blood pressure, renal function)
- ▶ 9% improvement in patients taking statins (improves hyperlipidemia)
- ▶ 1% improvement in patients taking anti-hypertensive medications (improves blood pressure control)
- ▶ 2% improvement in patients taking oral anti-diabetes medications (improves blood glucose control)
- ▶ 18% improvement in patients taking insulin (improves blood glucose control and is often underutilized in diabetes management)

For more information, contact:

Karen Bray, RN, CDE
Disease Management Program Director
Optima Health
4417 Corporation Lane
Virginia Beach, VA 23462
(757) 552-7198
KJBRAV@sentara.com

Chapter 3

Promoting Well-Child Care



Well-child visits provide an opportunity for children to receive physical assessments for growth and development, vision and hearing tests, and the full range of immunizations recommended by the American Academy of Pediatrics. During well-child visits in the adolescent years, health care practitioners can provide critical guidance on avoiding alcohol and drug use.

Medicaid's most comprehensive benefit focused on well-child visits and preventive health care for children is Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). EPSDT was established by federal law as part of the Medicaid program in 1989, and the benefit includes an assessment of both physical and mental health, a physical exam, immunizations, screening and lab tests as required by state law, and health education and counseling to both parents and children.

In establishing the EPSDT benefit, Congress sought to promote the early diagnosis and treatment of health problems among children in low-income families. Health insurance plans participating in the Medicaid program have used a variety of approaches to increase rates of child immunization and other well-child services. Among the tools that have worked effectively are birthday postcards and other mailings; telephone calls; home visits; and incentives for families, health care practitioners, and physician office staff. In addition to improving the health of children covered by Medicaid, these tools are producing significant savings. The National Committee for Quality Assurance reports that every dollar spent on immunization for children and adolescents in the United States saves more than \$5.

Partnership with the Children’s National Medical Center

In response to an American Academy of Pediatrics Call to Action on children’s flu vaccination, AMERIGROUP established an outreach program in 2002 to promote flu shots among children with chronic illnesses who are at risk of flu complications. The Centers for Disease Control and Prevention defines this group as children with asthma, diabetes, sickle cell disease, immunosuppressive conditions, cancer, or heart disease. The program sought to reach 17,000 low-income children with these conditions who were ages six months through 17 years and received primary care at any one of the Children’s National Medical Center’s (CNMC) eight outpatient clinics in the District of Columbia.

First, AMERIGROUP sent mailings to the parents or guardians of these children with information on the importance of having a flu shot. Subsequently, in December 2002 and January 2003, AMERIGROUP’s outreach staff made telephone calls and home visits to members in this group to ask parents whether they had received the mailings, whether they had taken their child for a flu shot, and whether they had plans to do so. During these contacts, AMERIGROUP’s outreach staff helped connect parents to a primary care physician’s office and arranged for transportation as needed. Outreach staff connected members who had not chosen primary care physicians to AMERIGROUP’s member services department for assistance.

A month after the initial mailing, AMERIGROUP sent a follow-up reminder to parents, along with a survey to assess barriers to having children immunized against flu and to determine which CNMC clinics members used most often. AMERIGROUP planned to use survey results to develop additional outreach programs with CNMC. Parents who completed the survey and took their child for a flu shot were offered a CVS gift card.

To accommodate the expected increase in appointments for flu shots, CNMC extended its clinic hours to 8 p.m. on weekdays. The clinic was able to provide same-day appointments, and it provided flu shots to any sibling who accompanied a child to an appointment.

As part of the program, CNMC also held “asthma tune-up clinics,” so that parents bringing their child in for a flu shot could meet with their primary care physician to review the child’s asthma action plan and reassess how effectively asthma medications were working.

Results

During the first season of the program’s operation (winter of 2002/2003), AMERIGROUP provided 1,600 doses of flu vaccine for children with chronic illnesses who received care at CNMC clinics. As a result, the number of flu vaccines received by this group of AMERIGROUP members increased more than tenfold, from 72 in 2001 to 851 in 2003.

Due to the initiative’s success, AMERIGROUP continued the program in the 2003-2004 flu season, and the number of children with chronic illnesses who received the vaccine increased to approximately 1,560.

For more information, contact:

Dianne Houston
Director, Health Promotion
AMERIGROUP
857 Elkridge Landing Road, Suite 300
Linthicum, MD 21090
(410) 981-4026
DHousto@amerigroupcorp.com

Immunization Reminder Program

In April 2004, Arizona Physicians IPA (APIPA) developed an outreach unit within its Prevention and Wellness Department to increase immunization rates for 20,000 Medicaid members under age 2. Outreach staff use a variety of outreach tools, depending on the child's age. For example, APIPA sends parents of 11-month-old children a birthday postcard with an immunization reminder. When the child is 15 months old, APIPA calls the parent to help schedule an immunization appointment and arrange transportation as needed. When children are 27 months old, outreach staff check the health plan's claim system and the state's immunization registry (the Arizona State Immunization Information System) to determine if they have received all the recommended immunizations. If not, APIPA staff send a request for records to the child's physician so they can enter the information manually into the registry, and they call the parents again to encourage immunization and arrange an appointment. If all other reminders have failed, they offer parents a \$25 gift certificate to Wal-Mart for completing their child's immunizations.

Communication with Physicians

Besides contacting members to encourage immunization, APIPA outreach staff send mailings and make phone calls to physicians to emphasize the importance of promoting recommended immunizations and to encourage them to register with Arizona's immunization registry, as required by state law. APIPA also highlights these issues in its physician newsletter.

Results

As a result of APIPA's outreach efforts, 31% of members whom APIPA outreach staff contacted successfully between April and December 2004 had their children immunized within six months. Nearly 60% of members who received birthday card or well-child reminders by mail during this time had their children immunized within six months. Immunization rates improved significantly over 2000-2001 rates, as follows:

- ▶ 93% of children received the recommended three H. influenza type B (HIB) vaccines in 2004, compared with 85% in 2000-2001;
- ▶ 91% of children received the recommended measles/mumps/rubella vaccine, compared with 87% in 2000-2001;
- ▶ 89% of children received the recommended three polio vaccines, compared with 87% in 2000-2001;
- ▶ 88% of children received the recommended three Hepatitis B vaccines, compared with 80% in 2000-2001;
- ▶ 84% of children received the recommended four diphtheria/tetanus/pertussis vaccines, compared with 80% in 2000-2001;
- ▶ 83% of children received the chicken pox vaccine, compared with 63% in 2000-2001.

For more information, contact:

Kimberly Gower, BSW, MBA
Director, Prevention and Wellness
Arizona Physicians IPA, Inc.
An AmeriChoice Health Plan
3141 N. 3rd Avenue
Phoenix, AZ 85013
(602) 664-5437
Kimberly_Gower@uhc.com

Tennessee Caring for Kids Initiative

BlueCross BlueShield of Tennessee analyzed Medicaid members' monthly EPSDT screening rates from December 1999 to June 2001 and found rates ranging from 48% to 52%. In response, the plan implemented the Tennessee Caring for Kids (TCFK) initiative from July 2001 through June 2002 to increase rates of EPSDT screening among Medicaid members under age 20 and to improve its tracking of EPSDT screening data.

Incentives for Parents and Practitioners' Office Staff

BlueCross BlueShield of Tennessee identified members who had not had their required EPSDT screening and sent postcards to the parents and guardians of those members to encourage them to schedule an appointment for EPSDT services. The health plan offered parents and guardians a \$5 Wal-Mart gift card for receiving the EPSDT services, obtaining their primary care physician's (PCP's) signature on the postcard (to attest that they had the screening visit), and returning the signed postcard to the plan.

Similarly, the health plan provided incentives to primary care practitioner (PCP) office staff for conducting outreach to members who had not received the recommended EPSDT screenings: placing EPSDT reminders for the PCPs in members' charts and working to ensure that data collection forms were returned to the plan. Staff members received a \$5 Wal-Mart gift card for each member-specific data collection form completed and returned to the health plan.

Collaboration with the State Health Department

BlueCross BlueShield of Tennessee collaborated with Tennessee's Regional Health Departments to obtain screening data for EPSDT members. The health plan provided the departments with lists of their members who were not up-to-date with their EPSDT screenings and encouraged staff to schedule and perform EPSDT screenings for any of these members who came to the health department for another purpose. Once the screenings were performed, health departments returned the lists with the relevant screening information to the health plan.

Improving Data Analysis to Identify EPSDT Screening

BlueCross BlueShield of Tennessee implemented two internal changes to better identify EPSDT screenings from its member database: (1) The plan constructed a cross-reference table linking members' alternate and/or temporary identification numbers with their permanent identification numbers. Many members had alternate or temporary identification numbers assigned to them before they received a permanent identification number. Because EPSDT claims are filed under the member's identification number at the time of the physician visit, EPSDT claims for members in some cases existed under more than one identification number. (2) In some cases, EPSDT claims for infants were filed under their mother's identification number and the infant's screening was not recorded. The plan linked identification numbers for female parents to the identification numbers of infants in the same household to confirm that EPSDT claims filed under the parent's identification number were in fact claims for the infant.

Survey of PCP Office Staff

BlueCross BlueShield of Tennessee surveyed PCP office staff to better understand how they conducted member outreach, how they changed office procedures to increase EPSDT screening rates, and what they viewed as the main barriers to EPSDT screening. Highlights from the survey include:

-
- ▶ Most respondents (56%) indicated that they conducted member outreach either in person (31%), by telephone (30%), and/or by mail (25%) to provide reminders or schedule appointments for screenings. The main obstacles encountered by office staff when trying to contact patients were invalid addresses or telephone numbers (32%) and the fact that parents/patients did not keep their scheduled appointment (29%).
 - ▶ Most respondents noted that they handle EPSDT differently as a result of the TCFK initiative. For example, office staff reported improvements in EPSDT medical chart documentation (39%), use of in-office EPSDT reminders (33%), and placement of EPSDT data collection forms in patients' charts as a reminder that an EPSDT screening is due (59%).

Results

From July 2001 through June 2002, the plan's EPSDT screening rate increased from 54% to 73%. As a result of this initiative, an additional 46,274 children received Medicaid EPSDT screenings. The component of the program that provided incentives to PCP office staff produced the most dramatic results—leading to 23,814 additional EPSDT screenings, compared with 770 additional screenings obtained from the incentive program for parents and guardians.

Based on the cost of the TCFK initiative, BlueCross BlueShield of Tennessee estimates that the cost of promoting EPSDT screening through outreach with PCP office staff would be as follows:

- ▶ \$2.32 per member per month (PMPM) for children under 1 year of age;
- ▶ \$1.39 PMPM for children 1 through 2 years of age;
- ▶ \$0.46 PMPM for children 3 years of age and older.

For more information, contact:

Sheila D. Keith
Manager, Medical Information Management
BlueCross BlueShield of Tennessee
801 Pine Street
Chattanooga, TN 37402
(423) 752-7603
Sheila_Keith@BCBST.com

Improving Preventive Care for Adolescents

In 2000, HealthPartners analyzed medical records for children and adolescents in its Medicaid member population and found that as children got older, they were less likely to visit clinics and receive the preventive care visits required under the federal EPSDT program (known in Minnesota as the Child & Teen Checkups (C&TC) program). Recognizing that adolescence can be a time of experimentation with risk-taking behaviors, HealthPartners sought to increase members' use of C&TC preventive services in order to screen for health risks, reinforce positive behaviors, identify early symptoms of physical and emotional problems, and offer early interventions as needed.

Using Incentives to Encourage Visits

To promote increased use of preventive care among adolescents, HealthPartners conducted a pilot study with approximately 2,200 children and adolescents in Ramsey and Hennepin Counties. Children in Ramsey County served as the study group, and children in Hennepin County served as the control group. April 2001 through March 2002 was the baseline year, and April 2002 through March 2003 was the intervention year. During this period, the health plan mailed Ramsey County members ages 10, 12, 14, 16, and 18 a reminder during the month of their birthday, encouraging them to visit their clinic for a checkup. The reminder included the name and telephone number of the member's clinic. The preventive visit was described as an important part of adolescent health care and an opportunity to privately discuss concerns with a doctor. The reminder offered children and teens a \$30 gift certificate to Target if they returned the reminder to the health plan with their health care provider's signature indicating that they completed the preventive care visit.

