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

› Topics

1. Behavioral Health Care

2. COVID-19 Interventions

3. Customer Experience

4. Delivery System Design

5. Health Equity

6. Integration of Care

7. Patient and Family Engagement

8. Use of Technology

› Selection Criteria

Winners were selected based on the following criteria.

- Innovation and creativity

- Sustainability

- Scalability

- Impact on intended audience

- Solution distinct from existing approaches

- Quantitative data show results/impact

- Potential for cost impact

- Potential for quality impact

- Added value for payer/provider/patient

*Winners and submissions are listed alphabetically.

ABOUT THE NCQA INNOVATION AWARDS

WINNERS

How a Re-Design of an Integration of Care Model Produces Life-Changing Results
Maternal-Child Health Initiative Payer/Provider/Patient Collaboration
Neighbors in Health: A Statewide Program to Advance Health Equity Through the Engagement of Community
    Health Workers
UnitedHealthcare Community Plan of Florida Housing Navigation Program

SUBMISSIONS ON BEHAVIORAL HEALTH

Behavioral Health Peer Led Advocacy Approach
Changing Pathways
Perinatal Support Washington—The Warm Line
Reducing Admissions with Collaborative Interventions
Suicide Prevention and Mental Wellness Program for Ages 10–26

SUBMISSIONS ON COVID-19 SOLUTIONS

COVID-19 Community Response to the Pandemic
COVID-19 Intervention
COVID-19 Proactive Preparation
Health Emergency
Hospital at Home
Improved Access to Needed Resources for Vulnerable Populations During the COVID-19 Pandemic
Member and Provider Incentives to Influence COVID Vaccination
Oncology Home-Based Therapeutic Infusions: A Patient-Centered Collaborative Pilot
S.T.O.P. COVID Initiative to Proactively Addresses Health Inequity

SUBMISSIONS ON CUSTOMER EXPERIENCE

Elevance Health's Oncology Practice Consultant and Cancer Care Navigator Program—Building Collaborative
    Partnerships to Advance Health Outcomes for Providers and Members
Hearing the Difference: A Holistic Engagement Model to Achieve Unparalleled Results for the Invisible Disease
Increasing Program Participation and Member Satisfaction with Better Insights
Specialty Provider Enablement Program—OB Practice Consultants and Value Based Care

SUBMISSIONS ON DELIVERY SYSTEM DESIGN

In Basketologist
Molina Quality Living Program: Aligning Incentives to Improve Care and Quality in Nursing Facilities
Text-Based Telehealth: Impact on Behavioral and Asthma Health

SUBMISSIONS ON HEALTH EQUITY

Affordable Primary Care That Meets Patients Where They Are
African American Family Focus Group
Breast Cancer Screening Disparity Project with Greater Fresno Health Organization
Building Climate Resiliency to Address Health Concerns
Community Health Workers Recruitment, Training, and Mobilization Initiative
Doula Workforce Development
Enhancing Diversity in Clinical Trials to Advance Health Equity
Equity Learning Collaborative Grant Program
Gee's MKE Wellness Clinic

Haircuts and Health Checks in New Jersey

Housing Partnership

Increase Colorectal Cancer Screening Using Faith Leaders and Culturally Relevant Materials

Increasing Engagement in Preventive Health Behaviors Among Medicare Beneficiaries Through an 8-week Faith-Based Organization Challenge

Innovative Partnership Focused on Addressing Food Insecurity in the City of Newark, NJ

Interpreters as Billable Providers

Multi-Sectoral Collaboration to Improve Race and Ethnicity Data Collection

Novel Health Equity Methodology and Executive Dashboard Incorporates Intersecting Dimensions of Inequity

REAL: We Ask Because We Care—Improving the Collection of Race, Ethnicity and Language Information

Responsible Artificial Intelligence Program

Social Determinants of Care—Meeting the Needs of Our Members

Taking Action to Reduce Health Disparities Through Education and Partnerships

UnitedHealthcare Project Detect

UnitedHealthcare Healthy at Home: Solving for Common Post-Discharge Social Determinants of Health Barriers

Using Doulas to Overcome Medical Mistrust in the Birth Experience of Black and Rural Mothers

SUBMISSIONS ON INTEGRATION OF CARE

Breathing Is Life: Enhancing Life Through Access to Medications for Asthma

CHAMP Housing Stability Initiative

Emergency Room Frequent Flyer Case Management Program

How a Re-Design of an Integration of Care Model Produces Life-Changing Results

Integrate and Collaborate: Closing the Gap Between Urban and Rural

Iowa Hispanic Diabetes Management Project

Meeting the Patient Where They Are

Serving High-Need, High-Cost Homeless Members Through Housing Interventions

Using Digital Support Tools for Patient Care of Prediabetes

Value Based Care—Annual Wellness Visit Focus

Whole Patient Care

SUBMISSIONS ON PATIENT & FAMILY ENGAGEMENT

Maternal-Child Health Initiative Payer/provider/patient collaboration

Meeting the Social Needs of our Members: Addressing Social Isolation and Loneliness

Schuyler Hospital Gaps in Care Committee

SUBMISSIONS ON USE OF TECHNOLOGY

Advancing Health Equity Through Provider Education on My Diverse Patients.com

Community Paramedicine

MedStar Health COVID-19 Remote Patient Monitoring Program

Remote Patient Monitoring

Utilizing All of a Person's Available Health Resources to Drive Toward Positive Health Outcomes with Personalized Health Programs

Winners

Project Title: **Neighbors in Health: A Statewide Program to Advance Health Equity Through the Engagement of Community Health Workers**

Organization: Horizon Blue Cross Blue Shield of New Jersey

Topic: Health Equity

Project Contact: Leslie Chaillet, RN, MSN; Clinical Design Liaison (Leslie_Chaillet@Horizonblue.com)

Project Overview: Horizon BCBS of New Jersey launched a statewide initiative—Horizon Neighbors in Health—to address social needs for medically and socially complex members through engaging nonclinical community health workers. Horizon co-funded a pool of over 45 Community Health Workers to support members who are predicted to have avoidable medical utilization and who live in communities disproportionately affected by negative social determinants of health. The Community Health Workers engage members and address social needs to avoid potential health and social crises. To date, the program has engaged over 9,000 members and will be extended to support members throughout 2023.

Innovation: Horizon BCBS identifies social risks among the member population and uses advanced analytics to identify those at risk for avoidable medical utilization. Community Health Workers conduct a telephone or face-to-face screening with a member, then work with the member to develop an action plan with targeted self-care interventions. The Community Health worker connects members to available community-based organizations through the Unite Us referral management platform and, with the help of the Horizon Social Mitigation Fund, assists with providing services or items the member may not be able to afford to achieve their goals. Community Health Workers/members also have a dedicated Horizon Personal Health Assistant, who helps members navigate their health plan. Horizon entered into a medical-legal partnership with the Community Health Law Project to provide members with guidance, education and, at times, representation. Members who complete their goals receive a graduation certificate, in addition to a 1-month follow-up call and survey to assess sustainability and satisfaction.

Outcome:

- Graduates were twice as likely to follow up with their primary care provider within 7–14 days after discharge from an inpatient/ED event, and spent an average of 1.4 fewer days in the hospital than patients who were not enrolled.

- Cost of care for participants with chronic disease (e.g., asthma, diabetes) trended lower than the overall Horizon member population.

- Neighbors in Health provided over 2,000 members with accessible COVID19 vaccinations, especially those who were homebound, homeless or without transportation.

- The medical-legal partnership has assisted over 40 members with disability paper work, wrongful evictions and social security benefits.

- One member in the program graduated and became a certified Community Health Worker.

Project Title: **UnitedHealthcare Community Plan of Florida Housing Navigation Program**

Organization: UnitedHealthCare Community & State, Florida Plan

Topic: Integration of Care

Project Contact: Ava Jones, PhD, MSM, RN; Director, Health Equity & Accreditation (ava_jones@uhc.com)

Project Overview: Since its inception in 2018, the Florida Housing Navigation Program has received approximately 1,600 referrals for members who were either literally homeless or in danger of being evicted. The program successfully placed 600 members with stable and/or affordable housing and secured housing-related resources (utility/rent assistance, furniture) for approximately 850 members. The Housing Navigation

Program has positively impacted member satisfaction and reduced costly ED utilization by 34%; total claims (including behavioral health) have resulted in a savings of $7,173,212.98. Reduction in ED utilization as a result of the program has been more effective than other initiatives, such as ongoing member education efforts and primary care provider collaboration. The UHCCP FL approach is one of a kind in Florida because it addresses the full member continuum of care from a holistic practice.

Innovation: The Housing Navigator Coordinator receives referrals from community stakeholders and UHCCP FL clinical teams regarding members who are experiencing homelessness and/or near eviction, and who have been predicted to be super-utilizers and in the top 5% of medical spend the following year. Intensive housing case management is initiated for these members. One intervention established to augment shelter security efforts is Health Plus Housing, which connects the members to medical and mental health providers, removes barriers to housing and secures furnished permanent housing.

Outcome: One member story in particular is the best illustration of the Housing Navigation Program's effectiveness and member and community benefit: A 66-year-old man with a history of chronic homelessness, acute renal failure, heart failure, leg amputation and other co-morbidities had 5 ED visits and 112 inpatient stay days in less than 12 months. He was referred to the Homeless Navigator in May 2019 and approved for fitting and physical therapy for a prosthetic leg; a motorized wheelchair; home-delivered medications and home health services; and outpatient behavioral health services. Following housing placement in a furnished apartment, he was provided financial management training, placement at an adult day care facility and assistance to receive food stamps and access to community resources to address food and nutrition needs. As of July 2022, he had not had any inpatient stays and had visited the ED once. He has consistently maintained affordable housing, manages his own finances and clinical concerns, schedules doctor visits and transportation, and has an active social life in his community.

Project Title: **How a Re-Design of an Integration of Care Model Produces Life-Changing Results**

Organization: Healthy Blue Louisiana

Topic: Integration of Care

Project Contact: Cheryll Bowers-Stephens, MD, MBA; Plan Performance Medical Director and BH Medical Director (foley.nash@healthybluela.com)

Project Overview: Healthy Blue's Integrated Collaborative Care Model (ICCM) is a value-based program that rewards collaboration for integrating evidence-based practices and care coordination while mitigating barriers to care, especially for vulnerable populations. ICCM rewards HEDIS performance, SDOH assessments, community-based organization referrals and successfully getting help for referred members.

Innovation: Navigators, empowered by ICCM providers, focus on members at risk of biopsychosocial needs, comorbid or chronic conditions or concurrent behavioral/physical health diagnoses. Navigation services include motivational interviews, discharge planning, medication reconciliation, person-centered planning, screening for anxiety, depression, ADHD and adverse childhood experiences, along with successful fulfillment of holistic SDOH care and ongoing health literacy education. The program identifies, engages and supports members by breaking down barriers to focus on what is most important and impactful to them, in a personalized fashion, collaboratively with providers.

Outcome: ICCM addresses the needs of members suffering from health disparities, especially related to comorbid chronic conditions, mental health issues and substance use disorder. Complementing evidence-based practices, together in a VBP, has resulted in a 17% reduction in ED visits and an 8% reduction in inpatient visits, year over year, since 2018. From 2019, cost of care savings has consistently been produced at a level of $2,000 or more, per member per year, largely due to reductions in emergency and inpatient visits. In 2021, ED and inpatient visits were reduced by over 50% for members assessed for SDOH and intervened upon. The ICCM program helps close gaps for HEDIS measures, including Follow-Up After Hospitalization for

Mental Illness at 7 days and 30 days post-discharge. These results motivated an expansion from 9 participating groups to 19, and includes primary care, pediatricians, behavioral health, specialists, facilities and more. Expansion further improves access to integrated, whole-health services, especially for vulnerable populations in rural and remote areas. This innovative, value-based community model has yielded life-changing and sustaining results for Medicaid members, particularly during the pandemic.

Project Title: **Maternal-Child Health Initiative Payer/Provider/Patient Collaboration**

Organization: UniCare Health Plan of West Virginia

Topic: Patient and Family Engagement: Payer/Provider/Patient Collaboration

Project Contact: Barbara Wessels, MS; Planning and Performance Director (barbara.wessels@anthem.com)

Project Overview: The Maternal-Child Health Initiative uses an integrated approach to improve maternal-child health outcomes and reduce incidence of neonatal abstinence syndrome by integrating physical and behavioral health while utilizing prevention, case-management, and provider and member education/outreach for pregnant women (and women of childbearing age) who have a history of substance use disorder. The Women's Wellness & Recovery Program supports members 15–44 years of age who are at risk of or have substance use disorder. For members identified for the program, the recovery specialist provides information and counseling related to contraception, shares provider identification, facilitates engagement in recovery and empowers healthy lifestyle choices before, during and after pregnancy. Case managers provide intensive, wraparound services through 6 months post-delivery, works with the NICU population post-delivery and refers babies to the Children with Special Health Care Needs program if necessary. Case managers prepare mothers to potentially deliver a baby born with neonatal abstinence syndrome, and encourage mother-baby bonding, newborn development and continued involvement in recovery and treatment.

