

*First
Annual
Innovation Award
for
Medi-Cal
Managed Care
Health Plans*

October 2015



2015

Award Winner

Inland Empire Health Plan

Charter Healthcare Group

Transitional Care Project

Runner-up

Contra Costa Health Plan

Reducing Early Childhood Caries

in the Medical Home

First Annual Innovation Award, October 2015

Department of Health Care Services (DHCS) Managed Care Quality and Monitoring Division (MCQMD)

The intent of the Innovation Award is to highlight the innovative interventions developed by our Medi-Cal Managed Care Health Plans (MCPs) that strive to improve the quality of health care for members. By highlighting these interventions DHCS hopes to facilitate and encourage the sharing of best practices.

MCPs were allowed to submit two nominations for the Innovation Award. The nominations needed to include a description of the target population, the scope of the problem, a description of why the intervention was innovative, and also any outcomes or results of the intervention if available.

MCQMD reviewed all of the submitted nominations and provided the summaries of the nomination to MCPs for voting. MCPs were asked to submit one vote, but were not allowed to vote for their own MCP.

DHCS received fifteen nominations from eight MCPs. DHCS also received two nominations after the submission deadline. These nominations are included in this document even though they were not received in time for the voting.

AWARD NOMINATION SUMMARIES

Anthem Blue Cross

1. PC Insite (Primary Care Insight into Behavioral Health)

In order to address the problem of underdiagnosed and undertreated behavioral health conditions due to members having difficulties accessing behavioral health (BH) services when primary care providers (PCPs) may not feel capable of delivering such services in their own clinics, Anthem instituted a program to have behavioral health staff reside in the primary care clinic. The staff complete a Patient Health Questionnaire-9 (PHQ-9*) screening of all clinic members at each visit (the 5th vital sign) to identify patients that need BH services. Then the BH-trained staff see the clinic member immediately and begin interventions the same day. This pilot has seen member PHQ-9 scores fall in 61% of members who initially screened positive, thus indicating a decreased depressive disorder disease burden.

2. Population Health Management

In order to provide screening programs for early diagnosis of Diabetic Retinopathy, Anthem implemented a project utilizing a combination of innovative technology and innovative collaboration model. The target population are members between 18-75 years of age with diabetes (type 1 and 2) who have not had a retinal or dilated eye exam in the measurement year/or a negative exam in the year prior to the measurement year. By utilizing Tableau Software for GeoMapping and Hot Spotting (Cluster Analysis) staff could identify access needs by looking at clusters of members and their access to VSP providers. Plan staff analyzed the results to schedule eye exam appointments for members based on the GeoMapping and Hot Spotting locations. Health educators were on site to provide member specific education. The project showed success in providing preventive eye exams for more than 50% of members identified (38 patients). Preliminary findings have driven the expansion of the program to more clinics and implementation of more services moving forward.

CalOptima

1. Personal Care Coordinators for Seniors and Persons with Disabilities (SPD) Members

CalOptima identified the need of personalized care coordination for SPD members due to the complexity of their medical issues, lack of familiarity with managed care, low health literacy, and cultural or linguistic barriers. CalOptima assigns a Personal Care Coordinator to be an SPD member's primary point of contact and do the following: work with PCPs, communicate in the member's language if possible, schedule appointments, coordinate Interdisciplinary Care Teams (ICTs) and Initial Care Plans (ICPs), work with case managers, complete paperwork, etc. Almost 40,000 Medi-Cal-only SPDs who are not dually eligible are covered through this project. There are no results to share yet, but the expected benefits include improved access to care, more effective ICPs and ICTs, and improved outcomes at the patient-level.

2. OneCare Connect Long Term Care (LTC) Program

Access to comprehensive health services and care coordination is limited for Dual-eligibles residing in LTC facilities, which causes frequent ED visits. In order to address this issue, CalOptima implemented a project for providing SPD members residing in LTC facilities with timely preventive services and urgent care LTC facility, through partnership with the Department of Healthcare Services (DHCS), Centers for Medicare & Medicaid Services (CMS) and health facilities. This program offers an alternative to the typically high opt-out rate for LTC residents. It offers enhanced reimbursement to facilities to encourage appropriate urgent care in LTC facility; ensures that LTC-dedicated PCPs will see residents a minimum of 3 times a month; social workers documenting members' expectations of care; and physicians and nurses being available 24/7 to manage medical needs. This program is expected to decrease costly utilization of the ED and prevent avoidable hospitalizations, while increasing member satisfaction and retention.

Contra Costa Health Plan (CCHP)

Reducing Early Childhood Caries in the Medical Home

In 2007, low-income young children faced significant challenges in accessing dental care (only 17% of Medi-Cal insured children aged 0-5 years visited a dentist annually). In response to this crisis, CCHP joined community partners to integrate preventive oral health practices into primary care settings and reduce early childhood caries (ECC). This project covers 18,000 children aged 12-59 months who receive well child care within the Regional Medical Center and Health Centers or Community Provider (CPN) networks. CCHP in partnership with the Regional Medical Center, local dentists and medical providers and the University of San Francisco (UCSF), developed clinical systems to apply fluoride varnish (FV) to young children's teeth at the time of their well-child exams, and also provided oral health education and dental referrals for them. Reporting shows a rate of 95% FV application and oral health education for 11,000 Regional Medical Center well-child visits, and predicts an additional 2500 FV applications annually. Consistent provision of FV in the medical home should decrease caries rates for children, and reduce future costs and risks of general anesthesia for young patients.