During the check-up, practitioners were expected to provide a complete physical exam, conduct hearing and vision tests, assess dental care needs, address behavioral and substance abuse issues as needed, and provide age-appropriate guidance on avoiding risk-taking behaviors. The Minnesota Department of Human Service Web site (www.dhs.state.mn.us) provides information for health care practitioners on talking with teens about behavioral and substance abuse issues.

Results

Children in both the intervention and control group increased their use of C&TC preventive care services during the intervention period, but the increase was 5.5% greater among children receiving the birthday incentive reminders. Overall, the claims rate of C&TC preventive care visits increased from 63% in 2000 to 82% in 2003. The greatest improvement occurred among 10 through 14 year-olds. Children and teens in the intervention group who were 12 years of age responded most frequently to the incentive offer (34%) and those 18 years old responded least frequently (5%).

In light of these positive results, HealthPartners' Quality Council recommended expanding the pilot project to include all the health plan's adolescent members receiving Medicaid benefits in 2004. Thus far, based on nine months of data, approximately 9% of those sent incentive offers have responded. The goals of the program are to reach more than 6,000 children and adolescents in 2005, and to keep HealthPartners C&TC claims rates at 80% or more in the years to come.

For more information, contact:

Cynthia J. Lord, MA, RN
Public Programs Health Coordinator
HealthPartners
8100 34th Avenue South
P.O. Box 1309
Mail Stop 21108X
Minneapolis, MN 55440-1309
(952) 883-6163
Cindi.J.Lord@HealthPartners.com

Kaiser Foundation Health Plan

Hawaii

Understanding Barriers to Child Immunization

In 1999, data analysis by Kaiser Permanente in Hawaii (KP Hawaii) found that approximately 68% of its Medicaid members and 80% of commercial members under 19 months of age were up-to-date on their childhood immunizations. As a first step to increasing immunization among its members, KP Hawaii sought to systematically identify major barriers to immunization, including missed opportunities in health care practitioners' offices, as well as obstacles facing parents.

To capture missed opportunities in practitioners' offices, KP Hawaii developed a tracking form on which practitioners and office staff listed reasons immunizations were missed. Among these reasons were patient or parent refusal, incomplete staff documentation, lack of an established patient chart and difficulties in contacting patients' previous health care practitioners. This information helped KP Hawaii develop appropriate strategies to boost immunization rates.

Initially, the most common barriers identified were failure to schedule physical exams after age 1 (i.e., at 15, 18, and 23 months), when many immunizations are recommended; lack of parental knowledge of the American Academy of Pediatrics immunization schedule; and failure of office staff to track members who were behind on immunizations. Barriers that continue to challenge practitioners and staff include failure to provide all needed shots during one visit and inability to contact patients due to invalid addresses and telephone numbers.

Conducting Outreach to Address Barriers

KP Hawaii's nurses and paraprofessional staff review medical records and analyze the health plan's databases to identify children behind in their immunizations. Staff attempt to contact parents by telephone, and they conduct home visits if members are homebound, do not have a telephone, or are unresponsive to phone calls and letters. During these contacts, KP Hawaii's staff educate members on the importance of immunization, keeping appointments, and taking recommended medications. They also provide help with transportation and appointment-making as needed.

Results

As a result of this program, immunization rates for Kaiser's Medicaid members in Hawaii rose from 68% in 1999 to 92% in 2004. KP Hawaii's Medicaid immunization rates have been in the 90% range for more than four years—some of the highest reported rates in the United States.

KP Hawaii's Medicaid childhood immunization rates have exceeded the rates in its commercial population by an average of 3 percentage points over the last four years. This is in contrast to the nation as a whole, where Medicaid childhood immunization rates were approximately 12 percentage points lower than those for commercial populations (62% versus 74%) in 2003.

For more information, contact:

Cynthia Nakasato, MD
Department of Pediatrics
Kaiser Foundation Health Plan
Kaiser Permanente Waipio Clinic
94-1480 Moaniani Street
Waipahu, HI 96797
(808) 432-0000
Cynthia.nakasato@kp.org

Medica Health Plans and Metropolitan Health Plan

Minnesota

The MATCH Program: A Grassroots Partnership

In March 2001, Metropolitan Health Plan, Medica Health Plans and the Allina Foundation established the Mothers Advocating Their Children's Health (MATCH) program to promote well-child care and EPSDT screening. The program began as a grassroots partnership with community clinics and faith communities, which encouraged mothers to educate peers in their community about the importance of well-child checkups. During the summer of 2001, the MATCH Steering Committee worked with Baptist churches and six community clinics to provide more than 140 well-child examinations for children up to age 20 from 18 faith communities in the Minneapolis area.

Due to the program's success, in August 2003, the MATCH Steering Committee decided to expand the program to other faith communities. Medica and Metropolitan Health Plan provided grants to the Greater Minneapolis Council of Churches (GMCC) to operate a program known as CATCH (Congregations Advocating Their Communities' Health), and GMCC recruited eight additional partner congregations.

CATCH developed a portfolio of educational materials on well-child care, which it distributed at local health fairs and church events. In 2004, GMCC worked with 16 faith communities—including Baptist, Lutheran, Catholic and Muslim organizations—to implement CATCH within their congregations and provide education on the importance of well-child checkups. The GMCC's CATCH coordinator provided support to participating faith communities through site visits, regular meetings, and financial assistance that allowed them to implement the CATCH program at their sites. During site visits and meetings, congregations shared information about their successes and challenges in conducting the program.

In October 2004, Metropolitan Health Plan, Medica, GMCC, and the Minnesota Faith Health Consortium hosted a MATCH conference called *In Good Health: Aligning Children's Health with Faith and Community Resources* for parents, church health advocates, nurses, and other health care professionals. The conference featured a keynote address on the role of faith in children's lives, and it included breakout sessions on asthma, children's mental health issues, Child & Teen Checkups (Minnesota's version of the federal EPSDT program), adolescent health, and strategies for working with government officials. Sessions on Child & Teen Checkups and children's mental health issues had the highest attendance.

Results

GMCC estimates that CATCH outreach efforts led to approximately 120 well-child visits for children up to age 20 in 2004. GMCC is developing translated materials on well-child care for congregations serving non-English speaking immigrant families, and it plans to recruit additional congregations for the program in 2005. Several congregations have expanded their outreach efforts to promote services besides well-child care, such as cancer screening, smoking cessation, and mental health and substance abuse education.

For more information, contact:

Glenn Andis
Senior Vice President
of Government Programs
Medica
Route# CP340
401 Carlson Parkway
Minnetonka, MN 55305-5387
(952) 992-3977
Glenn.Andis@medica.com

Medica Health Plans

Minnesota

Promoting Well-Child Screenings

In response to a Minnesota Department of Human Services (DHS) study indicating that 30% of children covered under Medicaid and other state health benefit programs had not received any preventive health care services, Medica implemented a children's home visit program for its public program members in 2001. The program's goal was to increase the rate of well-child screenings for these members.

Providing Telephone Outreach in Multiple Languages

Initially, the program focused on English-speaking families in Hennepin County with two or more children ages 0 through 9 who had not had a well-child checkup for more than a year. The project subsequently expanded to focus on all children over age 2, regardless of primary language, in western portions of Ramsey and Hennepin Counties. Medica conducts outreach by telephone to introduce the program and obtain member consent for a visit from a public health nurse. Initially, a nurse agency placed introductory calls. However, because of a low initial response, Medica began using its in-house customer service staff to make calls in the early evening, when more members were home. The plan's customer service staff can converse in five languages and uses AT&T's Language Line to access speakers in additional languages as needed.

Well-Child Checkups at Home

Once a family consents to the program, a nurse calls to schedule an in-home appointment for a Child and Teen Checkup (Minnesota's version of the EPDST program). During the visit, the nurse works with the parent or guardian to identify a primary care clinic to serve as their regular source of care. In addition, the nurse emphasizes the importance of routine preventive health visits for children and provides information on resources available in the community (e.g., sources for free or reduced-price food, assistance with housing and utility payments). The nurse also describes other Medica programs and services that could be helpful to the family.

Results

More than 1,600 children have received a visit through this program since 2001, and the number of well-child visits among Medica's public program members has increased substantially each year.

For more information, contact:

Glenn Andis
Senior Vice President
of Government Programs
Medica
Route# CP340
401 Carlson Parkway
Minnetonka, MN 55305
(952) 992-3977
Glenn.Andis@medica.com

Passport Health Plan

Kentucky

Using the “Screen Team” to Increase EPSDT Rates

Approximately 70% of Passport Health Plan’s (PHP’s) Medicaid members are under age 21. To increase understanding of EPSDT services that the Medicaid program requires for beneficiaries in this age group, PHP implemented the “Screen Team” campaign in 1997. Representatives from PHP’s EPSDT and Public Affairs departments collaborated on the campaign, which emphasized teamwork by the parent or guardian, child, and health care practitioner to ensure that children of all ages receive recommended preventive health services.

PHP staff made phone calls and home visits to families of children who had not had recommended EPSDT screenings, conducted outreach in health care practitioners’ offices to emphasize the importance of EPSDT visits, and sent postcard reminders to families of all newborn Medicaid members. In addition, PHP distributed a series of brochures, postcard reminders, and posters urging members to “Join the Screen Team” to obtain well-child services.

Partnering with Health Care Practitioners

To increase awareness of EPSDT screening among health care practitioners, PHP provides a bonus to participating health care practitioners who achieve an EPSDT screening rate greater than 83% in one year. On a quarterly basis, PHP sends letters to participating health care practitioners to inform them of the opportunity to earn the bonus. In addition, PHP describes the program in its health care practitioner newsletters, bulletins, medical office notes, and on its Web site.

On an annual basis, PHP outreach staff conduct site visits to offices of health care practitioners serving a high volume of Medicaid members to review requirements of the EPSDT program and help them compile and submit data required for the program.

Results

In 1997, 17% of Medicaid beneficiaries under age 21 in Kentucky had received all of the required EPSDT well-child services. By 2004, 83% of children covered by PHP had received the required services.

For more information, contact:

Jill Bell
Vice President of Public Affairs
Passport Health Plan
305 W. Broadway
Louisville, KY 40202
(502) 585-7079
Jill.Bell@amerihealthmercy.org

Santa Clara Family Health Plan

California

Using Physician Incentives and Member Outreach to Promote Well-Child Care

In 1997, Santa Clara Family Health Plan established an incentive program for participating health care practitioners to increase the proportion of Medicaid members ages 3 to 6 years who receive appropriate well-child visits. The health plan provides a fee-for-service payment in addition to the monthly capitation payment to physicians who conduct annual well-child exams with any patient in this age group. Incentive payments range from \$33 to \$55 for an established patient to \$44 to \$69 for a new patient.

In addition to these payments, the health plan sends participating health care practitioners a packet with children's preventive health care guidelines and a comprehensive well-visit checklist of all age-appropriate tests, treatments, exams, screenings, health education and preventive services. Together, the guidelines and checklist help ensure that children receive all the preventive services they need. The forms and guidelines also are available on the health plan's Web site.

Reaching Out to Physicians and Parents

The health plan reinforces the goal of promoting well-child visits by conducting regular outreach activities with network providers. Outreach activities include quarterly on-site visits to provider offices, quarterly meetings between medical groups/independent practice associations and the health plan's Quality Improvement and Provider Services staff, regular articles in the plan's monthly provider newsletter, postings on the health plan's Web site, and special mailings to provider offices.

The health plan also reaches out to parents with messages highlighting the importance of annual well-child exams. Vehicles for communicating this important message to parents include the health plan's quarterly member newsletter, welcome packets for new members, the health plan's evidence of coverage booklets, new member orientation classes, interactions with the health plan's member call center staff, and the health plan's Web site.

Results

From 2000 to 2004, the percentage of Medicaid members ages 3 to 6 years who received an annual well-child visit rose from 60% to 72%.

For more information, contact:

Stephen Robitaille
Consultant
Public Relations Department
Santa Clara Family Health Plan
210 E. Hacienda Ave.
Campbell, CA 95008
(408) 874-1842 or (510) 531-8062
sjrobitaille@sbcglobal.net

Incentives to Check Children’s Blood Lead Levels

In response to a State of Minnesota initiative to increase lead screening levels, UCare Minnesota piloted a lead screening incentive program for Medicaid members in 2002 and launched the full-scale incentive program in 2003. The program’s goal is to ensure that all children in its Medicaid health plan have a blood lead level test at ages 1 and 2 years. Families receive a \$10 gift certificate when each 1 or 2 year-old child completes a blood lead level test. The vouchers required to obtain the gift certificates are available in member newsletters or by calling UCare’s Customer Service number. A provider needs to sign the voucher documenting that the service was provided. The member then sends the signed voucher to UCare and the \$10 gift certificate incentive is mailed to the member. In addition, UCare sends automated phone messages to remind families about the need for lead screening.