Innovation: UniCare's program screens for substance use to decrease neonatal death rate and reduce short- and long-term medical impact of substances on babies' health outcomes. The program supports pregnant moms with SUD to reduce effects on the child with 1 year of postpartum substance use treatment, parenting and medical care for mom and infant. It includes interventions to address the impact of substance use before, during and after pregnancy, such as prioritizing pregnant women for substance use screening, providing wraparound case management services for pregnant women with substance use disorder and increasing familiarity of evidence-based standards of care for newborns with drug-withdrawal syndrome.

Outcome: In March 2017, UniCare had 4.27 admissions per 1,000 and cost was $6.29 PMPM. In March 2022, UniCare had 1.03 admissions per 1,000 and cost is $1.27 PMPM. Raw data from case management demonstrates a drop in neonatal abstinence syndrome cases from more than 49 cases per month in 2018 to 20 cases per month in 2021; and cost reduced from $350,000 in January 2018 to less than $150,000 per month in September 2021.

Behavioral Health

Project Title: **Perinatal Support Washington (PS-WA)—The Warm Line**

Organization: Amerigroup Washington, Inc.

Project Contact: David Escame, Director, Medicaid Sales and Marketing (david.escame@amerigroup.com)

Project Overview: The PS-WA telephone support line, the "Warm Line," matches new and expectant parents and/or caregivers experiencing depression, anxiety, loss, infertility, trauma and more, with trained English and Spanish speaking staff/volunteers. The Warm Line is free regardless of insurance, so new and expectant parents—including low-income families, undocumented immigrants and refugees, and pregnant/parenting youth—have greater, more equitable access to mental health services. Callers remain connected to support over weeks/months to identify barriers to care, connect with treatment options and make mental health wellness plans. In addition to intervening when parents need help, the Warm Line helps with mental health education and prevention, providing support and referrals to new parents, as well as their families.

Innovation: The Warm Line is staffed by parents who have experienced a perinatal mood and/or anxiety disorder and have recovered fully, or by licensed therapists with specialized training in perinatal mental health. PS-WA is experienced in serving same-sex partners and LGBTQIA+ families. With COVID-19, there was an increase in calls regarding postpartum psychosis, suicidal thoughts and feelings, relationship conflict and intimate partner violence, and an increase in families needing referrals to basic needs. In response, PS-WA doubled its number of volunteers; added staff to the live answering schedule; expanded services to include extended follow-up; and provided training opportunities to address calls that included more in-depth perinatal mental health information (e.g., domestic violence, perinatal loss, inpatient programs). Procedures for acute, more complex calls (e.g., postpartum psychosis, requests for inpatient) were handled by trained staff.

Outcome: In 2021, there were 875 calls—a 135% increase from 2020 and a 280% increase over pre-pandemic. Of survey participants after using the Warm Line, 70% began to see a therapist, 19% used referred community resources, 17% attended a support group and 9% began to see a provider for medication management. The Warm Line's free services reduce the cost of untreated mental health challenges to the state and promote healthy child development and family stability. Numerous parents who use the Warm Line return to become volunteers.

Project Title: **Suicide Prevention and Mental Wellness Program for Ages 10–26**

Organization: Elevance Health

Project Contact: Jessica Chaudhary, MD, Medical Director (jessica.chaudhary@anthem.com)

Project Overview: This clinical intervention targets members 10–26 years of age who are at high or critical risk for a first or subsequent suicide attempt over the next 12 months, based on a predictive analytics model. Risk is defined as having at least a 10% risk of a suicidal attempt or event in the forthcoming 12 months. The data-driven model examines health insurance behavioral and medical claims going back 2 years for risk factors including a history of suicidal ideation, substance abuse, medications, mental health diagnosis and being a victim of abuse, among others. The predictive algorithm identifies at-risk adolescents and young adults an average of 5 months before a suicidal event.

Innovation: Specific interventions include telephone case management support, crisis intervention, peer and parental support, access to a peer support specialist and connection to resources and other supports, including connecting to therapeutic supports. There is 24/7 access to the Behavioral Health Resource Center. The team works to combat loneliness and isolation, help decrease severe emotional pain, despair and hopelessness, and create trust and connection. The goal is to offset impulsivity and create a layer of safety. Care managers also work to help the member build healthier choices and habits, and may make referrals to treatment such as therapy. A telephonic care manager and/or peer support partner is provided to parent(s), if applicable, to help decrease parental anxiety and stress and provide coaching and education on threat assessment, means

reduction and appropriate boundaries, and provide related psychosocial support and skills training. A quarterly newsletter, published for the behavioral health clinical leadership, highlights success stories, shares the latest evidence-based literature and offers additional resources.

Outcome: To evaluate intervention effectiveness, members engaged in the program were compared against a matched control group. Among those in the matched control group, the rate of suicidal events from 12 months prior to potential referral to 12 months post potential referral fell by 26.3%; for those engaged in the program for 7 or more days, the rate change fell by 47.1%; indicating a net intervention effect of 20.8%. This amounts to 186 fewer individuals with a suicidal event in the engaged group than expected.

With regard to actual suicide attempts, the matched control had a pre-to-post rate change of 11.1%; the engaged group had a rate change of 21.4%, indicating a net intervention effect of 10.3%. This amounts to 92 fewer suicide attempts in the engaged group than expected.

Project Title: **Reducing Admissions with Collaborative Interventions**

Organization: UnitedHealthcare

Project Contact: Lorrie Jones-Smith RN, MSN, CPHQ; Clinical Quality Consultant (lorrie_jones-smith@uhc.com)

Project Overview: The Reducing Admissions with Collaborative Interventions Program (RACI) program is tied to member utilization and case management processes involving interdisciplinary collaboration. It targets members with frequent inpatient behavioral health readmissions, creating a forum for health plan teams, providers and others to address treatment barriers and enhance discharge plans. RACI has contributed to decreased member readmission rates, increased community tenure and improved provider partnerships. Of 17 participating states, 12 are home to Medicaid NCQA-Accredited health plans.

Innovation: RACI is an integrated behavioral/medical staffing program focusing on members with complex needs. An integrated team conducts a comprehensive evaluation of needs to help remove barriers and promote a successful discharge and post-hospitalization follow-up. Adult members and guardians for children are invited to share their goals and noted barriers to recovery. Specific readmission contributors addressed include non-adherence to medication/out-patient treatment, co-morbid mental health/substance use disorders, co-morbid medical conditions, transportation, housing, social support and factors unique to the individual member.

Outcome: Outcomes show that the 923 members involved in RACI from January 2020–June 2022 saw a 50% decrease in 30-day readmission rate, a 30% decrease in 90-day readmission rate and a 12% increase in 90-day community tenure.

Project Title: **Behavioral Health Peer Led Advocacy Approach**

Organization: UnitedHealthcare

Project Contact: Lorrie Jones-Smith, RN, MSN, CPHQ; Clinical Quality Consultant (lorrie_jones-smith@uhc.com)

Project Overview: The Peer Led Advocacy Approach provides advocacy for individuals with serious mental illness or substance use disorder. The vision is to engage individuals in their recovery in ways that work for them. This is achieved by building trust and rapport with patients and creating compassionate care experiences that deliver evidence-based interventions reflecting each person's unique needs and preferences that drive improved health. This program is a team-based care model that comprises a field-based Peer Support Specialist and a Behavioral Health clinical staff member who collaborate to engage individuals in their

recovery and provide person-centered care and crisis support tailored to individuals' unique needs and preferences. All 11 participating states are home to NCQA-Accredited health plans.

Innovation: The Peer Support Specialist and Behavioral Health clinical staff member are paired and share a case load. The Peer initiates contact with the individual by telephone and in person, and helps drive individual-led recovery processes; the Behavioral Health clinical staff member uses clinical judgment to determine if the individual's needs require clinical intervention, while providing care coordination. Peers are equipped with tools to guide engagement/work with individuals to develop recovery and safety plans. They establish weekly contact with individuals, working with them to address social needs, develop a crisis/safety plan, identify a preferred provider and help smooth transitions in the recovery journey.

Outcome: Eighty-one individuals are enrolled across participating states and, when compared with those not enrolled, experienced the following outcomes:

- 16.6 percentage point increase in behavioral health outpatient visits.
- 9.1 percentage point decrease in behavioral health inpatient admissions.
- 5.6 percentage point decrease in behavioral health ER visits.
- 32.2 percentage point increase in behavioral health medication adherence.
- Participants reflected a 40% improvement in overall MARS-12 assessment scores pre- to post-engagement.

Project Title: **Changing Pathways**

Organization: Beacon Health Options Connecticut

Project Contact: Sandrine Pirard, MD, PhD, MPH; VP, Medical Director (Sandrine.Pirard@beaconhealthoptions.com)

Project Overview: To address the opioid crisis in Connecticut, the Connecticut Behavioral Health Partnership, in conjunction with Beacon Health Options, is promoting medications for opioid use disorder (MOUD), the most effective treatment for opioid use disorder (OUD), through the Changing Pathways program. Changing Pathways educates individuals on the benefits of MOUD, beginning them on MOUD during withdrawal management (rather than after discharge) and providing a warm hand-off to a community provider for outpatient care.

Innovation: The Changing Pathways intervention focuses on incorporating the option for MOUD in withdrawal management, as an alternative to traditional withdrawal management. The program's essential components are: 1.) ongoing MOUD education for individuals with OUD during care; 2.) MOUD induction for individuals who choose it; and 3.) warm transfers that allow these individuals to seamlessly continue their MOUD post-discharge. Program providers use a multi-disciplinary approach (medical, nursing and clinical staff) to educate members about the MOUD options at multiple touchpoints. Additionally, a peer with lived experience supports members in their early recovery.

Outcome: A 2020 study examined the impact of MOUD induction during treatment and adherence to medication during the 90 days post-discharge. During this period, inducted members were significantly more likely to take their medications than were non-inducted members. Individuals who were MOUD adherent at least 80% of the 90-day period following discharge experienced a 74% drop in overdoses during that period vs. the 90 days before admission. In addition, adherent members showed a significant decrease over nonadherent members' utilization when comparing the 90 days following discharge to the 90 days before admission: average number of behavioral health ED visits (54% reduction vs. 7% reduction); inpatient days (40% reduction vs. 27% increase) and number of repeat withdrawal management episodes (56% reduction vs. 9% increase).

Project Title: **Suicide Prevention and Mental Wellness Program for Ages 10–26**

Organization: Elevance Health

Project Contact: Jessica Chaudhary, MD, Medical Director (jessica.chaudhary@anthem.com)

Project Overview: This clinical intervention targets members 10–26 years of age who are at high or critical risk for a first or subsequent suicide attempt over the next 12 months, based on a predictive analytics model. Risk is defined as having at least a 10% risk of a suicidal attempt or event in the forthcoming 12 months. The data-driven model examines health insurance behavioral and medical claims going back 2 years for risk factors including a history of suicidal ideation, substance abuse, medications, mental health diagnosis and being a victim of abuse, among others. The predictive algorithm identifies at-risk adolescents and young adults an average of 5 months before a suicidal event.

Innovation: Specific interventions include telephone case management support, crisis intervention, peer and parental support, access to a peer support specialist and connection to resources and other supports, including connecting to therapeutic supports. Peer support specialists offer their perspective on lived experiences with mental health concerns and serve as a peer resource. There is 24/7 access to the Behavioral Health Resource Center. The team works to combat loneliness and isolation, help decrease severe emotional pain, despair and hopelessness, and create trust and connection. The goal is to offset impulsivity and create a layer of safety. Care managers also work to help the member build healthier choices and habits, and may make referrals to treatment such as therapy. A telephonic care manager and/or peer support partner is provided to parent(s), if applicable, to help decrease parental anxiety and stress and provide coaching and education on threat assessment, means reduction and appropriate boundaries, and provide related psychosocial support and skills training. A quarterly newsletter, published for the behavioral health clinical leadership, highlights success stories, shares the latest evidence-based literature and offers additional resources.