Heath Plan of San Joaquin (HPSJ)

1. Transitional Care Behavioral Health Integration (TCBHI)

Coordinated care management for patients with serious Behavioral Health (BH) and Substance Use Disorder (SUD) issues combined with chronic physical illness is essential to improving the members' health. HPSJ implemented a coordination/collaboration project to identify members with serious BH-SUD issues who are hospitalized for a chronic physical illness. Upon identification the County Behavioral Health will be informed by the HPJQ staff. County Behavioral Health workers contact the member in the hospital and follow the member from hospital to home and back to the County BH Clinic. Through this project, patients receive coordinated case management (CM) by a behavioral health and physical health team (plan's social worker, health navigator and Case Managers) and joint home visits by a Community BH worker and a Nurse Practitioner (CM for physical health). Even though the sample size to date is too small to obtain statistically significant results, the program has shown significant positive impact on individual members.

2. Transitions of Care (TOC)

To address the high ED and inpatient utilization in San Joaquin County especially among the SPD member, HPSJ instituted a collaborative team approach between the health plan (health navigator, social worker and concurrent review nurse), hospital (case manager/discharge planner) and TOC nurse and PCP at the Federally Qualified Health Center (FQHC) to ensure a safe discharge with a good transition plan for every member hospitalized at Doctors Medical Center in Modesto. The TOC nurse funded by the plan was employed by the FQHC. The hospital, and the FQHC clinicians and the health plan had access to the discharge assessment through the plan's electronic portal (Direct Recording Electronic /DRE). Results showed a 5% increase in PCP post discharge follow up visits, a 40% decrease in readmissions, a 3% decrease in ED visits, and 75% member satisfaction with the TOC nurse and care coordination.

Inland Empire Health Plan (IEHP)

1. Charter Healthcare Group Transitional Care

With a large population of members with limited resources, low income and/or multiple co-morbidities, resulting in high (Emergency Department) ED visits and frequent inpatient admissions/readmissions, IEHP recognized the need for an innovative approach to improve the quality of care for these members. IEHP reached out to Charter Healthcare Group, a home health/hospice agency that provides transitional care services with the goal of keeping members safely in their home to improve care for high risk members. This project consists of locating these members; providing members with 24/7 direct access to Charter's clinical team; reaching members in an environment in which members feel most comfortable (i.e. in their home or in a public setting such as a park); allowing the member to remain in the home setting while providing the ability to administer treatment (i.e. pain management and IV hydration for members in an acute sickle cell crisis); and outreach to the members' PCP, specialists, and caregivers. Charter's clinical team meets onsite weekly with various departments, including Care Management, Behavioral Health, Utilization Management, Long-Term Services and Supports and Disabilities to discuss members currently on their service. The most current data shows 20 ED diversions in a one week period with a census of 167 members.

2. Illumination Foundation Recuperative Care

With a large population of homeless patients with limited resources, multiple co-morbidities, and extended inpatient stays, IEHP recognized the need for an innovative approach to provide on-going medical oversight with a safe and timely discharge from a hospital for these patients. IEHP reached out to Illumination Foundation (IF) Recuperative Care; a primary care clinic focused on the homeless population which is co-located within a homeless shelter that provides targeted, interdisciplinary services for the most vulnerable homeless patients. IF provides support and care for the patients who need time to recover while a team of nurses and case managers connects them to long-term medical, mental health, and social services including housing in the community. Through this project hospital readmission of homeless patients participating in the program has dropped by 50%, and in addition the daily cost of care for homeless patients decreased by almost 90%.

Molina

1. Community Connectors

Molina launched its Community Connector program to make meaningful contact with members, assist them with navigating the healthcare system, link members with social services, and rapidly respond to individual members in need of services. Community Connectors are non-clinical staff (bilingual and culturally diverse teams that live in the communities among the plan's members) of the case management team that functions as "extenders" for nurse or social worker case managers. Community Connectors connect members to plan services (e.g. making appointments), community resources (e.g. transportation, meal programs, social programs), social supports (e.g. preparation or accompany to a medical appointment), and make the initial contact with unreachable members, including members with inaccurate contact information, transient members, and homeless members. Molina currently has 55 Community Connectors in its 6 service areas. Outcome data is not available at this time, but the program has made significant impact to the health and well-being of individual members.

Molina

2. Collaborating to Improve Performance and Outcomes for Safety Net Practices

Molina recognizes the changing role of the health insurer from payer to partner in providing quality care to the underserved population. The underserved population usually receives care from overcrowded practices. As a result there is little time to successfully adapt new care models to better manage their population. To address this issue, Molina developed a practice transformation model that encompasses a team to support practices 2-4 hours per week for six months. Teams help practices to develop clinical decision support, to flag gaps in care and create patient registries, to identify patients who need a certain type of care and to aggregate practice level data to drive change. This program is expected to result in a 5% improvement in blood pressure and diabetes management measures.