Communication with Health Care Practitioners

UCare educates its participating primary care providers about the importance of lead screening for children ages 1 and 2 years, and sends “chart flags” to alert physicians of the need for screenings. Physician education occurs in many ways, including site visits from the plan’s medical director to key clinics, training for new medical residents, and program staff meetings with clinic staff.

Results

From 2001 to 2004, the rates of blood lead level screening for Medicaid members age 1 and 2 years old increased by 48%.

For more information, contact:

Ghita Worcester
Vice President
Public Affairs and Development
UCare Minnesota
P.O. Box 52
Minneapolis, MN 55440
(612) 676-3634
gworcester@ucare.org

Partnering with Health Care Practitioners to Promote Well-Child Care

Noting that 14% of children in its Medicaid population had not had any visits to the doctor in the past year, UCare Minnesota established an outreach program in 2001 to promote well-child services for members under the age of 20 years. The program involves ongoing communication with health care practitioners, to encourage them to provide well-child services at the appropriate intervals. Both Quality Management staff and Provider Network Management staff meet with clinical leaders from health care clinics to communicate the opportunity and ask for their partnership. Clinics that agree to partner with the health plan to promote well-child services are given member-specific information (e.g., demographic, primary language spoken) regarding children in need of care and are asked to conduct telephone outreach with these members to encourage well-child visits. All information provided by the health plan to the practitioners is organized to help them track the results of their telephone outreach attempts (i.e., whether the member presented for the appointment and all follow-up visits).

In addition, UCare provides “chart flags” to physician offices to remind them to conduct well-child screening tests at the appropriate intervals. The chart flags are printed on brightly colored card stock with large lettering noting that this child is due for a preventive visit. They are sent to the clinic along with a list of patients who are due for a visit and instructions for the office staff to put the flag at the front of the child’s medical record. When the clinic schedules the preventive visit, a staff member faxes the disposition back to the health plan so that the plan can track the efficacy of the flags.

Member Incentives

In addition to working with health care practitioners, UCare provides Medicaid members financial incentives to stay up-to-date on immunizations and lead screening. Parents receive a \$10 gift certificate if they have their children undergo a blood lead test at ages 1 and 2. The purpose of UCare’s program is to ensure that members are being screened at these ages. The \$10 voucher is available in member newsletters or by calling UCare Customer Service. A provider needs to sign the voucher documenting that the service was provided. The member sends a signed voucher to UCare and the health plan mails the \$10 gift certificate to the member.

A \$25 gift certificate is available to families when children receive all required immunizations by age 2, and again by ages 10 through 12. Vouchers are mailed monthly to member families. Vouchers are also available in member newsletters or by calling UCare Customer Service. A provider needs to sign the voucher documenting that the service was provided. The member sends a signed voucher to UCare and the health plan mails the \$25 gift certificate to the member.

Focus on the Hmong Population

Because the rate of well-child visits was particularly low in the Hmong population (29% of Hmong children had no doctor’s visit in 2001, compared with 13% of Caucasian children), UCare established a targeted outreach program for Hmong Medicaid members in 2002. UCare works with the health care clinics that have the highest volume of Hmong children who have not had a doctor’s visit in the past year. UCare nurses and social workers who speak the Hmong language partner with medical clinic staff to conduct outreach to Hmong Medicaid members. The outreach is conducted by telephone, and the purpose of the calls is to remind parents to take their children for the appropriate preventive care visits. UCare also conducts automated phone calls in Hmong to remind families of the need to have their children immunized.

UCare Minnesota (cont'd)

Minnesota

Results

From 2001 to 2004, the number of teen members receiving a well-child checkup increased by 65%, and the number of children who had at least one doctor visit (of any type) in the previous year increased by more than 1,000.

In the Hmong population, the percentage of children under the age of 20 who did not receive medical care dropped from 29% in 2002 to 20% in 2004.

For more information, contact:

Ghita Worcester
Vice President
Public Affairs and Development
UCare Minnesota
P.O. Box 52
Minneapolis, MN 55440-0052
(612) 676-3634
gworcester@ucare.org

Telephone Outreach to Promote Preventive Care for Children

To boost the rate of well-child visits among Medicaid members, UPMC for You (the University of Pittsburgh Medical Center's Medicaid health plan) implemented a telephone outreach project on a pilot basis in 2002. The health plan analyzed claims data to identify Medicaid members turning ages 2 and 13 who had not visited their primary care physician in the last 12 months.

Outreach staff from the health plan's preventive care outreach department called parents and guardians of these members to emphasize the importance of regular preventive care for children and to help them schedule an appointment with their primary care practitioner. If parents had not chosen a primary care physician for their child, outreach staff helped them choose one and also helped schedule an initial doctor's visit for their child as needed.

Extended Business Hours and Expanded Scope

To increase the percentage of members reached through the project, UPMC for You extended business hours for outreach staff to include evenings and weekends, when members were more likely to be at home. In addition, to increase the number of well-child visits for all Medicaid members, the health plan extended the pilot to include all children ages 2 and 13 who had not visited their primary care physician within the last 12 months.

Results

As of June 2004, 64% of children turning ages 2 and 13 whose families had been contacted (approximately 360 members) had visited their primary care physician at least once to receive the recommended well-child services.

For more information, contact:

Colleen Walsh
Senior Director, Medical Management
UPMC Health Plan (University of
Pittsburgh Medical Center)
112 Washington Place
Pittsburgh, PA 15219
(412) 454-2069
walshc@upmc.edu

Blue Cross of California State Sponsored Programs

California

Partnering with Physicians to Promote Child Immunization

In 2003, fewer than 25% of California children under age 6 were listed in the state's immunization registry. Immunization registries are the latest and most effective tool for improving immunization rates because they maintain accurate, computerized, up-to-date immunization histories; provide rapid access to immunization records for physicians; compound records when vaccines are given at different physician's offices; notify physicians and parents when shots are due assist with vaccine inventory; and assess levels of immunization coverage.

To increase the number of children who receive the appropriate immunizations, Blue Cross of California State Sponsored Programs has partnered with nine local immunization coalitions and seven local immunization registries to educate the community about childhood immunization and recruit physicians for participation in the state's immunization registry system.

Blue Cross of California's physician recruitment efforts include a health plan offer of free computers to physicians serving large numbers of Blue Cross of California Medicaid members. The computers are accompanied by an invitation to participate in California's immunization registry system, which is signed by the Acting Chief of California's Department of Health Services Immunization Branch. The technology assistance has served as an incentive to participate in immunization registries.

Blue Cross of California also collaborated with registries and coalitions to organize training sessions for health care practitioners led by representatives of "Every Child by Two" at local conference sites. "Every Child by Two" is a national organization developed in 1991 by Former First Lady of the United States Rosalynn Carter and Former First Lady of Arkansas Betty Bumpers to raise public awareness of childhood immunizations. The content of these training sessions is reinforced by Blue Cross staff in the physician's offices during subsequent visits.

As part of an intensive outreach pilot study implemented in January 2004, Blue Cross of California quality nurses conducted visits to the offices of 23 physicians serving a large volume of Medicaid members in Fresno County to encourage them to participate in the immunization registry. The nurses used this opportunity to further explain the benefits of registry participation and assist physicians with registry training for their staff.

Results

The number of California children ages 0 to 5 listed in state registries is estimated to have increased more than 10%, from nearly 607,000 in 2003 to approximately 670,000 in 2004. As of December 2004, 57.5% of Blue Cross of California's primary care physician sites in Fresno County, where the outreach pilot study was conducted, and 34% of Blue Cross of California primary care physician sites statewide have registered with the state's immunization registries.

For more information, contact:

John P. Monahan
Senior Vice President
WellPoint State Sponsored Programs
5151-A Camino Ruiz
Camarillo, CA 93012
(805) 384-3511
john.monahan@wellpoint.com

Chapter 4

Providing Prenatal and Postnatal Care



Medicaid provides comprehensive health coverage to more than 6.8 million women in their childbearing years and finances over one-third (37%) of all births in the United States. As a major source of health coverage for low-income women of childbearing age, the Medicaid program plays an important role in ensuring that women receive effective prenatal and postnatal care. For pregnant women, Medicaid covers prenatal visits, delivery, and other pregnancy-related care, as well as postpartum care.

For many years, before significant numbers of Medicaid beneficiaries were enrolled in health insurance plans, beneficiaries lacked a regular source of early and comprehensive prenatal care, and the problems of smoking and substance abuse among pregnant Medicaid beneficiaries were not addressed in a systematic way. As a result, Medicaid beneficiaries often had pregnancy complications that placed their health and their babies' health at risk and drove up costs in the Medicaid program. Nationwide, hospitalizations for pregnancy complications cost more than \$1 billion annually.

Across the country, health insurance plans participating in the Medicaid program have championed effective programs to increase early access to prenatal care, reduce premature births, and promote comprehensive patient education and awareness. These programs are providing significant savings. The National Committee for Quality Assurance reports that every dollar spent on prenatal care saves \$3.33 in postnatal care and \$4.63 in long-term disability costs. This chapter provides examples of health plan programs designed to promote healthy outcomes for pregnant Medicaid beneficiaries and their newborn children.

Taking Care of Baby and Me

To help pregnant Medicaid members avoid complications and hospital readmissions, AMERIGROUP implemented the Taking Care of Baby and Me program in 2002. The program focuses on member education and coordination of care.

AMERIGROUP identifies members eligible for the program through internal reports and claims data, including data on emergency room visits, inpatient admissions, member self-referrals, physician's office visits, and referrals from the health plan's 24-Hour Nurse Help Line. Obstetrical care managers contact members and administer a questionnaire to identify factors that increase the risk of pregnancy complications (e.g., smoking, chronic conditions, narcotics use). Care managers develop an individualized care plan for these members, and they contact them at least once a month to ensure that they are receiving the recommended prenatal and postpartum care.

All pregnant Medicaid members receive packets of information on prenatal and postpartum care and lists of health-related services available in the community, such as childbirth education classes. AMERIGROUP also offers gift incentives, such as baby care items, to encourage pregnant members to keep their doctor's appointments.

Results

Medicaid members participating in Taking Care of Baby and Me in 2002 had higher rates of prenatal and postpartum care than those not in the program, and rates of low birthweight babies and neonatal intensive care admissions were lower among program participants, as follows:

- ▶ 86% of program participants completed more than 80% of prenatal visits, compared with less than 11% for non-participants.
- ▶ 4% of babies born to program participants were categorized as low birth weight (under 2,500 grams), compared with nearly 9% for non-participants.
- ▶ 3.5% of babies born to program participants were admitted to the hospital's neonatal intensive care unit, compared with approximately 12% for non-participants.
- ▶ 100% of program participants received their six-week postpartum checkup, more than twice as many as non-participants (49%).

For more information, contact:

Dr. Michael Musci
Vice President
Associate Corporate Medical Director
AMERIGROUP
4425 Corporation Lane
Virginia Beach, VA 23462
(757) 518-3682
mmusci@amerigroupcorp.com

Group Health Cooperative

Washington

The Teen Pregnancy and Parenting Clinic

To reduce the risk factors and adverse outcomes often associated with teen pregnancy, Group Health Cooperative established the Teen Pregnancy and Parenting Clinic (TPPC) in 1990. The clinic staff provides education and support to help pregnant teens avoid risky behaviors—such as smoking, alcohol, and recreational drug use—that can lead to premature birth, low birthweight, and cognitive impairments.

Teens are referred to the TPPC from Group Health’s health care practitioners, local high school health programs, women who previously participated in the program, and others in the community. Program participants range in age from 13 to 25.

A Multi-Disciplinary Approach

Resident physicians and nursing and medical students from Group Health’s Family Medicine Residency program and from the University of Washington provide medical care for the program. Services include antepartum care, delivery, postpartum care, primary care, and pediatric follow-up. Dr. Michael Madwed, a primary care physician and clinic administrator, and his colleagues supervise these students as they provide services to the pregnant teens.