Outcome: To evaluate intervention effectiveness, members engaged in the program were compared against a matched control group. Among those in the matched control group, the rate of suicidal events from 12 months prior to potential referral to 12 months post potential referral fell by 26.3%; for those engaged in the program for 7 or more days, the rate change fell by 47.1%; indicating a net intervention effect of 20.8%. This amounts to 186 fewer individuals with a suicidal event in the engaged group than expected.

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COVID-19 Solutions

Project Title: **Improved Access to Needed Resources for Vulnerable Populations During the COVID-19 Public Health Emergency**

Organization: Amerigroup

Project Contact: Anya Nawrocky, MPA Director, Member Experience and Growth (anya.nawrocky@anthem.com)

Project Overview: Amerigroup created an outreach program to ensure that members, especially the most vulnerable, had access to needed resources during the COVID-19 public health emergency.

Innovation: Amerigroup stratified data to identify the most vulnerable members. Amerigroup Nurses and Social Workers conducted telephonic outreach to contact, screen and connect members to needed community resources. Members were able to refill their prescriptions early and get 90 days of maintenance medication at one time, to avoid having to leave home too frequently. Amerigroup representatives also coordinated provider visits for members through telehealth, including phone or video. If a member needed to see a provider face to face, transportation was arranged; transportation was also provided for members with COVID-19 symptoms. Members were also connected to SDOH resources. Members identified as food insecure were referred to food resources and SNAP enrollment. Amerigroup partnered with contracted meals providers to deliver meals to those members, and also partnered with local organizations to hold food distributions in communities with identified food insecure members. Amerigroup members were given access to the online "Find Help" community resource, a social care network. Plan associates and members can connect to resources that include housing, transportation, legal and other services.

Outcome:

- 8,786 members were identified as food insecure through the screening process and referred to food resources such as food pantries and SNAP.
- 4,043 members were referred for bridge meal boxes (1,063 received multiple boxes).
- 2,954 families received grocery boxes through Amerigroup's community-based distributions.
- In 2021, 2,017 members used Amerigroup's "Find Help" to connect themselves or others to services. Amerigroup also enlisted the aid of 255 employees to connect members in need of services through Find Help. Individuals were connected to 667 services and 122 referrals were made.

Project Title: **Member and Provider Incentives to Influence COVID Vaccination**

Organization: Anthem Kentucky Managed Care Plan, Inc

Project Contact: Kathryn Miller, LCSW, Health Equity Director (kathryn.miller@anthem.com)

Project Overview: Anthem Kentucky's goal used a three-phase strategy to get members vaccinated: 1.) increased digital connections to facilitate real-time outreach and keep pace with evolving information; 2.) provided information to assist in vaccine confidence; and 3.) encouraged first and second vaccinations through access to care, site of service information, affirmative statements about safety and efficacy and provision of financial incentives to facilitate vaccines for members who qualified.

Innovation: This program's focus is member outreach using multiple methods of contact to educate and assist members in scheduling vaccination appointments, including text messages, live calls, social media, ad campaigns and incentive programs. Through a partnership between the state Medicaid and Wild Health, the program hosted eight vaccination events across the state. The program additionally offers transportation for members to vaccination appointments, as well as 14 free home delivered meals for members released from the hospital after a COVID-19 diagnosis.

Outcome: On LouVax Volunteer Day, approximately 80 Anthem associates volunteered more than 320 hours at the LouVax clinic and helped administer nearly 2,000 vaccine doses. Anthem donated 500 water bottles, 500 weather ponchos and office supplies, to help with daily operations. Anthem Kentucky became the MCO with the highest vaccinated rate in the state, and increased vaccination rates in rural, predominantly vaccine-hesitant counties by 3%–4%.

Project Title: **Oncology Home-Based Therapeutic Infusions: A Patient-Centered Collaborative Pilot**

Organization: Horizon BCBS of New Jersey

Project Contact: Saira Jan, MS, PharmD, Vice-President & Chief Pharmacy Officer (saira_jan@horizonblue.com)

Project Overview: Horizon Blue Cross Blue Shield of New Jersey (Horizon) partnered with Rutgers' Cancer Institute of New Jersey (CINJ)/RWJBarnabas Health and Qualitas Pharmacy Services on a collaborative program pilot to promote home infusion of oncology and other injectable drug treatments as an alternative to the conventional receipt of therapy at an oncology infusion center. The goal of the project was to improve the patient experience while maintaining quality patient care.

Innovation: The Horizon, CINJ and Qualitas teams developed workstreams to develop and identify eligible patients for the program, address and resolve operation barriers and develop and track metrics. The program's objectives are:

- Improve patient satisfaction by minimizing travel, lessen public exposure and improve timeliness of care while delivering personalized patient care.
- Optimize an innovative benefit design to ensure cost-effective health care delivery.
- Deliver oncology medications safely and maintain a high quality of care in the home environment without interruptions due to COVID-19.
- Increase the hospital and infusion area capacity to facilitate more complex cases.

Patients who met all inclusion criteria were enrolled in the pilot.

Outcome: Eighty patients had been enrolled in the program as of June 2022, and an additional 107 patients are undergoing screening and evaluation. The program has a patient satisfaction survey score of 98%. No untoward toxicity and/or unexpected adverse events have been reported from home-based infusions.

Project Title: **S.T.O.P. COVID Initiative to Proactively Address Health Inequity**

Organization: UnitedHealthcare

Project Contact: Lorrie Jones-Smith, RN, MSN, CPHQ; Clinical Quality Consultant (lorrie_jones-smith@uhc.com)

Project Overview: In the early days of the COVID-19 pandemic, as significant disparities began to manifest in the testing, cases, hospitalizations and deaths among Black Indigenous and People of Color populations, UHG implemented S.T.O.P. (Safety Testing Overall Partnership) COVID. The goal was to solve inequitable access to testing and vaccine administration in communities. Based on the feedback, the efforts quickly expanded to provide needed social support, including food and safety kits and meaningful referrals to community organizations.

Innovation: In 2020, UnitedHealthcare Community Plan LA helped implement a program in targeted ZIP codes that offered: 1.) free testing, regardless of insurance status; 2.) health kit distribution (masks, hand sanitizer, health information sheets and more); 3.) food distribution to persons receiving tests; 4.) social

services referrals/community action kits; 5.) medical referrals. Services were provided at two pop-up locations. In 2021, five more ZIP codes in Orleans Parish area were targeted for program implementation over a 3-week period, with locally based teams working with community partners to deliver services at one or more pop-up sites. The program offered: 1.) health, safety and education kit distribution; 2.) Food box distribution; 3.) COVID vaccinations.

Outcome: For the 2020 testing campaign, 4,848 tests were performed; 4,916 health kits, 4,416 meals and 1,069 community action item kits were distributed. Individuals living outside the initial targeted ZIP code came for testing at intervention sites. There were 1,206 individuals tested from the targeted areas.

For the 2021 vaccine campaign, the largest number of vaccine recipients came from an adjacent ZIP code. Approximately 40% of vaccine recipients were Hispanic/Latino; 53% identified as African American. In partnership with other local health plans, similar S.T.O.P. COVID initiatives have also been deployed across the country.

Project Title: **Hospital at Home (H@H)**

Organization: Atrium Health

Project Contact: Samantha Cook, Director (samantha.cook1@atriumhealth.org)

Project Overview: Atrium Health Hospital at Home was developed and deployed in the first days of the COVID-19 pandemic. Its objectives were to increase inpatient bed capacity, monitor patients to ensure prompt intervention, decrease community spread and "wrap patients with care" to mitigate fear and anxiety. Hospital at Home enabled prioritization of hospital resources for the most severely ill COVID-19 patients. The program has provided care to over 5,100 patients in the comfort and safety of their home. The program has been expanded to include patients with congestive heart failure, COPD, pneumonia and numerous other conditions that otherwise would require admission to a traditional brick and mortar hospital.

Innovation: Patients were screened using adapted pneumonia risk assessment tools. Eligible patients were sorted into either the virtual observation unit (VOU) or the virtual acute care unit (VACU). VOU patients received daily check-in nurse phone calls. VACU patients also received 24/7 nursing monitoring, a daily virtual visit with a provider and daily in-person visits by community paramedics. The VOU was closed in May 2021, and the VACU was renamed "Atrium Health Hospital at Home." To plan, launch, and sustain the virtual hospital model, the team collaborated with numerous stakeholders to manage patients in a home setting that mirrored traditional inpatient care. Technology enhanced the program through telehealth services, the GetWellNetwork, for patient alerts and reminders, and GeoTab, to coordinate and track remote health care worker deployment.

Outcome: During the first 10 months of operation, the VOU handled approximately 51,000 patients and the VACU cared for nearly 2,500 patients, saving over 10,000 brick-and-mortar bed days. Hospital at Home delivered more cost-effective treatment than the brick-and-mortar equivalent, and patients preferred it to traditional in-patient care. Hospital at Home has cared for over 5,100 patients and has a staff of fully dedicated health providers.

Project Title: **COVID-19 Intervention**

Organization: Community Health Network (CHN)

Project Contact: Melialoha Bartlett, BHA, MBA; Director of Health Systems (mbartlett@sfachc.org)

Project Overview: MyCHN sought to answer the question of "How do we help people get the COVID-19 vaccine efficiently?"

Innovation: CHN, information technology, clinical, outreach, communications, patient services and revenue cycle management staff worked in partnership with EHR developers to build an online registration and event management system that allowed the health center to administer COVID-19 tests to 37,637 unduplicated individuals during the Delta, Omicron surges, and in between, at clinical outreach events. When the COVID-19 vaccine rolled out, CHN worked with its EHR vendor to develop an event management system that handled 1000s of registrants and coordinated follow-up care through virtual visits.

Outcome: A total of 15,046 individuals were fully vaccinated with the COVID-19 primary series, and 1,281 individuals received booster doses. An additional 3,913 individuals received the first dose of a two-dose COVID-19 vaccine.

Project Title: **COVID-19 Proactive Preparation**

Organization: Lāna'i Community Health Center (LCHC)

Project Contact: Diana M.V. Shaw, PhD, MPH, MBA, FACMPE; Executive Director (dshaw@lanaihealth.org)

Project Overview: Lāna'i Community Health Center is the only FQHC on Lāna'i, with a population of approximately 3,100. For the first 8 months of the COVID-19 pandemic, the island was sheltered from infections. But as people began to travel again, the positivity rate in the community skyrocketed overnight. Lāna'i quickly realigned resources and staff, developed and implemented systems to bring the community together to address the pandemic, while maintaining a focus on the needs of high-risk populations. LCHC became a primary leader in the community, and the extension arm of the State Department of Health.

Innovation: LCHC practiced as if positive rates were high on Lāna'i from day one of the pandemic by having staff wear personal protective equipment. It eliminated walk-in patient appointments and employed telemedicine for routine medical care. Patients who showed COVID-19 symptoms were directed to the center's parking lot, where they were tested in their vehicles. Dental was closed for all nonurgent appointments. Community Health Workers were trained to provide immunizations and deployed to maintain voice contact with high-risk patients, including running errands, picking up mail and providing groceries and other basic needs.

Outcome: The outcome and results of these efforts included an overall low positivity rate in infection and a strong groundwork for future public health emergencies. LCHC also addressed social determinants of health: CHWs assisted with distribution of donated food and supplies to families and individuals who were in isolation/quarantine (food insecurity), and our outreach worker addressing health insurance and housing needs (economic security). Through monitoring protocols, four patients were identified to require off-island hospitalization. With close communication and collaboration with EMS and the Lāna'i Community Hospital ER, all were safely transferred.

Project Title: **COVID-19 Community Response to the Pandemic**

Organization: Premier Medical Group

Project Contact: Deanna Shepard, Operations Support Manager, PCMH Coordinator (deannas@premiermed.com)

Project Overview: Premier Medical Group found new ways to provide primary care to well patients, initiate contact with potentially infectious patients via virtual technology and implement a safe approach to patient care for patients who are symptomatic with the potential for COVID-19 viral infection. Premier Medical Group established policies and procedures specific to the pandemic response to protect and serve our patients as well as our employees.

Innovation: Premier Medical Group Clinical was selected by the state as a COVID vaccine provider for adult and pediatric populations. Premier utilized its EHR to create outreach via phone and email to connect patients to information about COVID vaccines, testing and treatment available to them and their family. It also initiated virtual visits for patients unable to present for in-person treatment secondary to a medical history of high-risk conditions or a positive COVID test. A dedicated email address and website link were created so patients could contact Premier with COVID concerns. The email address was monitored 12 hours a day, 7 days a week by clinical staff, and patients were triaged and contacted within 8 hours of sending an email.