Partnership Health Plan of California (PHC)

1.Telehealth Specialty Access

Accessing specialty care in rural counties comes with significant barriers that include geography and limited resources. To address this issue PHC established a comprehensive telehealth network that provides increased access to providers and members. PHC contracted with TeleMed2U to provide an adult specialty telehealth network for 14 counties where members live in remote geographic locations and the need for specialty care surpasses existing capacity. PHC contracted directly with TeleMed2U, a 100% telehealth-based multi-specialty network, which sets up the telehealth services in health centers, which removes the burden of health centers to purchase appointment times (must pay the full cost for the block of time regardless if they are able to fill all of the appointment slots), provides them with more resources to care for patients, and gives them access to specialty care on demand. In the first year the program was implemented in eight health centers in six different counties, it has an additional six sites in the beginning stages of implementation, and has facilitated 293 telehealth consultations in seven specialties. This program eliminated the need for out-of-area travel for the members and significantly reduced the wait time for appointments for specialty care.

2.Provider Recruiting Program

The challenge of building healthy communities in rural counties is severely impacted by the shortage of primary care providers. PHC launched a project to recruit future providers who are nearing the end of their training as well as existing providers through advertisements and recruitment materials; hiring bonuses; subsidies to help with visits from providers and their families, including grandparents; and outreach from non-medical partners within a community. Over 21% of the 293 PHC contracted primary care health centers are receiving recruiting assistance through the program (e.g. working with UC Davis, and Betty Irene Moore School of Nursing to expand their training program into rural communities). In a short period of time, the Provider Recruitment Program has overcome the challenges of introducing new providers into rural communities (i.e. 10 Nurse Practitioner/Physician's Assistant students and 14 new physicians).

San Francisco Health Plan (SFHP)

1.Staff Satisfaction Pay-For-Performance Measure

Given the relationship between staff satisfaction and operational excellence (British Medical Journal, Szecsenyi et al, 2011) SFHP initiated incentivizing staff satisfaction through a pay-for-performance measure in 2014. Twenty community clinics and four medical groups who provide primary care to nearly 70% of the plan's membership (about 85,000 members) participated in this measure. SFHP provided structured technical assistance including coaching, and financial incentives to the clinics. Groups that put in a significant effort averaged a 61% relative improvement while groups that put in little or no effort saw an 88% relative deterioration in reported satisfaction.

San Francisco Health Plan

2. Community Based Care Management (CBCM) Program

A small group of high-risk plan members who have co-morbid medical and behavioral health diagnoses, housing instability, little social support, and have difficulty accessing needed health care, and social services account for a disproportionate use of acute health services and costs. To address this issue SFHP implemented a project to manage care for members across both the health system and the community at the point of care/in-person, and to coordinate care with PCPs and other providers. This program targeted patients with a minimum of 2 hospitalizations/year; 5 ED visits and 1 hospitalization/year; or 6 or more ED visits/year in the year before enrollment. A randomized trial is underway to evaluate health services use, programmatic, and health outcomes. FY 14-15 satisfaction survey had a 62.9% response rate in which 96% of respondents indicated their experience with CBCM program staff was helpful.

*California Health & Wellness (CHW)***

1. Telehealth Pilot Project

Access to both physical and behavioral health specialists in rural and remote communities remains a significant challenge. To address this issue, CHW aligned cutting-edge telehealth technologies to facilitate provider/specialist communication, increase capacity, efficiency, and access to care, while optimizing health outcomes and controlling costs of care delivery. Electronic consultation and promoting primary care provider and specialist communication during live-video telehealth specialty care appointments (i.e. diabetic retinopathy and dermatology imaging) and video remote translators are the features of this project. This project weaves a transformative approach into a technology-enabled model of health care delivery in remote communities by focusing on capacity building and primary care physician-to-specialist communication that fosters education, and optimal care coordination. Over 43,000 of the plan's members live in nine Telehealth contracted rural counties. So far through this project, CHW has facilitated over 1100 telehealth encounters in 38 clinics across 15 California counties.

2. Partnership with CHA-CHIP

CHW determined a pathway to complete a local health needs assessment and implement a community health improvement plan to form a community that supports and empowers all people to thrive and be healthy. For this purpose CHW initiated a collaborative partnership with the Imperial County Community Health Assessment and Health Improvement Partnership (CHA-CHIP) along with several local entities. The target population is Imperial County residents (about 55,000 members/30% of total membership). This project includes collecting more than 2,000 surveys from the community and hosting several community forum town hall meetings to discuss local health concerns in order to develop a list of the top ten most urgent health issues. The results from the survey and these town hall meetings will be used to design a long-term Community Health Improvement Plan, including planning health programs, services and policies for community improvement.

* The PHQ-9 is the nine item depression scale of the Patient Health Questionnaire. It is a tool to assist clinicians with diagnosing depression and monitoring treatment response.

** Nominations received after voting concluded were ineligible for award.