In addition to physicians, the TPPC care team includes a registered nurse; a social worker; a nutritionist; a representative from the U.S. Department of Agriculture’s Special Supplemental Nutrition Program for Women, Infants, and Children (the WIC program); and, a health educator. The registered nurse serves as the program’s “hub.” She meets with patients during every visit, helps assess their needs, and coordinates care with other team members. The social worker addresses psychological issues, which may include domestic violence and coping problems, and she helps program participants obtain resources they may need from the community, including transportation, housing, and consistent health care coverage. The nutritionist helps participating teens create a healthy diet appropriate for pregnancy, and the WIC provider helps them obtain vouchers for free groceries through the WIC program. The health educator teaches individual and group classes on parenting.

Participating teens visit the TPPC care team every one to three weeks throughout their pregnancy and have follow-up visits for up to a year after delivery. TPPC provides services to the children of TPPC participants for up to five years.

Results

The TPPC program provides care to approximately 50 teens and their children each year. Health outcomes among program participants have exceeded those achieved among comparable populations served by Seattle area community health centers. In 2004,

- ▶ 6.6% of program participants required C-sections.
- ▶ 6.6% of babies were born prematurely (before 37 weeks gestation).
- ▶ 6.8% of babies had low birthweight (less than five pounds).

For more information, contact:

Mary McGregor RN, MN
Practice Team Manager
Capitol Hill Family Health Center
Group Health Cooperative
125 16TH Ave E.
Seattle, WA 98112
(206) 326-3084
mcgregor.m@ghc.org

Passport Health Plan

Kentucky

The Mommy & Me Program

To address the high rate of preterm births in the State of Kentucky, in 1997, Passport Health Plan (PHP) established the Mommy & Me program to improve prenatal care and infant and maternal health for Medicaid members.

PHP identifies pregnant Medicaid members through (1) referrals from their OB/GYN, (2) member self-referrals, and (3) referrals from local health departments. The health plan mails these members materials to emphasize the importance of early prenatal care, introduce the Mommy & Me program, and tell them how to reach a program representative.

One week after sending these materials, PHP program representatives contact the members by phone to encourage early and regular prenatal care, identify factors (such as smoking, drug use, and inadequate nutrition) that could lead to pregnancy complications, and refer them to community agencies that can address these issues. For example, local offices of the U.S. Department of Agriculture's Special Supplemental Nutrition Program for Women, Infants, and Children (the WIC program) can provide vouchers for free groceries to help promote good nutrition.

Nurse case managers follow up with members to ensure that they receive the recommended prenatal care. As a first step, case managers send all program participants a comprehensive, easy-to-read guide to healthy pregnancy (*Mommy & Me Basics: A Guide to a Healthy Pregnancy, Delivery, and Baby Care*), which PHP developed specifically for young, pregnant Medicaid members who may have low literacy levels. Case managers talk with members over the phone to help them understand and use the book. In addition, case managers are notified by PHP's participating health care practitioners if a pregnant Medicaid member has missed an appointment for prenatal care. In these situations, the case manager works with the member to address reasons for missed appointments and ensure that they receive the recommended care.

Case managers contact members identified as having risk factors for pregnancy complications on at least a monthly basis (and more if needed) by phone to review the progress of their pregnancy, help them follow their plan of care, and help them address risk factors (e.g., by helping them enroll in a smoking cessation class). If phone contact proves to be ineffective, case managers visit these members at home to address their needs.

Two weeks and four weeks after delivery, case managers follow up with members by phone to encourage them to seek postpartum care, evaluate them for postpartum depression, and emphasize the importance of well-baby care. Case managers refer members who appear to have postpartum depression to their primary care physician or OB/GYN, and to the appropriate social service agency for assistance.

Passport Health Plan evaluates and updates the program each year, based on input from participating health care practitioners who serve on the plan's Women's Health and Quality Committees. As a result, PHP has increased outreach activities to Medicaid members and expanded the number of members who receive case management services.

Results

Approximately 6,500 pregnant Medicaid members receive services through the Mommy & Me program annually. From 2000 to 2003, the percentage of pregnant Medicaid members who received a prenatal care visit in the first trimester or within the first 42 days of enrollment increased from 85% to 89%.

The percentage of pregnant Medicaid members who received 81% or more of the recommended number of prenatal visits grew from approximately 69% in 1999 to 84% in 2003.

Whereas 58% of pregnant Medicaid members received a postpartum visit between 21 and 56 days after delivery in 1999, approximately 75% had a postpartum visit within this time frame in 2003.

For more information, contact:

Jill Bell
Vice President of Public Affairs
Passport Health Plan
305 W Broadway
Louisville, KY 40202
(502) 585-7079
Jill.Bell@amerihealthmercy.org

A Home- and Community-Based Strategy for Healthy Moms and Babies

In 2002, Optima Health established the Partners in Pregnancy program to promote healthy pregnancies and reduce premature births for Medicaid and commercial members. More than 60% of program participants are Medicaid beneficiaries.

Optima analyzes claims data to identify pregnant members and determine which members are at highest risk for pregnancy complications. A nurse case manager remains in contact with high-risk members throughout their pregnancies; communicates with their doctors when appropriate; and helps them access community resources such as WIC, childbirth classes, and other available social services as needed.

Optima also partners with Virginia's Comprehensive Health Investment Project (CHIP), an organization offering support and education to at-risk families throughout the state. CHIP provides home visits using teams of nurses and outreach workers to support high-risk pregnant women and their families by offering nursing assessments and support with medical follow-up, acting as clinical "eyes and ears" for the OB/GYN physician, and providing social and emotional support and coordination with local service organizations. Some examples of services offered by CHIP include transportation to medical appointments, connection with substance abuse programs, and training in anger management and parenting skills. Case managers work with local social service organizations such as the Virginia Department of Health and Social Services, Resource Mothers, Healthy Families, Community Services Boards, and Regional Development Services to provide educational resources; coordinate substance abuse/mental health needs and treatment; assist with temporary housing, food, and energy needs; and provide additional support for pregnant women and babies.

Optima also provides ongoing support to women considered to be at lower risk of pregnancy complications, as determined by claims analysis, medical information supplied by the physician, and member assessment. Health education staff remain in contact with such members by telephone throughout their pregnancy and monitor any changes in their risk for complications by using a database that guides them through an ongoing assessment of risk factors. If a change in risk level occurs, a referral to a nurse case manager for further triage is completed immediately, ensuring that subtle changes in health are identified and communicated to the physician.

Results

Optima documents about 7,000 births annually in its insured population. About two out of three of these births occur in the Medicaid population. As a result of this program, Optima estimates that nearly 3,000 days in the neonatal intensive care unit have been avoided since 2002, and for every dollar spent on the program, \$2.80 was saved.

In recognition of these results, the Partners in Pregnancy Program was featured as an example of a Best Practice at the Center for Health Care Strategies' National Quality Summit in October 2002. The Disease Management Association of America recognized the program as the Best Disease Management Program for Medicaid in 2004. Optima also received a grant from the Center for Health Care Strategies in 2004 to measure the long-range outcomes from May 2004 through October 2007 and calculate the return on investment for the program. Additionally, a March of Dimes grant of \$10,000 was received to educate and develop service coordination documents and standards between CHIP of Virginia and the Optima program.

For more information, contact:

Karen Bray, RN, CDE
Disease Management Program Director
Optima Health
4417 Corporation Lane
Virginia Beach, VA 23462
(757) 552-7198
KJBRAV@sentara.com

Chapter 5

Improving the Coordination of Care



Medicaid beneficiaries with chronic health conditions often need care from many health care practitioners who may not be in regular contact with each other. In its report titled *Crossing the Quality Chasm*, the Institute of Medicine recommended redesigning the health care system to provide more coordinated care.

Health insurance plans have developed a wide variety of programs to coordinate care for children and adults with chronic conditions. These programs focus on developing a plan of care; promoting ongoing communication between members and their health care practitioners; and helping with needs such as transportation, housing, and social services.

In addition to providing Medicaid beneficiaries with a regular source of primary and preventive care, health plans address the complex medical needs of disabled beneficiaries and work to ensure that medical and mental health care services are coordinated. The initiatives described in this chapter provide examples of how health insurance plans have been successful in promoting coordination and continuity of care for Medicaid beneficiaries.

Coordinating Care for Members with Chronic Disease

To address the high burden of illness and frequent hospitalization rate among members in the SSI program, AMERIGROUP established an outreach program in 2002. The program focuses on SSI members with any of the following conditions, which together account for approximately 90% of hospital admissions: asthma, diabetes, heart failure, sickle cell disease, end-stage renal disease, HIV/AIDS, and substance abuse. The goal is to enroll these members in a program of coordinated care to help them manage their illness on an ongoing basis.

Identifying New Members' Needs

At the outset of the program, AMERIGROUP used lists of members to identify patients who had been hospitalized for any of these conditions. To increase the proportion of members in the program, in 2004, AMERIGROUP's nurses and social workers began visiting hospitals and individuals' homes to find members who could benefit from the program.

In 2005, AMERIGROUP began using new software at the point of enrollment to identify new SSI members' clinical needs, determine whether they have a primary care physician, and identify a need for help with issues such as transportation and housing. AMERIGROUP staff who conduct welcome calls to new members forward this information in real time via the Internet to AMERIGROUP's case management nurses and care coordination staff so they can begin contacting new members immediately to address their needs.

Establishing an Ongoing Relationship

Through the care coordination program, AMERIGROUP's nurses work to establish an ongoing, trusting relationship with program participants through regular telephone contact, as well as hospital and home visits. Nurses assess whether members are receiving effective treatments, and they identify socioeconomic barriers to care, such as lack of transportation or housing. Nurses work one-on-one with members to prioritize issues that need to be addressed and to develop an action plan. They connect members with community resources that can help with transportation, housing, and other social service needs, and they remain in close contact with the member's treating physician and AMERIGROUP's medical director to ensure that treatment issues are addressed in a timely manner.

Results

From 2002 to 2004, the proportion of SSI members with chronic illness and frequent hospitalizations who received services through AMERIGROUP's care coordination program increased from 50% to 80%. Hospital admissions for the SSI population decreased slightly (by less than 5%). Therefore, AMERIGROUP plans to enhance its outreach and care coordination efforts for members with the most frequent admissions.

Start-up time for AMERIGROUP's care coordination efforts has improved significantly. Whereas in 2002, it took the health plan's nurse case managers and social workers three weeks to identify a hospitalized Medicaid member with chronic illness and refer the member to the care coordination program, by 2004, program staff

had reduced this time to an average of three days. As a result, AMERIGROUP is better positioned to ensure that these members keep their follow-up doctor's appointments, obtain the medicine they need, and access the home care and transportation assistance that are critical to their well-being.

For more information, contact:

Dr. Michael Musci
Vice President
Associate Corporate Medical Director
AMERIGROUP
4425 Corporation Lane
Virginia Beach, VA 23462
(757) 518-3682
mmusci@amerigroupcorp.com

Promoting Effective Home and Community-Based Care for Dually Eligible Seniors

In January 2004, BlueCross BlueShield of Minnesota and Blue Plus (its HMO product serving public program beneficiaries) received a Community Service/Service Development grant from the State of Minnesota to improve coordination of care and promote home and community-based care for senior citizens with chronic conditions who are eligible for both Medicare and Medicaid. In its initial phase, the project is focusing on elderly individuals with diabetes. Eventually, the scope will expand to include individuals with other chronic conditions. The program is a partnership between BlueCross BlueShield of Minnesota, four Minnesota counties (Kandiyohi, Swift, Chippewa, and Yellow Medicine), two regional Area Agencies on Aging, and a Volunteers of America project.

The first step in the program was to assess existing systems of care for dual eligibles with chronic conditions in these counties. The assessment found that better communication among county case managers, Blue Plus, and primary care clinics was needed to improve coordination of care. Therefore, Blue Plus worked with its project partners to develop a communications tool for achieving this goal.

The tool is a one-page information sheet called “Closing the Loop.” On this sheet, beneficiaries’ county case managers write comments relevant to the patient’s care and information about his or her medications, and they record clinical and lifestyle goals that they have helped patients develop. Case managers fax the information to the beneficiary’s primary care clinic before scheduled appointments so that the clinic has the information at the point of care.

Kandiyohi County, in partnership with physicians at the Affiliated Community Medical Center in Willmar, MN, is evaluating the effectiveness of “Closing the Loop” in improving care coordination for dually eligible Blue Plus members with diabetes who receive home and community-based services. The evaluation seeks to determine whether ongoing communication and follow-up between health and social service providers are helping members with diabetes stay on track in receiving recommended care. The project team also is evaluating the home care services that these members are receiving to determine which are the most effective and whether additional needs can be addressed during each visit.