Outcome: As of October 2020, Premier Medical Group had held 4 employee COVID vaccine clinics, 17 patient COVID vaccine clinics, provided a total of 6, 633 COVID vaccines, tested 31, 532 patients for COVID and treated 21,532 patients positive for COVID-19.

Customer Experience

Project Title: **Specialty Provider Enablement Program—OB Practice Consultants and Value-Based Care**

Organization: Elevance Health

Project Contact: Zeinah Malvaso, RN, BSN; Director I HCMS (Zeinah.malvaso@amerigroup.com)

Project Overview: Elevance Health insures 11% of the nation's births. It developed initiatives to enable its obstetric specialty providers to advance maternal health outcomes and achieve the triple aim by providing 1:1 practice-level support through an aligned provider consultant.

Innovation: The Specialty Provider Enablement Program uses Practice Consultants—clinicians with obstetric specialty practice expertise who focus on provider collaboration and are clinical liaisons. At the health plan level, they collaborate with stakeholders to support a high-performance network; facilitate referrals to care management or other services; participate in initiatives to close gaps in care; and increase access to services through collaboration with local markets and community-based providers. At the provider level, they visit network providers a minimum of 20 times/month, through virtual and in-person meetings, to build consensus and commitment to change as a trusted clinical liaison; facilitate enrollment and engagement in Elevance Health value-based care programs; share robust, real-time data with providers; coordinate referrals to applicable Elevance Health Solutions programs; and collaborate with providers to deliver actionable reports aimed at closing consumer gaps in care at the practice level.

Outcome: When the Practice Consultants and Individual Provider aspects of the program were paired, a 2021 evaluation showed a 5% decrease in total birth costs, 5% savings in maternal costs within the first year of delivery, a 9% reduction in primary c-section rates, a 19% decrease in low-birth-weight rates, a 14% favorable impact on the overall adequacy of prenatal care, a 91% increase in postpartum visit compliance and a 22% increase in VBAC rates.

Project Title: **Elevance Health's Oncology Practice Consultant and Cancer Care Navigator Program — Building Collaborative Partnerships to Advance Health Outcomes for Providers and Members**

Organization: Elevance Health

Project Contact: Virginia Plaisance, BSN, RN, CCM; Staff Vice President, Total Population Health (virginia.plaisance@anthem.com)

Project Overview: The Oncology Practice Consultants and Cancer Care Navigator Program supports providers in delivering quality, affordable care and positive health outcomes. At the practice level, providers receive 1:1 consultant support, along with actional data insights to address quality, cost and disparities. Members most at risk for adverse outcomes related to cancer treatment receive support from Cancer Care Navigators (CCN), who guide them along the care continuum.

Innovation: Members 18 years of age or older, with all types of cancer, are identified for inclusion in the program through multiple sources. Upon member enrollment, the CCN creates a patient-centered care plan, and, through real time and on-demand communications:

- Coordinates with members and providers to address potential side effects during treatment.
- Supports care transition during treatment or post treatment to the palliative care partner.
- Engages registered dieticians to counsel on nutritional therapy.
- Leverages pharmacists to counsel on medication adherence, financial assistance or new medication regimens.
- Coordinates member benefits to ensure adequate access and resources are available.
- Addresses SDOH that may be barriers to treatment.

Outcome: Since program launch in 2020, CCNs have managed 3,165 members and held 27,849 member conversations. Oncology Practice Consultants have supported 7,500 Oncology Medical Home value-based providers, with an attributed membership of 23,000 members with cancer. Elevance Health expanded the Oncology Practice Consultant and Cancer Care Navigator Program throughout the remainder of 2022.

Project Title: **Increasing Program Participation and Member Satisfaction with Better Insights**

Organization: Insightin Health

Project Contact: Yancey Casey, Senior Account Director (ycasey@acmarketingpr.com)

Project Overview: A regional health plan serving Dual Special Needs Plan members partnered with Insightin Health to implement a data-first approach to improve its model of care process and deliver better member experiences. The main challenge focused on completion rates of HRAs, which anchor the plan's ability to create custom, member-focused health care recommendations. Insightin Health's technology simplified this process to allow easier data collection and access on the plan side and timely communication, and more options for HRA access on the member side. This resulted in cost savings across the program, as well as a more efficient approach to the HRA process.

Innovation: The health plan implemented Insightin Health's cloud-connected technology, consolidating processes into a single platform. Machine learning-driven technology allowed the plan to aggregate member behavior and interactions, which enabled recommendations for improved member engagement and higher utilization for a healthier population. Reporting occurs in real time, allowing a constant view into performance. The technology also allowed the plan to reduce manual interventions, enabling care managers to reinvest more time into providing personalized member experiences. The AI-driven platform applied Natural Language Processing to collect HRA and SDOH data from multiple sources, instantly creating a personalized care plan for each member. This created a single point of access to the care management process and provided the health plan with the ability to drive personalized touchpoints with its members to trigger HRA completion. The platform's advance analytics capability allowed the plan to identify real-time risk stratification and provide compliance driven reporting, which is shared with CMS.

Outcome: Offering an omnichannel approach led to higher engagement and HRA completion rates, improving compliance adherence across the board. Reducing manual involvement from care navigators and call center staff decreased the program's cost, and consolidated workflows reduced spending on print materials. In addition to real-time activity tracking, the health plan increased provider engagement by 75% and gap closures by 40%. Additionally, the plan experienced an 866% increase in overall HRA completion, including a 596% increase in HRA completion via mail. Star ratings for member engagement increased from 3.0 to 3.5 in the first 12 months, and case management engagement for members who completed an HRA increased 41%.

Project Title: **Hearing the Difference: A Holistic Engagement Model to Achieve Unparalleled Results for the Invisible Disease**

Organization: NationsBenefits®

Project Contact: Kal Gajraj, Communications Director (kgajraj@nationsbenefits.com)

Project Overview: In 2020, NationsBenefits introduced an engagement program to impact comorbidities associated with hearing loss. It developed pre- and post-treatment engagement solutions to encourage appropriate testing and treatment, prepare patients for rehabilitation and actively participate in reacclimating to daily life experiences once hearing aids are issued. The NationsBenefits Hearing Outcomes program, offered at no charge to health plan partners, promotes proactive treatment and technologies that encourage hearing aid acceptance and adoption.

Innovation: NationsBenefits developed and deployed a holistic engagement solution that supplements traditional hearing benefits to reduce hesitancy in seeking treatment, and provides therapeutic rehabilitation support. Digital hearing screening tools, virtual appointment support, learning resource libraries and a gamification application target appropriate patients and promote treatment adoption. During rehabilitation, the intervention team employs a 12-month multi-channel solution that includes timed educational elements, progress assessments, product samples and active conversational engagement. Throughout the program, patients' needs are assessed and addressed, while measuring improvement in physical, mental and social health factors to customize future interactions. Patients are encouraged to participate until they have achieved optimal results, but continue to receive ongoing support to ensure all future needs are met proactively.

Outcome: Roughly 30% of all program participants attribute their positive results to the engagement model, educational materials, unique tools and intervention support. Within 3–6 months of treatment, 33% of program participants experiencing imbalance and fall risks before treatment no longer experienced those issues. 52% of program participants reported improvement in mental health from program engagement, while 68% reported increased social activity through proper hearing-aid utilization. More than 33% of participants directly attributed their hearing rehabilitation progress to physical activity and overall physical health improvements. Results consistently outperform other nationally published studies. Program participation and associated results have continuously improved throughout the program's lifecycle, leading to a rapidly increasing number of impacted lives and reduced clinical expenses for health plan partners.

Delivery System Design

Project Title: **Molina Quality Living Program: Aligning Incentives to Improve Care and Quality in Nursing Facilities**

Organization: Molina Healthcare

Project Contact: Deborah Wheeler, MSPH; Vice President, Quality (deborah.wheeler@molinahealthcare.com)

Project Overview: Molina Healthcare of Texas implemented an innovative payment model for its nursing facilities. All participating facilities may be awarded Platinum, Gold or Silver status based on achieving rates based on the CMS 5-star system. Pay for quality incentives are based on per resident per month fees in addition to nonfinancial incentives for employee engagement.

Innovation: The Molina Quality Living Program includes financial and nonfinancial incentives through an alternative payment model. Financial incentives are awarded through tiered status levels of Platinum, Gold and Silver. Facilities achieve the highest level of payment by receiving high scores on measures included in CMS's 5-star nursing facility rating system, with high achievement for at least one measure related to quality. Accompanied by higher pay for quality per resident per month awards, Platinum status facilities also may host additional Molina-sponsored employee/staff engagement functions. Molina gives all participating facilities the ability to receive advance payments earned, as an extra participation incentive.

Outcome: Molina Healthcare of Texas has issued $6 million in payments to facilities that achieved program goals. In a 2021 survey, 90% of facilities stated they were positively satisfied with the service coordination provided by Molina. Over 90% of facilities were positively satisfied with the responsiveness and courtesy of Molina's team. These outcomes show the critical value of partnering with facilities that deliver health care to members with complex physical and mental health issues.

Project Title: **Text-Based Telehealth: Impact on Behavioral and Asthma Health**

Organization: CirrusMD

Project Contact: David Ehrenberger, MD, Telehealth Physician and Consultant (drehrenberger@gmail.com)

Project Overview: Telehealth-based primary care services offer real-time, 24/7 access, low overhead, rigorous application of best-practice monitoring and meeting the growing demand for "health care by wire." This project leverages a chat-based telehealth continuity practice whose goal is demonstrating substantial near-term improvements in depression and anxiety, and in poorly controlled asthma. The patient population is national and spans payer groups, including Medicaid, commercial plans and employer-insured/uninsured enrollees.

Innovation: Once identified, patients with anxiety and/or depression are interviewed to clarify their clinical presentation and exclude confounding factors. Patients with clinically significant major mood or anxiety disorders are counseled about treatment, including pharmacologic options, talk therapy and referral for in-person care. Most of CirrusMD's patients have no or limited access to local primary or behavioral health care, and are then managed by primary care physicians and a psychiatrist through its online continuity clinic. Patients at significant risk for suicide are referred for local emergency care; those with complex mental health conditions are referred to local, in-person behavioral health specialists. Treatment plans focus on pharmacologic therapy; proactive follow-up occurs at 2, 4, 6 and 8 weeks to reassess clinical progress and suicide risk, and to optimize treatment regimens.

Patients with asthma and asthma symptoms, or requests for inhaler refills, are evaluated for current and ongoing severity using the standardized Asthma Control Tool (ACT). These patients are most often using only rescue inhalers, and have ACT scores of ≤19, indicating suboptimal or poor control. An evidence-based asthma care plan, including the use of inhaled steroids, is discussed and medications prescribed. Patients are

referred for ongoing follow-up, repeat ACTs and management by physicians. Patients with symptoms suggesting significant respiratory distress, often confirmed by a video encounter, are referred for emergent treatment at a local ER.

Outcome:

Behavioral health:

- At initial presentation, the mean PHQ-9 score for 317 patients was 17 (moderately severe). Over 8 weeks and a mean contact frequency of 4.5 encounters, PHQ-9 scores improved by a mean of 8 points. The overall final PHQ-9 score was 9 (mild). Patients with a PHQ-9 reduction of at least 5 points was 72%.

- For anxiety, the overall mean presenting GAD-7 score was 15 (just within severe). Over 8 weeks and a follow up frequency of 4.5 visits, patients with anxiety saw a reduction in GAD-7 scores of 7 points with a mean final score of 8. Wilcoxon Ranked Sum analysis confirmed improvement in both depression (PHQ-9) and anxiety (GAD-7) to be highly significant ($p < 0.0001$ for both).

Asthma:

- During the study, 27 patients completed both the initial ACT score and at least one follow-up ACT score 28 or more days after the initial assessment. After referral to the primary care clinic, 23 (85.2%) patients had a change in their asthma medication based on asthma treatment standards, including addition of or change in an asthma controller medication. Twenty-five patients had an initial ACT score ≤17 (partial to poor control). These patients had an average ACT score of 10.8 (poor control) at presentation and a final ACT score of 17.5 (fair-good control). The average ACT difference was 6.6 (95% CI: 4.5, 8.8).

These studies demonstrate clinically significant improvements in both depression and anxiety and in poorly controlled asthma.

Project Title: **In Basketologist**

Organization: WellSpan

Project Contact: Stephen Flack, MD; Primary Care In Basketologist (indirect work provider) (sflack@wellspan.org)

Project Overview: From exit interviews, WellSpan learned that many providers were leaving primary care due to indirect work overload. The project provided care teams with additional members working from home to address indirect work, like labs and x-rays, more quickly. This provided an improved patient experience and questions were answered more quickly, which led to improved provider and staff satisfaction.