Results

The 14 physicians participating in the project report that “Closing the Loop” is effective in providing them with insight into their patients’ needs. Dually eligible Blue Plus members participating in the program indicate that the information sheets help them better articulate their needs and concerns. Whereas previously they often would forget important information in the rush of a doctor’s visit, they now have the opportunity to share this information in a relaxed setting with a social worker with whom they have a trusted, ongoing relationship.

The State of Minnesota extended the grant through 2005 in the four participating counties. In addition, this year, the state is expanding the “Closing the Loop” process into three counties not in the pilot and is initiating a similar project to coordinate care for dually eligible beneficiaries in four additional counties.

For more information, contact:

Beth Nelson
Manager, Strategic Development
BlueCross BlueShield of Minnesota
P.O. Box 64560
Route R337
St. Paul, MN 55164
(651) 662-6882
Beth_B_Nelson@bluecrossmn.com

Case Management for Children with Ongoing Health Care Needs

In Fall 2003, in response to a new state requirement to promote case management for children in the Medicaid population, CareSource established a case management program for Medicaid members ages 6 months to 21 years with asthma, HIV, teen pregnancy, and other ongoing health care needs. The program sought to improve the health care and quality of life for this population and to increase the percentage of children receiving case management services from 0.8% to 2.5% (the new state benchmark).

Identifying Members for the Program

Upon enrollment in CareSource, the parent or guardian of new members age 6 months to 21 years receives a telephone call from a nurse, who administers a health questionnaire to identify the presence of asthma, HIV, teen pregnancy, or other health conditions that require ongoing care. If the child has any of these conditions, a case manager calls the parent or guardian to determine whether the child could benefit from case management. CareSource also identifies children for the program through claims data analysis; referrals from the local emergency department (for members who visit the emergency room at least four times in six months); referrals from medical management staff and staff of its 24-hour nurse hotline; visits to health care practitioners serving a high volume of obstetric and asthma patients; and on-site nurse liaisons in hospitals with large numbers of Medicaid patients.

Developing an Individualized Care Plan

Once a child is enrolled in the case management program, a nurse case manager is in regular telephone contact with the parent or guardian—and with the child if he or she is old enough -- to provide education about the condition, set goals for better health, and develop a care plan. Case managers discuss the member's use of medication, the importance of working with a primary care physician, and other benefits available through CareSource, such as transportation to medical appointments and the plan's 24-hour nurse hotline.

The case manager notifies the member's primary care physician in writing about the member's participation in the program and seeks to work with the physician on an individualized care plan. The case manager follows up by phone with the member or parent at regular intervals to ensure that the plan is being followed.

Results

Through this program, CareSource increased the percentage of children receiving case management services from 0.8% to 3.23%—exceeding its initial goal of 2.5%. The percentage of children ages 6 months to 21 years who are screened for case management increased from 56% in 2002 to 80% in 2004. The percentage of children with asthma who participated in the plan's case management program increased from 6% in 2002 to approximately 45% in 2004.

The program also increased members' use of effective treatments and services. The percentage of children using appropriate asthma medications rose from 50% in 2002 to nearly 57% in 2004. During this period, the percentage of children receiving well-child visits increased in every age category tracked by the state:

CareSource (cont'd)

Ohio

- ▶ Among children 0 to 15 months old, the percentage receiving well-child visits increased from 33% to 38%.
- ▶ Among children ages 3 to 6, the proportion receiving well-child screenings rose from 56% to 60%.
- ▶ For children ages 12 to 21, the percentage of children receiving well-child visits grew from 32% to approximately 33%.

Largely due to the health plan's success in increasing the number of children in case management, the Ohio Department of Job and Family Services rated CareSource as "excellent" in the state's Performance Enhancement and Incentive System for fiscal year 2004.

For more information, contact:

Cathy Becker
Communications Specialist
CareSource Management Group
One Dayton Center
One South Main Street
Dayton, OH 45402
(937) 531-2273
cathy.becker@care-source.com

Neighborhood Health Plan

Massachusetts

The Care Partnership Program for Patients at Risk of Hospitalization

In November 2002, in response to rising hospital costs among Medicaid and commercial members and to promote high-quality care, Neighborhood Health Plan implemented the Care Partnership Program (CPP) for patients at risk of hospitalization within a one-year time frame. The program uses education and one-on-one coaching to help members manage chronic conditions effectively.

Whereas traditional disease management programs generally identify members who can benefit from care coordination after an acute-care event such as hospitalization or an emergency room visit, the CPP program uses claims data and modeling software to identify members before such events occur. A CPP nurse contacts these members by phone to assess their care needs. Based on these needs, the nurse works with members and their primary care physician to develop a customized care plan. Care plans focus on individual goals, shared action plans, and reinforcement of lifestyle changes that improve health. Nurses conduct periodic follow-up telephone calls with members to evaluate the care plan and revise it as needed. Typical enrollment in the CPP program ranges from two months to ten months.

Results

From November 2002 through October 2003, hospital admission rates per 1,000 members declined 27% for the CPP population, compared with a nearly 8% increase for the total member population. CPP participants continue to report improvement in their quality of life since enrollment in the program.

For more information, contact:

Kathleen Bibo RN, BSN, MBA
Director of Clinical Operations
Neighborhood Health Plan
253 Summer Street
Boston, MA 02210
(617) 204-1435
Kathleen_Bibo@NHP.org

Case Management for Adults with Disabilities

In 1997, Passport Health Plan (PHP) established a case management program for adult Medicaid members with disabilities. The program coordinates health care and other services for members with HIV/AIDS or chronic obstructive pulmonary disease, members who have had organ or bone marrow transplants, individuals with terminal illnesses and those receiving palliative care, as well as members undergoing rehabilitation for physical, occupational, or speech conditions.

Members can be referred to the case management program by primary care physicians, specialists, nurses, through PHP departments such as member services, or they can self-refer. Case managers make at least two attempts to contact the member or caregiver by telephone. During these calls, case managers assess members' overall health and determine their needs. When it is not possible to reach members by phone, case managers mail them a letter explaining the help they can provide.

Advocating for Members and Coordinating Services

Case managers coordinate health, social, and community services for members and act as advocates by helping them identify and use available resources. For example, case managers coordinate home care such as chemotherapy and home intravenous (IV) services, and they help members obtain durable medical equipment, such as wheelchairs and walkers. Case managers also show members how to keep a log of their symptoms, and they help them communicate effectively with their physicians. In some cases, they accompany members to doctor's visits.

Results

Approximately 5,300 members have been served through the program. Throughout 2004, the percentage of program participants reporting that they were highly satisfied ranged from 96% to 99%. During the same time period, the proportion of members reporting that their health and quality of life had improved as a result of the case management services they received was 98% or higher.

Eighty-five percent of the health care practitioners serving members who participated in the program said the case manager's services and coordination of care were useful.

As reported by Milliman USA, from 1999 through the end of 2003, Passport Health Plan provided cost savings to the Commonwealth of Kentucky of \$110 million. These savings were generated as a result of successful programs such as case management, disease management, utilization management, and pharmacy management.

For more information, contact:

Jill Bell
Vice President of Public Affairs
Passport Health Plan
305 W. Broadway
Louisville, KY 40202
(502) 585-7079
Jill.Bell@amerihealthmercy.org

Passport Health Plan

Kentucky

The Tiny Tot Transition Program

To promote a smooth transition to home for newborns with serious health conditions and to reduce the risk of rehospitalization, Passport Health Plan (PHP) established the Tiny Tot Transition Program for Medicaid members in 2001. A key part of the program is educating new mothers about infant care and the importance of creating a healthy home environment.

Ongoing Coordination of Care

PHP identifies Medicaid beneficiaries for the program based on administrative data and contacts parents while they are still in the hospital. Tiny Tot program coordinators work to promote communication among the neonatologist, pediatrician, neonatal intensive care unit nurse, and other members of the infant's health care team. Program coordinators are responsible for discharge planning and working with the family for at least 30 days following discharge.

PHP program coordinators act as liaisons among the family, the doctors and hospital, and any home care agencies working with the family. In this role, coordinators seek to ensure that the family has access to all of the health and community-based resources they need. For example, coordinators may set up transportation to and from members' appointments, help members obtain baby supplies such as car seats and cribs, and link them with community agencies that can help with payments for utilities or rent. In addition, program coordinators assess the family's home environment and facilitate any changes necessary to protect the child's health and well-being. If the family needs assistance beyond 30 days after discharge, program coordinators refer them to PHP's case management program.

Results

In 2002, 411 babies were served by the program, and in 2003, 461 babies were served. From 2002 through 2003, the average length of stay for newborns in the program fell by 12%. Emergency room visits after discharge declined from 7% in 2002 to 4.5% in 2003.

For more information, contact:

Jill Bell
Vice President of Public Affairs
Passport Health Plan
305 W. Broadway
Louisville, KY 40202
(502) 585-7079
Jill.Bell@amerihealthmercy.org

Chapter 6

Addressing Cultural Diversity



As the U.S. population becomes increasingly diverse, the health care system faces new challenges and opportunities. Recent reports by the Institute of Medicine and the Agency for Healthcare Research and Quality have documented significant disparities in health care for racial and ethnic minorities. For example, African American and Hispanic children are more likely to be hospitalized for asthma than their white counterparts and are less likely to receive follow-up care for the condition. In addition, the Centers for Disease Control and Prevention’s REACH 2010 Risk Factor Survey found that Hispanics and Asian/Pacific Islanders have lower rates of pneumonia vaccination, cholesterol screening, and cervical cancer screening than white Americans.

Health insurance plans participating in the Medicaid program serve populations with diverse backgrounds, needs, and perspectives on health care. To address these issues, health insurance plans are pursuing a variety of strategies to promote cultural competency among staff and physicians. For example, they are providing member materials in several languages, establishing member advisory groups with representatives from multiple communities, providing staff training on cultural competency, and establishing community-based resource centers to help members with a variety of needs.

In addition to promoting high-quality care for Medicaid beneficiaries, these programs are helping to foster understanding and trust among Medicaid members, health plan staff, and health care practitioners. The initiatives described in this chapter highlight several innovative health insurance plan programs to address cultural and language issues affecting Medicaid members.

Addressing Members' Limited English Proficiency

In early 2003, L.A. Care Health Plan conducted evaluations of its contracted provider network and members and found a gap in understanding of documents that the health plan routinely provides to Medicaid members. These documents were not written in the major languages that many of its members speak: Armenian, Spanish, Chinese, Farsi, Korean, Khmer, Russian, Tagalog, and Vietnamese. As a result, many were not understood by members with Limited English Proficiency.

Using the Web to Provide Translated Information

To address this problem, in December 2004, L.A. Care created an area on its Web site where participating health care practitioners can download documents in all of the major languages spoken by its members and can personalize the plan's letters and forms in the member's primary language.

The plan also has an area on its Web site where members can download information in English, Spanish, and Armenian, the languages spoken by the vast majority of its Medicaid members. L.A. Care continues to provide translated information to its members who speak other languages, and it provides translated materials to community-based organizations working with these populations. The Web repository of translated materials will be updated with new materials as they become available or as they change due to regulatory requirements.

Translated materials available for members and providers through the L.A. Care Web include the following:

- ▶ Informed consent forms
- ▶ Member notification letters describing changes in health care practitioners, office location, or other routine changes
- ▶ Grievance forms and letters
- ▶ Health education information
- ▶ Immunization information
- ▶ A glossary of more than 3,300 terms commonly used in the health care industry
- ▶ Sample medication labels with instructions on proper medication use
- ▶ A guide to anatomical terminology
- ▶ A guide to medical terminology

Members, health care practitioners, and any other health care organization can access all documents at no cost at www.lacare.org. No password is necessary. In January 2005, L.A. Care mailed postcards to members, health care practitioners, and community-based organizations in English, Spanish, and Armenian to inform them of new features on the Web site.

L.A. Care will monitor the number of hits on its Web site and track use of the translated materials as part of its annual auditing process. The plan will make adjustments to the Web site as needed.

For more information, contact:

Beatriz M. Solís, MPH
Director of Cultural and Linguistic Services
L.A. Care Health Plan
555 West 5th Street
Los Angeles, CA 90013
(213) 694-1250, extension 4278
BSolis@lacare.org

Passport Health Plan

Kentucky

Cultural and Linguistic Services to Promote Member Understanding

In 1999, Passport Health Plan (PHP) staff found that many Medicaid members were having difficulty communicating in English. In some cases, members had little or no understanding of their health benefits. In other cases, members and their health care practitioners had difficulty interpreting cultural issues affecting communication about health care. To address these issues, PHP established the Cultural and Linguistic Services (CLS) program in 2000.

Providing a Member Advocate

As a first step toward promoting understanding among Medicaid members facing cultural and linguistic barriers to health care, PHP appointed a CLS program coordinator. The coordinator serves as the main point of contact for PHP members and staff on diversity-related issues. The coordinator assesses members' needs; works to improve cultural sensitivity among PHP staff, participating physicians, and in the organization as a whole; and informs members and staff about translator and interpreter services. The coordinator contacts physician's offices to identify members who could benefit from these services, and physician's offices refer members to the CLS program. Often the coordinator accompanies Medicaid members to their doctor's visits to help promote effective communication.

In 2004, PHP hosted its first annual conference on cultural and linguistic competency in health care. Representatives from physician's offices, PHP's medical staff, the State's Department of Medicaid Services, and consumer advocacy groups attended. In conjunction with the conference, the CLS program coordinator created and distributed a tool kit for health care practitioners and social service professionals on cultural and linguistic competency in health care. The kit is a collection of resource materials designed to increase awareness of cultural competency, provide an overview and introduction to Standards for Cultural and Linguistically Appropriate Services in Health Care, and clarify key federal regulations.

Materials in Multiple Languages

As part of the CLS initiative, Passport's Public Affairs Department developed the following materials for members with limited English proficiency (LEP):

- ▶ A Spanish version of the quarterly member newsletter;
- ▶ A revised version of the member handbook and new member welcome kit to include culturally appropriate photos and graphics;
- ▶ A new welcome kit envelope with instructions on how to obtain assistance in multiple languages;
- ▶ A Spanish version of a videotape promoting KCHIP (Kentucky's SCHIP program), provided free of charge to caseworkers and social service agencies in the community;
- ▶ Mass transit advertising and posters to promote KCHIP, featuring photos of children with different ethnic backgrounds;
- ▶ Information sheets on member benefits in five languages;
- ▶ A Web site with the health plan's materials translated into multiple languages; and
- ▶ A phone service devoted exclusively to the needs of members with LEP.

Passport Health Plan (cont'd)

Kentucky

In addition, the Public Affairs Department conducted training in cultural diversity issues from 2000 to 2002 for home care nurses serving PHP's prenatal care and EPSDT programs. The training explained federal regulations and mandates that apply to cultural diversity in health care.

The Task Force on Cultural Proficiency

In 2000, PHP created a Cultural Proficiency Task Force to brainstorm about member diversity and discuss how PHP's CLS initiatives could expand. The task force, which meets bi-monthly, is composed of the Cultural and Linguistic Services coordinator and staff from all the health plan's departments.

Task force members have conducted training in cultural diversity issues for PHP staff and training for participating health care practitioners on providing care to patients who have limited English proficiency. In addition, they arranged for on-site, multi-week Spanish immersion classes for PHP's Community Affairs and other interested staff, and they produced a Cultural Proficiency Binder, which was added to PHP's employee handbook. Currently the task force is conducting on-site training in cultural diversity issues in participating physicians' offices upon request.

Results

As a result of the CLS program, Spanish-speaking members can speak with PHP staff who are fluent in Spanish, and they have reduced their use of AT&T's telephone interpreter by 75%. This change has produced significant cost savings for the Medicaid program.

The CLS program has received special recognition from the Louisville Mayor's Office of International Affairs and Kentucky Refugee Ministries, a refugee resettlement agency. In addition, PHP received a Best Practices Award from AmeriHealth Mercy Health Plan for implementation of the program in 2002.

PHP has conducted presentations on the CLS program at national conferences such as Diversity Rx, the National Health Care Congress, and the National Association of Urban-Based HMOs.

For more information, contact:

Jill Bell
Vice President of Public Affairs
Passport Health Plan
305 W Broadway
Louisville, KY 40202
(502) 585-7079
Jill.Bell@amerihealthmercy.org

Santa Clara Family Health Plan

California

Using a Member Advisory Committee to Promote Accountability and Understanding

As part of ongoing efforts to seek member feedback on its services to Medicaid and SCHIP members, Santa Clara Family Health Plan established three member advisory committees: an English-speaking advisory committee in 1999; a Spanish language advisory committee in 2002; and a Vietnamese language advisory committee in 2003. Health plan members were recruited to serve on the advisory committees in a variety of ways, including announcements on the health plan Web site, member newsletters, and inserts in welcome packets sent to new members. There are currently 12 advisory members on the English-speaking committee, 25 on the Spanish language committee, and 17 on the Vietnamese language committee.

The committees meet monthly at the health plan's office to discuss issues such as access to services, educational programs, grievances, and outreach and communications strategies. The health plan's Member Services and Community Relations departments coordinate the meetings, and the agendas are set based on feedback from health plan staff and committee members. Committee members regularly review the health plan's marketing materials, flyers and brochures, orientation information, and member letters for effectiveness, relevance to the target population, and cultural and linguistic appropriateness. Health plan staff research issues raised by committee members and implement their recommendations as needed.

Conducting Community Outreach

In addition to providing ongoing feedback to the health plan, advisory committee members have twice testified at hearings before the state legislature regarding proposed Medicaid cutbacks. They also conduct outreach, enrollment, and education activities in their communities and identify unmet needs. For example, Vietnamese-speaking committee members regularly staff booths at community outreach events. Members also identify member education needs. In 2004, the Spanish-language committee recommended that the health plan provide member information on community intervention programs for victims of domestic violence. The health plan currently is developing materials on this issue.

Results

The member advisory committees have become an important vehicle for improving the health plan's member services, promoting accountability, and enhancing responsiveness to member concerns.

For more information, contact:

Stephen Robitaille
Consultant
Public Relations Department
Santa Clara Family Health Plan
210 E. Hacienda Ave.
Campbell, CA 95008
(408) 874.1842 or (510) 531-8062
sjrobitaille@sbcglobal.net

Blue Cross of California State Sponsored Programs

California

The People of Promise Community Partnership

To meet the needs of its culturally and linguistically diverse member population, Blue Cross of California's State Sponsored Programs established 10 Community Resource Centers (CRCs) throughout California, in the neighborhoods of Medicaid members. CRC staff work with Medicaid members and health care practitioners to resolve service-related issues, and they coordinate with community-based organizations to meet the needs of the communities served. These needs include child immunizations, health education programs, and awareness of, and access to, state and federal support resources.

As part of the partnership, each Blue Cross of California State Sponsored Programs CRC provides mini-grants of \$500 to as many as 10 organizations each year to provide important services to Medicaid and State Children's Health Insurance Program (SCHIP) members. Among the programs supported through these grants are after-school learning programs; Healthy Start programs offering parents on-site access to social services, health education, and nutritional resources at schools; crisis centers for children and adults; citizen associations; and Sober Grad Night programs, which provide cab rides for high school students attending proms.

Since 1994, CRC staff have participated in more than 650 community coalitions that directly benefit the health and well-being of members in their own neighborhoods. The health plan's long-term partnerships with community-based organizations have led to the creation of a variety of programs, such as the following:

- ▶ Free English-as-a-second-language classes for Spanish-speaking members (through a partnership with the Mexican-American Community Service Agency);
- ▶ New member orientations in Spanish, held at members' homes and at Casa en Casa, a Hispanic community-based organization;
- ▶ A diabetes self-management class taught in Vietnamese (run by Mission College's Community Education Program). A Vietnamese pharmacist who specializes in diabetes teaches the class;
- ▶ Asthma specialist physician visits in school clinics via telemedicine videoconferencing (through the San Francisco Asthma Task Force); and
- ▶ A symposium on donor milk banking and breastfeeding (presented by the Human Milk Banking Association of North America and the Mothers Milk Bank) to educate medical and health professionals about the effectiveness of donor milk treatment for preterm infants, international applications of the use of donor milk, and the current data on the effects of breastfeeding on obesity and diabetes.

For more information, contact:

John P. Monahan
Senior Vice President
WellPoint State Sponsored Programs
5151-A Camino Ruiz
Camarillo, CA 93012
(805) 384-3511
john.monahan@wellpoint.com

Results

Blue Cross of California State Sponsored Programs' 2003 member satisfaction survey found that 88% of Medicaid and SCHIP members were satisfied overall with the plan, 84% had trust in Blue Cross of California, and 92% said that Blue Cross of California did more than they promised.

A Four-Part Strategy to Improve Care for African American Members with Asthma

African Americans represent more than a third of UniCare's members with severe asthma. They accounted for nearly half of the members treated in an emergency room or hospital for asthma who had not seen a physician or taken medication for the condition in 2003. To improve treatment for African American members with asthma, UniCare Health Plan of Virginia implemented a four-part program from April 2003 through June 2004.

STAR Day Health Fairs

UniCare worked with the Urban League, a local Boys & Girls Club, the Allergy & Asthma Network Mothers of Asthmatics, two hospitals, and two churches to conduct two asthma health fairs—called STAR Days (“Steps to Asthma Relief”)—in two communities where most African American members with asthma live. Each organization managed an interactive learning station to teach participants about asthma triggers and the principles of asthma management. The learning stations were staffed by a pediatrician specializing in asthma management, a respiratory therapist and representatives from the Allergy & Asthma Network Mothers of Asthmatics.

Because smoking exacerbates asthma, UniCare invited representatives from the Virginia Tobacco Settlement Fund to operate a video booth at STAR Day to emphasize the dangers of smoking. Individuals attending the fair viewed messages from children explaining how secondhand smoke can make asthma worse. Attendees then had the opportunity to record and view their own anti-smoking message, including requests for a smoke-free environment, especially in their homes.

Training for Physicians

All physicians in the network received an asthma management program description, a summary of the National Heart Lung Blood Institute Asthma Management Guidelines, sample UniCare member educational materials, and information on their patients' asthma-related use of hospital and pharmacy services. In addition, 100 physicians in the two communities with the largest number of African American members with asthma were invited to a 90-minute asthma training luncheon. Physicians were invited based on the number of members with asthma in their care. A UniCare representative presented UniCare's asthma management program and two local physicians specializing in asthma care spoke about diagnosis and treatment of asthma. In addition, the group discussed common barriers to appropriate asthma care, including cultural issues. Four representatives from the Virginia Department of Medical Assistance also attended and participated in the discussion.

Home Visits

In addition to conducting STAR Days, UniCare Health Plan of Virginia established a home visit program targeting African American members with asthma. UniCare outreach staff encouraged the members to make an appointment with their primary care physician and provided the members with non-medical information on asthma management, how to work together with their doctor to manage their care, and a list of common asthma triggers.

UniCare Health Plan of Virginia (cont'd)

Virginia

Member Incentives

UniCare Health Plan of Virginia offers a choice of incentives (e.g., clip-on inhaler case, dust mite pillow cover, or children's asthma story) to encourage members to visit their primary care physician and develop an asthma action plan. The incentive is mailed after the physician verifies that a member has completed the asthma action plan.

Results

Approximately 300 members attended the STAR Days health fairs, and 46 physicians received training in asthma management. The percentage of African Americans with asthma who had severe symptoms declined by more than 6% from the beginning of the asthma initiative in April 2003 to its completion in June 2004.

For more information, contact:

John P. Monahan
Senior Vice President
WellPoint State Sponsored Programs
5151-A Camino Ruiz
Camarillo, CA 93012
(805) 384-3511
john.monahan@wellpoint.com

Chapter 7

Providing Additional Services



Health insurance plans recognize the importance of developing and implementing innovative approaches to respond to the needs of the communities they serve. Health insurance plans have developed programs to address a wide array of health care, social service, and safety issues affecting the Medicaid population. The initiatives featured in this chapter focus on the areas listed below.

- ▶ Care-seeking
- ▶ Preventive screening and safety
- ▶ 24-hour nurse line
- ▶ Smoking cessation
- ▶ Chronic obstructive pulmonary disease
- ▶ Childhood obesity
- ▶ Women's health
- ▶ Sickle cell disease
- ▶ Dental care
- ▶ Telemedicine

Healthy Streets Program: Encouraging Medicaid Enrollees to Use Health Care Services

In July 2003, Affinity Health Plan implemented “Healthy Streets,” an outreach and education program to encourage care-seeking that ultimately will improve Medicaid members’ health. Through the Healthy Streets program, new Medicaid members receive a telephone call welcoming them to Affinity. During this call, a trained interviewer conducts a brief health risk assessment survey, the results of which Affinity uses to link members to the appropriate disease management programs, health education mailings and additional information about their benefits.