Innovation: Using the metric of 11000 patient volume to support a full-time "In Basketologist," WellSpan provided primary care offices with work-from-home staff to manage indirect work load. The In Basketologist covered out-of-office providers first, providers on PTO/sick/FMLA next, then priority messages and test results. Providers would review their "baskets" throughout the day and address what they could manage. The end-of-day goal was that all items for all providers were addressed and all patient messages answered or reviewed.

Outcome: Metrics are tracked through Signal (Epic platform) for total office work volume and for time to return message. Press Ganey scores that query "provider gets back to me in 24 hours with response to my question" are tracked. In Basket providers track daily production in spreadsheets for comparison and quality measurement.

Health Equity

Project Title: **Interpreters as Billable Providers**

Organization: AllCare Health, Inc.

Project Contact: Stick Crosby, Sr.; Network & Health Equity Director (stick.crosby@allcarehealth.com)

Project Overview: Health care providers frequently care for patients with limited English proficiency. These patients experience challenges accessing health care, and are at higher risk of receiving suboptimal health care. Health care interpreters are crucial partners to help break down communication barriers and prevent these patients from facing health care inequities. But many providers lack the skill set and knowledge that are vital to successful collaboration with an interpreter.

Innovation: AllCare developed a policy and process to credential and contract with interpreters to bill directly under a clinic through an 837P transaction or a CMS 1500 form.

Outcome: $300 per member per month reduction of costs in care for Spanish speakers; 30% increase of preventive care services.

Project Title: **Innovative Partnership Focused on Addressing Food Insecurity in the City of Newark, NJ**

Organization: Amerigroup

Project Contact: Anya Nawrocky, MPA; Director, Member Experience and Growth (anya.nawrocky@anthem.com)

Project Overview: Amerigroup New Jersey partners with United Community Corporation (UCC) of Newark to address food insecurity for Amerigroup members and the Newark community. The collaboration includes Community Food distributions, the UCCafé free mobile food truck and the Community refrigerator project.

Innovation: In 2021, Amerigroup partnered with UCC to begin a monthly food distribution. Members identified as food insecure were targeted to receive food packages. Other community events were also identified for food distribution, such as COVID testing and vaccinations and back-to-school events. UCC's food pantries were also enhanced with new refrigeration units. UCC also placed four refrigerator pantries, filled with necessities like bread, eggs and fresh produce, in Newark's identified food deserts, with plans for more. Refrigerators are accessible to the public 24/7, and are protected by a wooden structure built by UCC's Youth Build construction students. Additionally, with support from Amerigroup, UCC converted a food truck that serves prepared and packaged meals directly to those in need of food assistance, with a particular focus on feeding the homeless—the UCCcafé. Amerigroup works in tandem with the UCCcafé to provide health education and access to health and social supports. The UCCcafé can bring food directly to Newark and surrounding cities in Essex County.

Outcome: To date, 2,954 families have received grocery boxes through the community-based distributions. From installation of the first community refrigerator, 16,660 people have been served, for an average of 2,776.7 people per month. Since it began serving, the UCCafé has served 6,524 people, for a monthly average of 1,631 people. All activities are sustainable and scalable programs designed to increase access to fresh, healthful foods. Based on the success to date, the partnership is looking to expand upon all three initiatives.

Project Title: **Haircuts and Health Checks in New Jersey**

Organization: Amerigroup

Project Contact: Anya Nawrocky, MPA; Director, Member Experience and Growth
(anya.nawrocky@anthem.com)

Project Overview: Amerigroup New Jersey collaborated with local community partners to address medical mistrust, disease prevention, vaccinations and access to health screenings. The Haircut and Health Check event series began during the pandemic as way to encourage COVID vaccinations, and was expanded to include men's health screenings. The event series gave community members the opportunity get vaccinated or screened, receive health education and get answers to their questions.

Innovation: Participants receive COVID vaccinations and/or free screenings that include blood pressure and blood glucose tests, and are then offered free haircuts. Amerigroup health educators discuss men's health topics with regard to healthy eating, lifestyle choices and recommended screenings for cancers prevalent in men. FQHC staff are on hand if participants required further follow-up.

Outcome: Five events to date have screened 219 community members, and 146 COVID vaccinations and 78 flu vaccines have been administered. These events have been effective in getting needed screenings and vaccinations effectively and at low cost, and have also strengthened partnerships with community organizations. Amerigroup is exploring expanding to nail and beauty salons, to focus on women's and maternal health issues.

Project Title: **Community Health Workers Recruitment, Training, and Mobilization Initiative**

Organization: Amerigroup

Project Contact: John McCalley, Health Equity Director, john.mccalley@amerigroup.com

Project Overview: In June 2021, Amerigroup Iowa launched its Community Health Workers Recruitment, Training, and Mobilization Initiative with ICCC. This partnership represented the first time that a Medicaid managed care organization made a major investment in community health worker training in Iowa. The initiative sponsored community health worker training for 100 individuals. Amerigroup Iowa focused on specific counties where HEDIS® measures demonstrated statistically significant differences for Black and Latinx members. Community health workers worked in communities to advance population health initiatives focused on managing chronic conditions.

Innovation: The overall goal of the program was to build Community Health Worker capacity and implement population health initiatives initially focused on maternal and child health, diabetes and asthma, and then in future years, expand to address other chronic conditions. It will offer the first-ever CHW continuing education, which will include basic training on chronic conditions like diabetes and asthma, to individuals who may not otherwise be conversant on chronic conditions and the resources available in the community to support people with them.

Outcome: By the end of March 2022, 100 CHWs had been trained. To ensure this work's sustainability, the initiative obtained funding in the Amerigroup Iowa 2022 budget. ICCC and Amerigroup Iowa will offer continuing education for CHWs on chronic conditions, behavioral health, maternal and child health, disabilities, health disparities and health equity. This training series will continue to advance the skills and the knowledge base of this important workforce.

Project Title: **Gee's MKE Wellness Clinic**

Organization: Anthem

Project Contact: Marvin Hannah, MS; Community Relations Consultant (marvin.hannah@anthem.com)

Project Overview: Gee's MKE Wellness clinic addresses health disparities in vulnerable and underserved communities through a wellness clinic inside Wisconsin's largest barbershop. The clinic aims to connect individuals with a provider and resources enabling them to identify barriers to their health and take active steps to prioritize their overall wellness. A licensed clinician provides blood pressure, blood glucose, BMI checks, vision, monthly HIV/STI screenings and general health education. In collaboration with community partners, the clinic also provides referrals for medication adherence, health insurance and primary care/specialist navigation, job assistance, training and development of interpersonal skills, as well as helping individuals obtain higher education.

Innovation: Taking into account the mistrust individuals have for the health systems and their reluctance to discuss their health and wellness in clinics, Gee's MKE Wellness Clinic approaches these conversations in an environment where they feel comfortable. The rapport between barbers and clients helps build awareness about the clinic and its efforts. Barbers receive quarterly education from clinician partners to help them navigate conversations with their clients. Barbers are given the most up-to-date information about issues in the community, and how Gee's MKE Wellness Clinic can help.

Outcome: Since its inception, Gee's MKE Wellness Clinic has seen over 6,000 individuals, provided over 1,000 COVID-19 vaccines and 500 seasonal influenza vaccines and has helped over 500 individuals secure a primary care provider and/or specialist.

Project Title: **Increase Colorectal Cancer Screening Using Faith Leaders and Culturally Relevant Materials**

Organization: Anthem Kentucky Managed Care Plan, Inc

Project Contact: Kate Miller, LCSW, Health Equity Director (kathryn.miller@anthem.com)

Project Overview: This project aims to reduce cancer disparities by leveraging faith-based Community Health Advisors to educate community members in predominantly Black communities. CHAs will use culturally tailored audiovisual tools to educate, increase awareness and motivate behavior change to complete FIT kits.

Innovation: Pilot a community based colorectal cancer screening intervention in a Black church in Louisville that is a trusted source for promoting cancer screenings and education. The project incorporates education on cancer screening and FIT distribution, follow-up and patient navigation. Audiovisual tools feature local care providers and colorectal cancer survivors who deliver audio-recorded screening education and provide simplified instructions for FIT completion. These resources—provided in a trusted space, by faith leaders in the church—are an important educational tool and a way to build trust with community members.

Outcome: Gathering preliminary data on viability of future implementation for healthy behaviors in faith-based settings—do screening rates increase, and does knowledge and perception about the importance of screening change post intervention?

Project Title: **Using Doulas to Overcome Medical Mistrust in the Birth Experience of Black and Rural Mothers**

Organization: Anthem Kentucky Managed Care Plan, Inc.

Project Contact: Kathryn Miller, LCSW, Health Equity Director (kathryn.miller@anthem.com)

Project Overview: This project trains and places racially and culturally sensitive doulas in underserved areas to advocate for positive birth outcomes for Black, Indigenous and People of Color, and rural mothers. Additional layers of support both pre- and post-delivery empower mothers and help to overcome barriers to preventive health for mothers and babies. Birth and postpartum doula services offer a wide variety of amenities that support mothers before, during and after birth, and address barriers to care.

Innovation: Women of low-income communities can access these services without having to pay for them. Birth doula services include judgment-free support (e.g., for an unmedicated birth, epidural, planned c-section), positive relationships and collaboration with all care providers, answers to questions, birth support and continuity of care. Postpartum doula services include meal preparation/planning, cleaning, running errands, infant care, hands-on support and education, confidence building of the family unit, PPD assessment and referrals and physical recovery after birth. Services are offered from newborn through 2 years of age, and can be ended whenever the individual wants them to end. The program also offers lactation support.

Outcome: Twenty-four doulas were recruited and trained.

Project Title: **Equity Learning Collaborative Grant Program**

Organization: Community Health Plan of Washington

Project Contact: Colleen Haller, MPH, Director of Quality (colleen.haller@chpw.org)

Project Overview: Community Health Plan of Washington created a 3-year Equity Learning Collaborative Grant program to fund projects at the community health centers that make up the Community Health Network of Washington, centered on advancing health equity and reducing health disparities. Each CHC is eligible to receive up to $50,000 each year to cover the costs of project implementation in 2021, 2022 and 2023.

Innovation: Learning opportunities focus on the organizational infrastructure necessary to take on equity work. This includes training for staff on diversity, equity and inclusion; data infrastructure to support analysis by diversity dimensions; requirements and expectations around root cause analysis; structures to support patient/member engagement in program design; and leadership buy-in to bring an equity lens to everything the organization does. These foundational elements are essential to ensure that grant funding is part of a larger shift in approach to health care delivery, rather than one-time projects.

Outcome:

- The Member Experience and Access to Care cohort increased access for non-English speaking patients; increased access to physical/behavioral health for students in a rural area; funded community health workers; and created an online Spanish radio platform to engage patients.

- The Pregnancy Care cohort redesigned the clinic's OB program, leading to an increase in postpartum care visits for non-English speaking patients by 46%; and gathered feedback from non-English speaking patients to understand and address barriers to postpartum care.

- The Chronic Condition cohort hosted diabetes management groups for Pacific Islander patients, increased access to home BP monitoring devices and collected social drivers of health data for diabetic patients to inform specialized support.

- The Behavioral Health cohort provided additional support for patients experiencing homelessness, increased depression screening in multiple languages and developed care pathways that increase provider collaboration for supporting patients with depression.

Project Title: **Enhancing Diversity in Clinical Trials to Advance Health Equity**

Organization: Elevance Health

Project Contact: Darrell Gray, MD, MPH, Chief Health Equity Officer (darrell.grayii@elevancehealth.com)

Project Overview: Prioritizing health equity as part of its whole-health strategic pillar, Elevance Health (formerly Anthem Inc) partnered with the National Institutes of Health's All of Us Research Program. We believe the program can help shape the future of healthcare and our partnership is one of the greatest ways we can help to advance health equity, so all people have a fair and just opportunity to be as healthy as possible.

Innovation: In 2021, Anthem began an NIH All of Us Research Program campaign to engage associates, members and community partners. Anthem established a "roadshow," talking with leaders and members of its nine business resource groups; hosted an enterprisewide "fireside chat"; leveraged internal platforms (e.g., town halls, blogs) and external communication channels to bolster awareness and engagement among members and community partners. Anthem also hosted a national, industry-leading virtual roundtable, "Leveraging Data as a Foundation for Advancing Health Equity."