For example, if a member completing a telephone health risk assessment indicates that he or she has asthma, Healthy Streets program staff create an electronic record that is automatically forwarded to Affinity’s asthma disease management team. Within a short time, this member receives an outreach call from an asthma clinical outreach specialist, who conducts a condition-specific assessment and helps the member make doctor’s appointments and access other services as needed. In addition, Affinity mails asthma education materials to the member’s home.

Results

Among Medicaid members who completed Healthy Streets risk assessments between 2002 and 2004, use of primary and preventive care was higher and emergency room use was lower than for members who did not complete the assessments:

- ▶ Nearly 70% of all new Medicaid members who completed the health risk assessment had a health care encounter within 90 days of enrollment, whereas 57% of new members who did not complete an assessment used services within this time frame.
- ▶ Approximately 45% of members completing the health risk assessment sought primary care or OB/GYN services within 90 days of enrollment, compared with 33% who did not complete the assessment.
- ▶ Approximately 8% of members who completed the assessment sought care in a hospital emergency room within 90 days of enrollment, compared with 10% of members who did not complete the assessment.

For more information, contact:

Susan J. Beane, MD
Chief Medical Officer
Affinity Health Plan
2500 Halsey Street
Bronx, NY 10458
(718) 794-7171
sbeane@affinityplan.org

Mammography Incentive Program

In an effort to boost mammography screening rates among Medicaid members ages 50 through 69, Affinity established an incentive program in January 2001. Outreach specialists try up to four times to contact women who have not received a mammogram in the past year. The member is initially contacted by phone; if the attempts are unsuccessful, Affinity sends a letter. Outreach specialists make an additional two calls in an effort to reach the member. If these efforts are unsuccessful, Affinity puts the member on a list for renewed contact attempts in the next quarter. Outreach specialists help members schedule appointments with their primary care physician, make reminder calls to members a week before the appointment, and mail them a reminder notice.

Both the outreach call and the reminder notice emphasize the importance of having a mammogram and inform members that they can receive a \$25 gift certificate to one of more than 200 stores—including but not limited to movie theaters and retail stores—for keeping the appointment.

Results

The proportion of Medicaid members who received a mammogram increased from 65% in 2000 to 72% in 2002. This rate was significantly higher than the statewide average of 66% for Medicaid beneficiaries.

For more information, contact:

Karen Romero
Manager, Health Initiatives
Affinity Health Plan
2500 Halsey Street
Bronx, NY 10461
(718) 794-6647
KRomero@affinityplan.org

An In-House, 24-Hour Nurse Hotline

In 2002, to help Medicaid members navigate the health care system and promote use of appropriate sites of care, CareSource replaced its contract nurse hotline with CareSource 24, an in-house, 24-hour, toll-free hotline for Medicaid members.

CareSource publicizes the hotline's toll-free number to Medicaid members through flyers in new member kits, marketing materials to prospective members, postcards mailed to members' homes, and stories in the member newsletter.

CareSource 24 is staffed by experienced nurses around the clock. Because the program is integrated with all other CareSource departments, nurses can help coordinate members' care, answer questions about covered benefits, and use real-time messaging to help members access services they may need from different CareSource departments.

CareSource nurses use nationally recognized care guidelines to assess members' symptoms, determine their urgency, and direct them to the most appropriate site of care.

Results

In 2003, 58% of the nearly 9,000 Medicaid members who contacted CareSource with plans to visit the emergency room decided to seek care in a setting more appropriate to treat their condition. Results in the first half of 2004 were similar: 57% of the approximately 5,000 Medicaid members seeking care in the emergency room chose a more appropriate care setting after speaking with a CareSource 24 nurse. Of the approximately 1,500 members surveyed about the program, 98.5% said they were satisfied with the service they received.

In recognition of these positive results, CareSource 24 won a Meritorious Award for exemplary customer service from the Ohio Association of Health Plans in 2003.

For more information, contact:

Cathy Becker
Communications Specialist
CareSource Management Group
One Dayton Center
One South Main Street
Dayton, OH 45402
(937) 531-2273
cathy.becker@care-source.com

Fallon Community Health Plan

Massachusetts

Helping Medicaid Members to Quit Smoking

In response to growing concern about the high prevalence of tobacco use among members, Fallon Community Health Plan (FCHP) developed a tobacco cessation program for commercial and Medicaid members in July 2000. The program consists of several components, including group sessions, telephone counseling, and access to nicotine replacement therapy.

Although the program is open to anyone who wants to participate, FCHP proactively encourages participation among Medicaid members in two ways: (1) All new Medicaid members are screened over the phone by a nurse and are asked if they currently use tobacco. If they answer yes, they are asked if they would like to be referred to the tobacco cessation program. FCHP calls all identified members and attempts to enroll them in the tobacco cessation program. Written information about the program is mailed to members who cannot be reached by telephone. (2) FCHP regularly includes information about the tobacco cessation program in its member magazine, *Healthy Communities*.

Group Sessions

FCHP currently runs six weekly tobacco cessation group sessions at five locations. The sessions are free to participants and run year-round. The sessions are one hour long and include a combination of support group activity and educational instruction. Twice a month at each site, FCHP holds a 45-minute orientation session for new participants.

The instructors have completed a Basic Training for Tobacco Treatment course, offered through the University of Massachusetts Medical School and funded by the Massachusetts Tobacco Control Program. The sessions take place year-round and people attend on a drop-in basis. New people join the group on a continual basis, and the groups include an average of six to eight people. People may attend for as long as they want. If they have succeeded in quitting, they are welcome to drop in for extra support, anniversaries, or if they have relapsed.

FCHP provides program participants with handouts on a wide range of topics related to smoking cessation (e.g., stress, weight loss, withdrawal symptoms, and exercise). People are encouraged to pick their own quit date (the actual day they plan to quit smoking). Most people quit within the first two weeks of attending the group sessions. Individuals who are not 100% successful the first time are encouraged to continue attending and to try again with a new quit date.

Nicotine Replacement Therapy

FCHP members can purchase nicotine replacement therapy (NRT), such as nicotine patches or nicotine gum, at the group sessions for \$10 per week. Program participants are required to attend each week to receive a supply of seven patches for that week. FCHP provides nicotine gum for members who prefer to chew the gum or who cannot wear nicotine patches. The program also allows people to use up to two pieces of Nicorette gum a day in addition to wearing the patches. Nicorette gum provides an extra dose of nicotine that may help people cope with a particularly strong craving to smoke. FCHP also encourages people to use Zyban (also known as Wellbutrin or Bupropion), which requires a doctor's prescription.

Fallon Community Health Plan (cont'd)

Massachusetts

Telephone Counseling

FCHP recently expanded the tobacco cessation program to include weekly telephone counseling as an alternative to attending group sessions. The phone counseling is done by a certified tobacco treatment specialist. The counselor schedules calls each week and makes them at the designated times. If the client is not available, follow-up calls are made to try to reach the person. The material covered in the calls is similar to that covered in the groups and includes topics such as getting ready to quit, strategies to keep from smoking, tips on dealing with cravings, and the role of exercise. Members participating in the phone counseling submit their forms and the money for patches and gum by mail. NRT products are then mailed to participants. Use of this option has been growing, particularly since it was mentioned in FCHP's member magazine.

Results

Of all FCHP members who participated in the program from 2000 through 2004, 46% were smoke-free three months after the end of the program, 32% were smoke-free at six months, and 28% were smoke-free at 12 months. Among Medicaid members enrolled in FCHP as of 2004, 41% were smoke-free at three months, 28% were smoke-free at six months, and 10% were smoke-free at 12 months.

For more information, contact:

Ivona Wisniewski
Senior Program Manager, MassHealth
Medicare/Medicaid Programs
Fallon Community Health Plan
10 Chestnut Street
Worcester, MA 01608
(508) 368-9134
ivona.wisniewski@fchp.org

Great Lakes Health Plan

Michigan

One-on-One Assistance from Respiratory Therapists

In 2003, Great Lakes Health Plan (GLHP), the AmeriChoice Health Plan in Michigan, responded to the needs of its Medicaid members with chronic obstructive pulmonary disease (COPD) with a program of one-on-one assistance from respiratory therapists. The program is based on guidelines from the National Heart, Lung and Blood Institute, the World Health Organization, and the Global Initiative for Chronic Obstructive Lung Disease.

Registered and certified respiratory therapists work closely with GLHP case managers, members' physicians, and other health care practitioners to develop individual programs for members with COPD, based on their needs, living environment, and support systems. Therapists make home visits or contact members by phone, depending on the severity of the member's condition. During these contacts, therapists assess each member's symptoms, medication regimen, and home environment and provide the information to their physician for follow-up. Based on information gathered during the assessment process, therapists provide members with a COPD self-management guide that contains individually tailored information on seasonal changes affecting COPD, lifestyle changes to improve health, exercise, and breathing techniques, and recommended medications.

Therapists help members understand and manage their condition, for example, by recognizing symptoms and learning how to relieve them effectively. They work with members to make lifestyle changes (such as quitting smoking, exercising, improving their nutrition) to improve health. They also remain in regular contact with members to ensure that they keep wellness appointments, follow their individual care plans, and keep immunizations up-to-date.

Results

More than 3,200 GLHP members have participated in the program since 2003, and from 2003 to 2004, hospital admission rates among members with COPD declined 13.5%.

For more information, contact:

Steven Matthews
Vice President, Public Affairs
AmeriChoice, A UnitedHealth Group Company
8045 Leesburg Pike
Vienna, VA 22182
(703) 287-3062
smatthews@americhoice.com

***Be in Charge!*SM Weight Management for Children and Adolescents**

Because a growing number of children and teens in its Medicaid and State Children's Health Insurance Program (SCHIP) population were overweight and suffering negative health consequences, Health Net established a *Be in Charge!*SM weight management program for Medicaid and SCHIP members ages 10 through 20 in January 2004.

Nutrition Information and One-on-One Consultation with a Dietician

Children and adolescents are placed in two categories according to their Body Mass Index (BMI)—a measure of body fat that depends on height, weight and age—as identified by their primary care physician.

Upon request from members or their physicians, members in the first category—those with normal weight (BMI below the 85th percentile) or who are at risk of becoming overweight (BMI at the 85th-94th percentile)—receive information on nutrition, physical activity, weight management, and community resources that can help with weight loss (e.g., YMCAs). In addition, they have access to a registered dietician by appointment through the toll-free, 24-hour Nurse Advice Line. Health Net members receive information via the quarterly newsletter, welcome packets, and an annual mailing.

Members may self-refer to the program via Health Net's Health Education Information Line, member services department, or directly, using a toll-free line. The Health Education Department also provides referrals to a dietician, who calls the member for a consultation. The dietician provides advice and educational materials based on the member's needs. Dietitians can set up additional phone sessions and check on members' progress upon request.

Free Weight Watchers® Program

Members in the second category—those who are overweight (BMI at or above the 95th percentile)—receive the information and services described above, and are eligible for a free, 10-week Weight Watchers® program sponsored by Health Net. Physicians must sign a referral form and provide their license number.

Upon receiving the physician referral, a Health Net health educator contacts the member—and, for members under 18, the parent or guardian—by phone to help find a Weight Watchers® Program conveniently located and to explain how Weight Watchers® works. Parents or guardians accompany members ages 10 through 14 to Weight Watchers® meetings. Members receive prepaid coupons to attend five meetings. After the initial five weeks, members submit to Health Net their Weight Watchers® membership book documenting their attendance and weight measurements, and Health Net sends additional coupons for the remainder of the program. After completing the second five weeks, members who return evaluation forms are entered into a raffle drawing for a gift certificate to a sporting goods store.

Because some members said they could not attend Weight Watchers® sessions, Health Net is developing a home-based, five-week learning module, to be introduced on a pilot basis with English- and Spanish-speaking families. Recognizing that parents often make the decisions about what their children eat and about physical activity, the module is directed at the entire family. The module consists of a spiral-bound packet with weekly activities and messages to encourage weight loss. Participants complete a pre- and post-questionnaire to evaluate their physical activity and food choices.

Results

As of January 2005, nearly 350 Medicaid and SCHIP members (from approximately 500 physician referrals) had been contacted for enrollment in the Weight Watchers® program. From 2004 to 2005, 312 children from the Medicaid program enrolled in the Weight Watchers® program. Enrolled children's average age was 13 and average weight was 197 pounds.