Outcome: Anthem is the top recruiting Blue Cross Blue Shield Association partner in the NIH All of Us Research Program, with nearly 2,400 participants—more than an 18,000% increase in participants from when the campaign began. Anthem has also formed a health equity coalition to further engage civic, community and academic partners.

Project Title: **Building Climate Resiliency to Address Health Concerns**

Organization: Elevance Health

Project Contact: Hakon Mattson VP, Chief Sustainability Officer (hakon.mattson@elevancehealth.com)

Project Overview: In September 2021, over 200 medical journals issued an unprecedented joint statement that climate change is the "greatest threat" to global public health. As the complex relationship between climate change and human health has become increasingly pronounced, it is critical that the healthcare sector responds. Elevance Health is addressing the critical physical, behavioral and social drivers that influence health outcomes, all of which are impacted by climate change.

Innovation: Improving the carbon footprint of the health ecosystem can have significant health benefits. In 2019, Elevance committed to sourcing 100% renewable electricity by 2025—it reached that goal 4 years early. It also purchases carbon offsets, which support conservation of managed forestland in northeast Tennessee, while also stimulating recreation-based tourism in an economically at-risk region. In 2021, 23% of Elevance's in-scope supplier spend had established greenhouse gas emission reduction goals. Throughout 2022, Elevance has further engaged with suppliers to set targets and disclose climate-related information, as well as assessing value chain, climate-related risks and opportunities.

Outcome: Climate change is a driver of health, exacerbating health inequities. Actions to mitigate greenhouse gas emissions and operate more sustainably contribute to the health of humanity. Elevance is committed to net zero emissions by 2050. It continues to reduce greenhouse gas emissions and help members build climate resiliency. In 2021, Elevance became the first major U.S. health benefits company to achieve 100% renewable electricity, followed by carbon neutrality for direct operations in 2022.

Project Title: **Responsible Artificial Intelligence Program**

Organization: Elevance Health

Project Contact: Julia Meade Tulli, MPA, Tech Compliance Senior Advisor (julia.tulli@carelon.com)

Project Overview: Carelon Digital Platforms, an Elevance Health brand, established its Office of Responsible AI in 2021 to help address both the opportunities and challenges of artificial intelligence and machine learning. The goal is to support equitable, trustworthy, explainable, transparent and fair solutions. Responsible AI (RAI) is a new domain where best practices are slowly emerging. RAI focuses on amplifying the benefits of innovation, while also helping identify and address opportunities to support health equity for those we serve.

Innovation: The RAI program helps associates to think about the impacts of an AI solution and integrate RAI requirements by design. Prior to and post deployment, relevant AI solutions are evaluated for fairness. Solutions are evaluated for biased predictions against a particular group (e.g., discriminative outcomes on grounds of race, biological sex, age). Model performance is compared across cohorts, populations and groups. This is an easy-to-use methodology in the hands of data scientists to standardize bias testing. RAI is critical to adoption of ethical AI/ML solutions that can help members, providers, communities, and associates. This program enables technology that helps Elevance Health realize the full the potential of its innovation.

Outcome: Elevance Health believes that commitment to Responsible Artificial Intelligence is paramount. Applying the Carelon Digital Platforms' RAI framework enables it to evaluate models prior to their deployment. The best outcome Elevance has realized as a result of implementing the RAI program is that internal and external stakeholders appreciate the proactive nature of the use of AI/ML, which why RAI exists.

Project Title: **Multi-Sectoral Collaboration to Improve Race and Ethnicity Data Collection**

Organization: Elevance Health

Project Contact: Jennifer Kowalski, VP, Public Policy Institute (Jennifer.kowalski2@elevancehealth.com)

Project Overview: Health plans do not have complete, high-quality race and ethnicity data, impeding efforts to achieve health equity. Many challenges contribute to incomplete collection of these data. To better understand the barriers and identify possible solutions, Elevance Health funded and collaborated with the Urban Institute, the Deloitte Health Equity Institute and the American Benefits Council on a multi-pronged research project.

Innovation: On July 20, the Urban Institute, American Benefits Council and Deloitte Health Equity Institute, with support from Elevance Health, released a report synthesizing the findings and recommendations from their work: "Collection of Race and Ethnicity Data by Health Plans Can Advance Health Equity." The report is intended a call to action for health plans, providers, employers, policymakers, regulators and other stakeholders. Race and ethnicity data are only the starting point; many other types of data, like sexual orientation, gender identity and disability data, are needed to understand and improve inequities in health care experiences and outcomes.

Outcome: Key findings were:

- Health plans must clearly articulate the value of improved collection of race and ethnicity data and their intention to act on the collected data to advance health equity.
- Organizations must build trust among individuals and engage communities in developing data collection practices and use cases, including guardrails.
- Data collection standards are outdated and should be updated to be inclusive and reflective of individuals and communities' identities.

This report serves is a springboard to action to improve on inequities in health care experience and outcomes.

Project Title: **Breast Cancer Screening Disparity Project with Greater Fresno Health Organization**

Organization: Health Net

Project Contact: Rhonda Dick, MPH, Senior Quality Improvement Specialist (rhonda.l.dick@healthnet.com)

Project Overview: CalViva Health in Fresno County, California identified a high-volume clinic with a breast cancer screening compliance rate below the minimum performance level of 58%. The clinic serves a predominantly Hmong/Laotian population; this ethnic group had the lowest compliance rate (18.3%) compared to other ethnic groups.

Innovation: An innovative Member Centered Approach was implemented, utilizing: 1.) A mobile mammography unit; 2.) culturally tailored and educational reminder calls; and 3.) onsite interpreters during each event. Patients completed a survey regarding their experience and received an incentive gift card at the point of service.

Outcome: Data showed a significant disparity with the Hmong population. Members receiving breast cancer screening who spoke Hmong were found to be statistically less likely (28.46%) to have completed a screening than members completing a screening who spoke English (37.72%). After the March mobile mammography event, 73% completed a BCS exam; after the June event, 75% completed an exam. Additional events were planned throughout 2022.

Project Title: **Doula Workforce Development**

Organization: Simply Healthcare Plans

Project Contact: Adriel Gomez, Manager, Quality Management (agomez2@simplyhealthcareplans.com)

Project Overview: Simply Healthcare partnered with Indian River County Healthy Start Coalition (IRHSC) and its Community Doula Program to help pay for certification of new doulas. Simply Healthcare funded local training and certification efforts to reduce barriers to entry for doulas from underserved rural and urban low-income communities, and communities facing linguistic and/or cultural barriers.

Innovation: Upon completion of training, the National Doula Network work with each doula graduate to credential them for billing through Medicaid. Healthy Start Coalitions supports and guides the newly trained and certified doulas, ensuring that doula care is enhanced in their communities, and embeds doula care in coordinated intake and referral, allowing many more families to take advantage of this service. The National Doula Network supports and mentors doulas, to ensure success, and IRHSC hosts virtual continuing education.

Outcome: To date, Simply Healthcare has funded 40 scholarships that bring certified, bilingual doulas to areas in need and help address cultural barriers to doula support. Outcomes for members who received include higher average gestational age; fewer preterm births; higher percentage of vaginal deliveries. 98% of women who remain active in the doula program have a prenatal visit.

Project Title: **Housing Partnership**

Organization: Sunshine Health

Project Contact: Joseph Medina, Senior Manager, Operations JOMEDINA@SunshineHealth.com

Project Overview: The purpose of this program is to increase affordable housing options for members transitioning from the custodial care to the community, as well as community members needing affordable housing options.

Innovation: Sunshine Health partnered with Florida Housing Finance Corporation to offer members available low-income housing. This program helps meet the needs of community members in finding affordable housing options.

Outcome: By mid-2022 there were 35 housing placements. The average turnaround time from referral to placement is 30 days.

Project Title: **UnitedHealthcare® Healthy at Home: Solving for Common Post-Discharge Social Determinants of Health Barriers**

Organization: UnitedHealthcare

Project Contact: Joseph Agostini, MD, Chief Medical Officer, UnitedHealthcare Retiree Solutions (joseph_agostini@uhc.com)

Project Overview: UnitedHealthcare's Retiree Solutions team serves over 1.7 million Medicare Advantage members. The member population has a high rate of healthcare utilization, consistent with other Medicare populations. The program goal is to reduce avoidable hospitalizations, identify barriers to care and improve retirees' overall health care experience. Providing additional support to keep people safe and healthy at home has been an increasing focus. In doing so, the program also addresses SDOH that impact health outcomes.

Innovation: UnitedHealthcare Healthy at Home is available to Medicare Advantage members following every eligible inpatient or skilled nursing facility discharge. Services offered include 1.) post-discharge meal delivery (two fresh meals per day for 2 weeks); 2.) post-discharge transportation, which includes up to 12 one-way rides to and from medical appointments and to the pharmacy; and 3.) in-home personal care, which provides up to 6 hours of in-home personal care, using background-checked professional caregivers across all 50 states.

Outcome: Of the 31,850 discharges that received proactive outreach, 21% were members at high risk for readmission and 79% were at moderate risk. Within the first 6 months of the program, members completed over 3,594 rides; had 183,125 meals shipped to their homes; and had 1,691 caregiver hours provided in-home, including 2,654 care tasks and 234 referrals to primary care providers. The Healthy at Home post-discharge service bundle will be expanded to over 500,000 additional Medicare Advantage members in 2023.

Project Title: **Social Determinants of Care—Meeting the Needs of Our Members**

Organization: UnitedHealthcare

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

Project Overview: UnitedHealthcare has a cross-functional effort to identify barriers to access, care or outcomes and create interventions based on members' social, cultural and/or linguistic needs. SDOH data are collected using claims data claims, 834 files and non-standardized screening tools conducted by the health service team. Data are displayed on an enterprisewide dashboard that allows health plans and SDOH teams to understand population needs and develop strategies to address those needs. Each state plan also receives an annual population health report that provides assessment and evaluation of the enrolled population, and analysis of SDOH and actions taken by the plan to address those needs.

Innovation: UnitedHealthcare Community Care Plan Kansas and Hawaii used the SDOH action framework to address the challenges their members were facing: 1.) SDOH screening to identify needs; 2.) risk stratification; 3.) referral to resources and ensuring needs are met; 4.) comprehensive data evaluation. The UHCCP KS team implemented a Housing Navigator and a Food Specialist to support care management teams. UHCCP HI began implementing Accountable Health programs. In Honolulu, staff including 12 navigators dedicated to

reducing barriers to care and homelessness, were put in place to support the AHC model. In 2019, the program was expanded to include Supportive Housing Services.

Outcome: 2020 data show that in Kansas, 97% of members referred for a service had their needs met; in Hawaii, the rate was 92%. Overall 2021 intervention outcomes in 2021 resulted in over 4 million UnitedHealthcare members being screened for SDOH. Three out of four individuals with identified needs were referred in their community; of those, 80% had their identified need met.

Project Title: **UnitedHealthcare Project Detect**

Organization: UnitedHealthcare

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

Project Overview: Through the UnitedHealthcare HouseCalls program, Project Detect addresses health disparities by identifying members that are at risk, screening for complex conditions, identifying gaps in care and connecting these members to appropriate health care services. Project Detect engages members to screen for commonly underdiagnosed and asymptomatic conditions, including diabetes, prediabetes and hepatitis C. These conditions have higher prevalence in People of Color and in dual-eligible members.

Innovation: The goal of UnitedHealthcare Project Detect is to help members with abnormal test results seek care for an undiagnosed condition via interaction with their primary care provider. A nurse administers the test in the member's home. If a test result is abnormal, the nurse notifies the member, the member's primary care physician, or both, and helps the member with next steps and scheduling a visit with their physician.

Outcome: Through the HouseCalls program, more than 1 screening tests were offered in 2021–2022 (through July 22), with approximately 660,000 tests completed.

Project Title: **Increasing Engagement in Preventive Health Behaviors Among Medicare Beneficiaries Through an 8-week Faith-Based Organization Challenge**

Organization: UPMC Health Plan

Project Contact: Camille Clarke-Smith, EdD, MS, CHES, CPT, Program Director (clarkeca2@upmc.edu)

Project Overview: The Medicare Faith and Wellness Program (MFWP) builds relationships with churches, engages with members where they live and worship, delivers preventive health messages and provides resources needed to live healthier lifestyles. The goal was to develop and deliver culturally specific and relevant programs and materials. In 2021, the program involved 31 churches in 16 neighborhoods, with 249 participants.

Innovation: Faith-based organizations are invited to register for the MFWP 8-week challenge. The challenge focuses on Wellness, which is defined as mind, body, soul, spirit or mental, physical, emotional and spiritual/social. Faith-based organization compensation is based on the number of participants they can engage, and keep engaged, in healthy activities, with an extra bonus for improving participants' health. At the end of the challenge, there is a celebration of the participants and organizations, and community and local state representatives are invited to participate and spread the message of preventive health.

Outcome: In 2019, the program engaged 13 churches in 8 communities in Allegheny County, with 155 participants; in 2020, the program expanded to 17 churches in 10 communities, with 167 Medicare beneficiaries; in 2021, the program expanded to 31 churches in 16 neighborhoods, with 249 participants. UHC

also engaged churches as a part of the Health Disparity conversation, and partnered in vaccine events and outreach.

Project Title: Taking Action to Reduce Health Disparities through Education and Partnerships

Organization: Elevance Health, Inc.

Project Contact: Jennifer Hausman, MPH, Program Director, Community Health Initiatives (jennnifer.hausman@elevancehealth.com)

Project Overview: Take Action for Health originally focused on screenings for some of the most serious health conditions facing Black communities, to reduce morbidity and mortality and promote health equity. Its sister website for Latino communities, Taking Action for Our Health, was launched in 2021.

Innovation: Both Take Action for Health and its bilingual sister site, Taking Action for Our Health, promote preventive health screenings for Black and Latino people. Each features a culturally relevant, four-part workshop series with a leader guide. In 2021, Elevance sent culturally distinct emails to members containing video testimonials by prominent Black and Latino leaders, with a call to action to visit the websites and get screened. Black and Latino community bloggers and media outlets wrote stories about the websites to create awareness of and promote utilization of the sites.

Outcome: Interventions implemented to date have resulted in 33,000 unique users. Take Action for Health users visited the emotional health module most often; Taking Action for Our Health users visited the heart health module most often. Emotional health has remained a top priority for Black people; heart health, for Latino people. It is hypothesized that the outreach campaigns will increase screenings by 2%–3% for Black and Latino members.

Project Title: **REAL: We Ask Because We Care—Improving the Collection of Race, Ethnicity and Language Information**

Organization: Denver Health

Project Contact: Maria Casaverde, Marin MHA Quality Improvement Operations Coordinator (maria.casaverdemarin@dhha.org)

Project Overview: Denver Health identified a lack of clarity experienced by front office staff in how to ask patients personal questions. By redesigning scripting to be more culturally sensitive and developing a campaign around questions are asked, staff were empowered to understand the importance of collecting accurate demographics data.

Innovation: Through a series of surveys, PDSA cycles and focus groups, Denver Health developed a more culturally appropriate script that met the needs of patients, and redesigned its EMR system to collect more inclusive ethnicity data that reflect the true identities of patients. Denver Health also developed an organizationwide marketing campaign—We Ask Because We Care—that emphasized the importance of and reasons for collecting the data.

Outcome: A new data field has over 300 ethnic categories that represent community members. Missing race information was reduced from 7% to 1%; missing ethnicity information was reduced from 8.6% to 1.1%; missing language data was reduced from 12.7% to 4.0%; missing country of birth information was reduced from 27.4% to 9.6%.

Project Title: **Affordable Primary Care That Meets Patients Where They Are**

Organization: HealthTap

Project Contact: Sean Mehra, CEO + Founder (healthtap@astrskpr.com)

Project Overview: HealthTap's mission is to place affordable, quality, primary care at every American's fingertips. For less than the average monthly internet streaming bill, subscribers gain access to HealthTap's online primary care clinic, where they can choose a board-certified doctor for ongoing care, schedule video appointments and text with their doctor. By utilizing technology as a platform for providing ongoing primary care, HealthTap provides quality, accessible health care to anyone—regardless of race, ethnicity, education, location or income.

Innovation: HealthTap created a user-friendly online platform that allows patients to connect with a doctor of choice and stay in touch through direct video and text communication. Patients only need internet connection, a phone, tablet or computer. HealthTap's subscription-based model means anyone, regardless of insurance status, can afford to see a primary care doctor for ongoing care. Since creating its doctor Q&A platform, HealthTap has amassed a network of nearly 90,000 doctors across 147 specialties who volunteer their time to answer consumer questions posted on the website. Consumers receive answers within 24 hours and have a trusted source of health information at their fingertips.

Outcome: On average, patients who choose HealthTap's primary care clinic stay subscribed for 4 years. An average primary care visit rating is >4.9 stars. Each primary care doctor is handpicked for their focus on patient-centered care, to ensure that consumers receive the best medical attention available. With a growing subscriber base of more than 50,000 Americans, HealthTap's satisfaction rate is seven times higher than the general health care industry's.

Project Title: **African American Family Focus Group**

Organization: Nationwide Children's Hospital Primary Care Network

Project Contact: Kimberly Regis, DNP, RN, NEA-BC, CPNP-PC, BCC; VP of Operations, Chief Nurse Executive of Ambulatory (kimberly.regis@nationwidechildrens.org)

Project Overview: Nationwide Children's Hospital implemented a Somali Family Focus Group and an African-American Family Focus Group to get feedback through virtual, telephone and in-person survey contact with families. The information gathered helped build relationships and inform clinic processes and workflows. Staff involved included social workers, nurses, coordinators, planners, marketing, protective services, physicians, and many others. The core team has successfully sustained the project for 2 years. The clinical staff and families have also built partnerships with organizations in the surrounding community, including the local police department—a significant aspect of diversity, equity and inclusion.

Innovation: The Focus Group provides a way for families and staff to communicate and work together. Its members (from a population identified through patient satisfaction data, no-show rates and/or quality metrics) represent patients and families served by Nationwide Children's Primary Care Center. Participation leads to planning that ensures services meet patients' needs and priorities. The group promotes effective partnerships between families and health care staff, creates a link between the clinic and the community and provides increased emotional support and access to information.

Outcome: Families provided ideas for improving the check-in process and gave insight into additional resources, sometimes as simple as moving the television in the waiting room so children did not obstruct office traffic. The culmination of the project is a yearly family fair, staffed by clinic staff and administrators and including participation by community sponsors, the police and fire departments and more than 100 attendees.

Project Title: **Novel Health Equity Methodology and Executive Dashboard Incorporates Intersecting Dimensions of Inequity**

Organization: Sutter Health

Project Contact: Kristen M.J. Azar, RN, MSN/MPH, PhD(c), FAHA; Scientific Medical Director, Sutter Health Institute for Advancing Health Equity (kristen.azar@sutterhealth.org)

Project Overview: To identify health inequities at the intersection of different social axes, Sutter Health designed and implemented a methodology and dashboard in which health metrics are tracked by patient race and ethnicity, sex and neighborhood median income simultaneously, in order to identify subpopulations at highest risk and support development of targeted interventions.

Innovation: In 2021, Sutter Health's Institute for Advancing Health Equity convened a workgroup to develop health equity metrics to include on Sutter's executive dashboard. The group identified the need to leverage established quality metrics to align with system priorities, and the need to consider multiple dimensions of inequity to inform development of targeted interventions. As of March 2022, Sutter tracked health equity for four ambulatory metrics (breast cancer screening, colorectal screening, diabetes HbA1c control among those with diagnosed type 2 diabetes, BP control among those diagnosed with hypertension), and three acute care metrics (NTSV Cesarean sections, all-cause 30-day readmissions, sepsis mortality). For each measures, a health care equity index score is assigned to patient populations based on race and ethnicity, sex and socioeconomic status. The system uses this information to inform targeted interventions to close identified equity gaps and track progress.

Outcome: As a result of the novel methodology applied to our system's executive dashboard, data are actionable and resources can be allocated to close identified equity gaps with a previously unavailable level of precision. For example, while the current standard allowed identification of Black individuals as having suboptimal cancer screening rates, the new methodology reveals that the equity gap affects low-income Black males. This allows care teams and operators to allocate resources and target interventions with increased specificity and, ultimately, effectiveness. This project is part of a larger body of work to bring rigor to quantifying equity gaps. In 2021, Sutter Health developed the COVID-19 Vaccine Equity Index, which uses EHR data to identify patient groups at increased risk of infection and hospitalization. Findings are used to design tailored solutions to address identified equity gaps.

Project Title: **Interpreters as billable providers**

Organization: AllCare Health, Inc.

Project Contact: Stick Crosby, Sr., Network & Health Equity Director (stick.crosby@allcarehealth.com)

Project Overview: Health care providers frequently care for patients who have limited English proficiency. These patients experience challenges accessing health care and are at higher risk of receiving suboptimal health care. Health care interpreters are crucial partners to help break down communication barriers and prevent health care inequities. Many providers lack the skill set and knowledge that are vital to successful collaboration with an interpreter.

Innovation: AllCare developed a policy and process to credential and contract with interpreters to bill directly under a clinic through an 837P transaction or a CMS 1500 form.

Outcome: $300 per member per month reduction of costs in care for Spanish speakers and a 30% increase of preventive care services.

Project Title: **Enhancing Diversity in Clinical Trials to Advance Health Equity**

Organization: Elevance Health

Project Contact: Darrell Gray, MD, MPH, Chief Health Equity Officer (darrell.grayii@elevancehealth.com)

Project Overview: The NIH's All of Us Research Program (AoURP) is a historic, longitudinal effort to gather data from at least 1 million people living in the United States to accelerate research and improve health. Elevance Health has partnered with AoURP, has engaged associates and community partners in the effort and has been recognized as an exemplar by the Blue Cross Blue Shield Association.

Innovation: In 2021 Elevance began an AoURP campaign across to engage associates, members and community partners. It established a "roadshow," talking with leaders and members of business resource groups, and leveraged internal and external communication channels to bolster awareness and engagement among members and community partners. Elevance also hosted a national, industry-leading virtual roundtable in partnership with NIH AoURP, United Way and the George Washington University Rodham Institute, "Leveraging Data as a Foundation for Advancing Health Equity." These enterprise- and industrywide conversations highlighted the necessity for accurate representation in research and increased engagement in NIH AoURP.

Outcome: Elevance is the top recruiting Blue Cross Blue Shield Association partner in the NIH AoURP, with nearly 2,400 participants—an over 18,000% increase in participants since fall 2021, when the campaign began. Elevance has also formed a health equity coalition to further engage civic, community and academic partners in this national effort.

Project Title: **Taking Action to Reduce Health Disparities through Education and Partnerships**

Organization: Elevance Health, Inc.

Project Contact: Jennifer Hausman, MPH, Program Director, Community Health Initiatives (jennnifer.hausman@elevancehealth.com)

Project Overview: Elevance Health is partnering with national organizations to develop innovative programs that advance whole health and health equity in communities nationwide. One such program, Take Action for Health, was launched in 2017. The concept for this initiative started with a key recommendation to promote preventive health screenings, to increase early detection of breast cancer in Black women. The scope of Take Action for Health was broadened to focus on screenings for some of the most serious health conditions facing Black communities. Elevance Health launched its sister website for Latino communities in 2021, Taking Action for Our Health.

Innovation: Take Action for Health and Taking Action for Our Health promote preventive health screenings for Black and Latino people. Each features a culturally relevant, four-part workshop series with a leader guide. Interventions include newsletter articles, conference exhibits, social media campaigns and community activation interventions. To increase recommended screenings, adult commercial and Medicaid members received culturally distinct emails containing video testimonials by prominent Black and Latino leaders with a call to action to visit the websites and get screened. A subset of members also received ads to drive them to the websites. Black and Latino community bloggers and media outlets wrote stories about the websites to create awareness of and promote utilization of the sites.

Outcome: Interventions implemented to date have resulted in 33,000 unique users. Take Action for Health users visited the emotional health module most often; Taking Action for Our Health users visited the heart health module most often. Emotional health has remained a top priority for Black people; heart health, for Latino people. It is hypothesized that the outreach campaigns will increase screenings by 2%–3% for Black and Latino members.

Project Title: **Breast Cancer Screening Disparity Project with Greater Fresno Health Organization**

Organization: Health Net

Project Contact: Rhonda Dick, MPH, Senior Quality Improvement Specialist (rhonda.l.dick@healthnet.com)

Project Overview: CalViva Health identified a high-volume clinic with a breast cancer screening compliance rate below the minimum performance level of 58%. The clinic serves a predominately Hmong/Laotian population with approximately 222 CalViva patients eligible for screenings each year. The Hmong/Laotian ethnic group had the lowest compliance rate (18.3%) compared to other ethnic groups.

Innovation: An innovative member-centered approach was implemented, utilizing: 1.) a mobile mammography unit; 2) culturally tailored and educational reminder calls; and 3.) onsite interpreters during each event. Patients completed a survey regarding their experience and received an incentive gift card at the point of service.