Health Net recently introduced an incentive program to encourage additional participation in the program. Medicaid and SCHIP members receive a gift related to physical activity or nutrition after completing the first five weeks of Weight Watchers®.

For more information, contact:

Anita Keneipp, MS
Senior Health Education Specialist
Health Net of CA, Inc.
1055 E. Colorado Blvd. Suite 300
Pasadena, CA 91106
(626) 683-6488
anita.keneipp@healthnet.com

Keystone Mercy Health Plan

Pennsylvania

Health Ministry Program for Women

To address the fact that low-income and minority populations suffer disproportionately from cardiovascular, respiratory, and chronic diseases, Keystone Mercy Health Plan created the Health Ministry Program for Women in 1999. The program uses the church as a vehicle to increase awareness of African American women's health issues, promote access to appropriate health care, and encourage women to take action to improve their health. The program focuses specifically on helping African American women take control of health issues associated with life cycle changes such as menopause, aging, and chronic disease stress management. Interactive workshops and demonstrations encourage participation in a variety of activities, including healthy cooking and high- and low-impact exercise.

Working with the Community

Keystone Mercy promotes and coordinates the program and encourages its Medicaid members, local health care practitioners, and the community at large to participate. The 2004 program focused on wellness and provided workshops on how to achieve lifelong health. The workshops were divided into three areas: body, mind, and spirit. Each area emphasized the importance of preventive health care, including the importance of regular checkups and screenings; becoming aware of and taking control of problems with high blood pressure, cholesterol, blood sugar, and weight; managing and defusing stress; and identifying symptoms of depression.

The Health Ministry Program for Women is offered through a variety of congregations throughout the year, and each session highlights a different health or lifestyle topic. The program culminates in the fall with a daylong conference featuring wellness and health education workshops, free health screenings, and cooking demonstrations.

Results

In the five years that the Health Ministry Program for Women has been conducted, more than 30,000 African American women of all ages have participated in its workshops, demonstrations, and other activities.

For more information, contact:

Rick Buck
Vice President, Communications
Keystone Mercy Health Plan
200 Stevens Drive
Philadelphia, PA 19113
(215) 863-5102
rick.buck@kmhp.com

Keystone Mercy Health Plan

Pennsylvania

Coordinating Care for Members with Sickle Cell Disease

To improve ongoing care for Medicaid members with sickle cell disease, Keystone Mercy Health Plan developed a disease management and care coordination program in 2000. The program's main components are (1) collaboration between members, their health care practitioners, and a case manager to develop an effective plan of care; (2) member education about the disease and lifestyle changes that can improve health; and (3) disease management strategies such as pain management and changes to the patient's environment that can improve health.

Tailored Interventions Based on Severity of Condition

Keystone Mercy uses claims data, member records, and referrals from primary and specialty physicians to identify members with sickle cell disease. The health plan provides materials and services to these members based on the severity of their condition. Patients whose condition is mild receive a packet of information that explains the program and describes how to prevent disease complications and make lifestyle changes to improve health. Keystone Mercy case managers help members access health and social services, and they make periodic follow-up calls to check on members' condition.

Case managers contact members whose condition is moderate at least every four weeks by phone and conduct home visits as needed. During this time, case managers review members' medications, help them understand the appropriate dosage, and explain how to obtain refills. They emphasize the importance of informing physicians when medications are ineffective, and they encourage members to visit their doctors regularly to keep prescriptions and care plans up-to-date. They also provide information on pain management strategies such as diet, exercise, hydration, and avoiding extreme heat and cold. Case managers work with members and their physicians to develop a plan of care, and they help members follow the plan. Case managers contact members whose condition is severe at least every two weeks by phone, and they conduct home visits as needed.

Centers of Excellence

Keystone Mercy members with sickle cell disease have access to four Centers of Excellence: Children's Hospital of Philadelphia, Saint Christopher's Hospital for Children, Mercy Hospital of Philadelphia, and Pennsylvania Hospital. The Centers provide on-site education and support groups for patients with sickle cell disease. Medical staff at these centers work with members and case managers to develop comprehensive treatment plans.

Results

From 2000 through the first half of 2004, emergency room visits among Keystone Mercy's Medicaid members with sickle cell disease fell by 50%, and use of inpatient services dropped by nearly 20%, despite the fact that more patients with sickle cell disease were identified during that time period.

During the same period, use of physician office visits, home care, and laboratory services for Medicaid members with sickle cell disease increased 35%. In addition, during that time, member surveys showed that increased use of pain management techniques increased members' desire and willingness to participate in job training and other classes.

For more information, contact:

Rick Buck
Vice President, Communications
Keystone Mercy Health Plan
200 Stevens Drive
Philadelphia, PA 19113
(215) 863-5102
rick.buck@kmhp.com

Medica Health Plans

Minnesota

The Way to Better Health: A Member Incentive Project

In 2000, to reduce barriers in access to care and increase use of preventive care among Medicaid and MinnesotaCare members, Medica established The Way to Better Health (TWTBH) program. The program was based on findings from focus groups with Medicaid and MinnesotaCare members and on Medica's national review of health plans' member incentive programs.

Prevention, Education, Healthy Lifestyle, and Safety

Medica found that most health plans' member incentive programs focused on four areas: disease prevention, childbirth education, promoting a healthy lifestyle, and car safety. Focus group participants suggested that they would respond to incentives related to these issues. Therefore, Medica developed incentive programs in these areas. The health plan provides gift cards to members who complete recommended prenatal visits, take their children for well-child checkups, undergo various cancer screening tests, take childbirth classes, or complete smoking cessation programs. In addition, Medica distributes free car seats for Medicaid and MinnesotaCare members with children up to age 2. To ensure proper installation, Medica distributes the seats through public health agencies and direct mailings with video instructions.

Members receive information about Medica's incentive programs and vouchers through the health plan's mailings, member newsletters, and Web site. To receive an incentive, members must have their health care practitioner or class instructor initial a voucher at the time of service. The member returns the voucher to Medica, and the health plan orders gift cards from Target and ensures that they are distributed correctly. Members can redeem the gift cards for any item in the store.

Results

From 2000 to 2004, in conjunction with several Medica programs to increase use of preventive care among Medicaid and MinnesotaCare members, rates for cancer screening, well-child care visits, and prenatal care increased. For example, the percentage of Medicaid and MinnesotaCare members receiving prenatal care increased from approximately 70% to 80%; the percentage of children with six or more well-child visits in the first 15 months increased from 33% to 40%; and rates for breast cancer screening increased from 58% to 65%. Eighty-six percent of Medicaid and MinnesotaCare members surveyed about The Way to Better Health incentive program in 2002 rated it as "good" and were satisfied with it. Seventeen percent of program participants said they would not have taken action without the incentives.

For more information, contact:

Glenn Andis
Senior Vice President
of Government Programs
Medica
Route# CP340
401 Carlson Parkway
Minnetonka, MN 55305-5387
(952) 992-3977
Glenn.Andis@medica.com

Neighborhood Health Plan

Massachusetts

Helping Members Meet Basic Needs

Recognizing that many of its Medicaid and commercial members have pressing needs beyond health care, Neighborhood Health Plan established the Social Care Management Program in 1998. The program addresses financial, housing, and nutrition issues, as well as needs related to utilities, personal care, homemaking, transportation, appointment-making, and other issues. Helping members meet these basic needs allows them to focus on their health.

Neighborhood Health Plan identifies members who could benefit from the program through needs assessments conducted with new members, referrals from the plan's staff and participating health care practitioners, and through member self-referrals. Social and human services professionals contact these members by telephone to conduct an in-depth needs assessment. Based on the information gathered, they link members with the medical, behavioral health, and community-based services they need. In addition, these professionals conduct home visits to help homebound members with a variety of tasks, such as completing applications for financial assistance or subsidized housing. In some cases, program staff deliver donated clothing to members in need.

Results

In 2004, the program provided varying levels of assistance to approximately 1,000 members in areas such as housing, clothing, food, and finances.

For more information, contact:

Kathleen Bibo RN, BSN, MBA
Director of Clinical Operations
Neighborhood Health Plan
253 Summer Street
Boston, MA 02210
(617) 204-1435
Kathleen_Bibo@NHP.org

UCare Tooth Care

Because many Medicaid members lack access to regular dental care, UCare Minnesota established a mobile dental unit, UCare Tooth Care, in 2002. Since then, UCare Tooth Care has been traveling throughout Minnesota to bring state-of-the-art dental care to UCare members. The health plan uses a 37-foot Winnebago, equipped with dental chairs and cleaning tools, to provide dental cleanings and checkups to Medicaid and MinnesotaCare members who live in areas where there is limited access to dentists. Members can schedule appointments by calling a toll-free phone number. The van operates Mondays through Fridays from 8:30 a.m. to 3:30 p.m.

UCare See-A-Dentist Guarantee™

To address concerns about waiting times for dental appointments among its Medicaid and Medicare members, UCare launched the UCare See-A-Dentist Guarantee™ program in 2003. The program seeks to ensure that Medicaid and Medicare members can schedule a visit for preventive dental care within 30 days. Members who call the toll-free UCare See-A-Dentist Appointment Hotline receive personal assistance in obtaining an appointment with one of UCare's participating dentists. Appointments can be made to see a dentist in an office or the mobile dental unit, depending on what is convenient for the member and whether the mobile unit will be in the member's service area within the coming 30 days. UCare publicizes the program through direct mail brochures, program descriptions in all member materials (e.g., member guides, provider directories, and Summary of Benefits), member newsletters, and UCare's Web site.

Results

Since 2002, staff of the UCare Tooth Care mobile dental unit have conducted over 8,700 dental cleanings and checkups for more than 2,500 UCare Medicaid and MinnesotaCare members.

Since the launch of the UCare See-A-Dentist Guarantee™, appointment wait times for routine, urgent, and emergency visits have improved significantly. By the end of 2003, 80% of clinics saw members with urgent needs within 48 to 72 hours, and 82% saw members with emergency needs within 24 hours. All Medicaid members calling the UCare See-A-Dentist Appointment Hotline have received an appointment for routine care within 30 days.

For more information, contact:

Ghita Worcester
Vice President, Public Affairs and Development
UCare Minnesota
P.O. Box 52
Minneapolis, MN 55440
(612) 676-3634
gworcester@ucare.org

Blue Cross of California State Sponsored Programs

California

Rural-Urban Telemedicine Consultations

In 1999, through a grant from the California Managed Risk Medical Insurance Board, Blue Cross of California State Sponsored Programs implemented a telemedicine program to improve access to specialty care for low-income members living in rural areas. The program allows patients and primary care practitioners to access specialty services in urban centers via live video consultations and through store-and-forward software, which uses computer technology and medical devices to capture and transmit medical data and images.

Live video consultations allow a rural physician, a patient, and a specialist to see and talk with each other even when they are miles apart. The second method, store-and-forward, allows the rural physician to record and store an electronic medical record that contains pictures and video clips of the patient's condition, dictated (audio) notes, laboratory test results and other necessary information. This information is transmitted electronically to a specialist, who reviews the record and returns a diagnosis or second opinion regarding treatment or management of the patient's condition.

Through additional grants received in 2004 from the California Managed Risk Medical Insurance Board and collaboration with other telemedicine programs throughout the state, Blue Cross of California expanded its telemedicine network to include 57 rural presentation sites comprising physicians and clinics as well as six specialty locations in urban areas. This offers rural Californians in communities near the 57 presenting sites the ability to access 20 specialties ranging from dermatology to psychology. Once a telemedicine site is established, any of the physicians' or clinics' patients may use the technology. Blue Cross of California pays the fees associated with their members.

Results

Since the program's inception, rural Californians, including Blue Cross of California State Sponsored Programs' Medicaid and State Children's Health Insurance Plan members, have had more than 8,500 telemedicine encounters. The annual number of consults has increased steadily each year, rising 28%, from approximately 1,300 in 2002 to approximately 1,650 in 2003. Both of these indicators suggest that Blue Cross of California's public program members and health care practitioners are accepting telemedicine as an appropriate means to improve access to specialty care in rural areas.

For more information, contact:

John P. Monahan
Senior Vice President
WellPoint State Sponsored Programs
5151-A Camino Ruiz
Camarillo, CA 93012
(805) 384-3511
john.monahan@wellpoint.com



America's Health
Insurance Plans

601 Pennsylvania Ave., NW
South Building
Suite Five Hundred
Washington, D.C. 20004

202.778.3200
www.ahip.org