Outcome: The sample population was collected through administrative data using a rolling twelve-month methodology. Member data was also received for race, ethnicity, language and geographic location. Data showed that members who spoke Hmong were statistically less likely to have completed a screening than members completing a screening who spoke English. At the March 2022 mobile mammography event, 54/74 (73%) completed an exam; at the June event, 18/24 (75%) completed an exam.

Project Title: **REAL: We Ask Because We Care—Improving the Collection of Race, Ethnicity and Language Information**

Organization: Denver Health

Project Contact: Maria Casaverde Marin, MHA, Quality Improvement Operations Coordinator maria.casaverdemarin@dhha.org

Project Overview: Denver Health identified a lack of clarity experienced by front office staff in how to ask patients personal questions. By redesigning scripting to be more culturally sensitive and developing a campaign around questions are asked, staff were empowered to understand the importance of collecting accurate demographics data.

Innovation: Through a series of surveys, PDSA cycles and focus groups, Denver Health developed a more culturally appropriate script that met the needs of patients, and redesigned its EMR system to collect more inclusive ethnicity data that reflect the true identities of patients. Denver Health also developed an organizationwide marketing campaign—We Ask Because We Care—that emphasized the importance of and reasons for collecting the data.

Outcome: A new data field has over 300 ethnic categories that represent community members. Missing race information was reduced from 7% to 1%; missing ethnicity information was reduced from 8.6% to 1.1%; missing language data was reduced from 12.7% to 4.0%; missing country of birth information was reduced from 27.4% to 9.6%.

Integration of Care

Project Title: **Iowa Hispanic Diabetes Management Project**

Organization: Amerigroup

Topic: Integration of Care

Project Contact: John McCalley, Health Equity Director (john.mccalley@amerigroup.com)

Project Overview: Rural Hispanic communities experienced high rates of COVID-19 and encountered other barriers to health, including residing in food deserts, in addition to experiencing temporary work loss during the pandemic due to closure of meat processing plants. The Iowa Hispanic Diabetes Management project focuses on improving health outcomes for Latino adults diagnosed with diabetes and hypertension. It does so with individual and group education and referrals to programs assisting with food, housing and other basic needs, PCP assignment and health care navigation support and more.

Innovation: To improve diabetes management, Amerigroup Iowa's initiative assessed members' social determinants of health, provided education about diabetes management in Spanish and English, made referrals to area resources and offered interpreters for health care navigation in-person and via five newly funded tablet devices for video interpreter services. The initiative asked members to complete at least two hemoglobin A1c rests and to attend Living Well classes, offered in Spanish at the Iowa State University Extension office. Amerigroup Iowa's target population was all 510 adult members with diabetes who received care at Siouxland CHC, with a priority focus on Spanish-speaking patients.

Outcome: The initiative met its HgA1c control and blood pressure control goals, and developed a tailored action plan to meet the eye exam goal that included providing case management to secure referrals; scheduling monthly calls with health plan representatives and Siouxland CHC; distributing a comprehensive list of in-network, local retinal eye exam providers; donating $10,000 to Siouxland CHC to purchase a retinal eye exam camera to be utilized in the primary care setting, and/or to support licensing and result-reading fees. The program was extended to 20 additional counties in 2021 and is expanding outreach to engage the Black community.

Project Title: **CHAMP Housing Stability Initiative**

Organization: Amerigroup

Topic: Integration of Care

Project Contact: John McCalley, Health Equity Director (john.mccalley@amerigroup.com)

Project Overview: In 2019, Amerigroup Iowa launched the first phase of Changing Health: Amerigroup-Monroe Partnership (CHAMP), a pilot project addressing housing instability and homelessness, food insecurity and other social determinants of health. With grant funding, Amerigroup Iowa formed a housing stability fund and expanded the CHAMP initiative to 21 counties, to support members facing homelessness and housing insecurity. Grant funds allowed CHAMP to address unmet needs, including housing application fees and rent, utility bills, transportation to grocery stores, medical appointments or job interviews, automobile repairs and more. CHAMP also provided transitional housing, including hotel accommodations for those transitioning from homeless shelters and incarceration.

Innovation: The CHAMP housing stability initiative helps members navigate their health needs through Medicaid benefits and non-Medicaid wraparound services. CHAMP housing stability funds are a last resort and individually tailored. When a member needs short-term assistance, Amerigroup works with the participating CBO to secure a motel/hotel room for no more than one week at a time until permanent housing is secured. CHAMP also works with Amerigroup's diabetes and hypertension management program. Individuals can learn about the initiative through one of 21 participating CBOs, or through Amerigroup case managers and outreach specialists.

Outcome: Amerigroup Iowa helped more than 640 members in 21 counties retain secure housing, avoid eviction or transition from homelessness. All members completed initial health screenings and were enrolled in case management. Case managers also collected and cataloged member success stories.

Project Title: **Using Digital Support Tools for Patient Care of Prediabetes**

Organization: Anthem Kentucky Managed Care Plan, Inc.

Topic: Integration of Care

Project Contact: Kathryn Miller, LCSW, Health Equity Director (kathryn.miller@anthem.com)

Project Overview: This program uses a digital Diabetes Prevention Program platform to provide scalable, virtual, compassionate care for those struggling with (or at high risk of) diabetes by providing pre-diabetes education, a weight management activities log and 24/7 personalized health coaching to members identified as prediabetic. Interaction is fully digital and occurs at the member's discretion, with digital reminders. A scale and fitness tracking device are provided to help monitor outcomes, recognize acute or emergent health measures and automatically connect members to a nurse or live coach. This is done in conjunction with member outreach objectives that include email and SMS campaigns, as well as social media posts and engagement.

Innovation: Members are considered engaged in the program if 5 coaching conversations (digital) occur per month to teach members about healthy eating and exercise to prevent diabetes. The platform tracks data such as exercise, meals, weight over time, general activity, and gives tips and tricks to eat better and get more activity through daily monitoring.

Outcome: The program resulted in high levels of engagement through 6 months. 19% of Anthem members achieved a loss of 5% of their body weight. Only 5% of members had access to an in-person DPP in their zip code, if not for Anthem's virtual care offering. Anthem member participants with available weight data achieved an average 8.8 pound weight loss, and 79.2% lost weight while enrolled.

Project Title: **Breathing Is Life: Enhancing Life through Access to Medications for Asthma**

Organization: CareFirst Community Health Plan District of Columbia

Topic: Integration of Care

Project Contact: Jason Lam, PharmD, Clinical Pharmacist (jason.lam@carefirstchpdc.com)

Project Overview: The CareFirst Community Health Plan District of Columbia (CHPDC) pharmacy team recognizes the disproportionately large impact asthma has on the DC Medicaid population. To improve asthma control, in 2020 the CHPDC pharmacy team began covering and aggressively encouraging 90-day supplies for control asthma inhalers. In 2021 the team implemented a novel method of tracking and reaching enrollees who need 1:1 education on how to manage their asthma symptoms.

Innovation: The CHPDC pharmacy team implemented two interventions. The first allowed medications for asthma to be filled with a 90-day supply, reducing multiple trips to a pharmacy for refills and reducing the risk enrollees would run out. In the second, the CHPDC pharmacy team calls select enrollees to educate them on adherence to control asthma inhalers and, when possible, to provide medication therapy management. If necessary, the team would inform providers that three inhalers could be prescribed at a time and would be covered by the enrollee's CHPDC Medicaid plan.

Outcome: In 2020, the health plan had an AMR score of 53.64%, correlating with a 1-star rating. In 2021, the plan's score rose to 66.28%, correlating to a 3-star rating.

Project Title: **Serving High-Need, High-Cost Homeless Members through Housing Interventions**

Organization: Simply Healthcare

Topic: Integration of Care

Project Contact: Chris Durrance, MPA, Housing Program Manager (cdurrance@simplyhealthcareplans.com)

Project Overview: Simply Healthcare manages the Florida Housing Waiver Program, a Medicaid 1115 Waiver Pilot Project that provides Medicaid-reimbursable services for providers serving at-risk and homeless households. Primary goals of the program are 1.) achieve housing stability; 2.) improve SMI/SUD health outcomes, including Opioid Use Treatment; 3.) reduce unnecessary ER and inpatient hospitalizations.

Innovation: Members selected for this initiative are often high-cost, high-need consumers with chronic physical and behavioral health disorders. Once enrolled, members are linked with community service providers contracted to provide the four core services of the program: transitional housing services, tenancy sustaining services, mobile crisis services and peer support services. All services are Medicaid-reimbursed, providing new, leveraged funding for many community service providers, who often lack needed resources. Members also receive ongoing case management services from Simply case managers to address other SDOH needs, such as food insecurity, and disease case management needs.

Outcome: The pilot is a 5-year initiative and will be completed in December 2024. Substantial improvement has occurred in several key areas of this intervention, with the most significant outcome in reduction in unnecessary ER and inpatient hospitalization (60%).

Project Title: **Emergency Room Frequent Flyer Case Management Program**

Organization: Simply Healthcare Plans

Topic: Integration of Care

Project Contact: Vonda Forrester, RN, CCM Director, Health Care Management (vonda.forrester@anthem.com)

Project Overview: Simply Healthcare's Case Management program works to reduce preventable ER utilization by identifying key drivers behind ER visits, including an integrated approach with physical and behavioral health and engaging members in care with PCPs/specialists, telehealth options and resources to resolve/address SDOH needs.

Innovation: Members are identified for the program by utilizing admission, discharge and transfer data and health information exchange platforms. Case managers communicate with ER clinicians on the platform about attempts to engage members and care plan milestones. Common interventions in the program are linking to and coordinating care with medical and/or behavioral health, leveraging provider engagement, conducting motivational interviewing and providing education on plan benefits and community resources.

Outcome: A 2021 analysis showed a per member per month inpatient savings of $1,097 and an OP ER of $95.68.

Project Title: **Integrate and Collaborate: Closing the Gap Between Urban and Rural**

Organization: South Carolina Office of Rural Health

Topic: Integration of Care

Project Contact: Lindsay Williams, RHIT, CCA, PCMH-CCE, Practice Transformation Consultant (lindsay@scorh.net)

Project Overview: The Chronic Conditions Care Collaborative (4C Collaborative) is a 5-year program that focuses on improving chronic illness care in rural practices. All participating practices were located in rural areas and in counties with some of the lowest health outcome rankings. The purpose of the initiative was to engage, support, and help practices sustain improvement efforts for patients with diabetes, pre-diabetes, undiagnosed hypertension, hypertension, and hyperlipidemia.

Innovation: The biggest impact came from connecting practices to community-based programs. Some change concepts included creating diabetes standing orders; developing an internally structured diabetes education class; identifying undiagnosed hypertension and developing a protocol to address the needs of those patients; and blood pressure monitoring standardization and training.

Outcome: Each practice created a standardized process for incorporating and integrating community-based programs; all expanded access to rural patients to support chronic disease management. Results of the various innovations included a 27% decrease in poorly controlled diabetic patients, an increase of 7% in controlling blood pressure, and, for patients in a weight loss program, a decrease in systolic blood pressure of 9 points and a 12.1 point decrease in cholesterol.

Project Title: **Whole Patient Care**

Organization: Community Health Network

Topic: Integration of Care

Project Contact: Melialoha Bartlett, BHA, MBA, Director of Health Systems (mbartlett@sfachc.org)

Project Overview: MyCHN provides whole-person care, which includes all aspects of patient care: mind, body and spirit.

Innovation: MyCHN created intervention pathways to address multiple whole-person concerns on the same day and in the same appointment time.

Outcome: As an example: A pregnant patient in the office for an OB appointment screens positive for depression; a therapy consultant intervenes during the appointment and conducts a therapy visit, and ensures the patient has a warm hand-off with a continuing care therapist before the end of the visit. This has improved our patients' overall care by addressing items that may have been missed during conventional appointment scheduling and protocols.

Project Title: **Value Based Care—Annual Wellness Visit Focus**

Organization: Self Regional Healthcare

Topic: Integration of Care

Project Contact: Chandler Skelly, Practice Manager (chandler.chapman-skelly@selfregional.org)

Project Overview: The goal is to increase patient compliance with annual wellness visits, increase quality outcomes and assess SDOH needs for the Medicare population. This approach supports the patient (easy access and scheduling), the provider (engages the patient with preventive health) and the payer (provides a more accurate reflection of the patient's health).

Innovation: Self Regional Healthcare now has a fleet of nurse practitioners that visit patients in their home, focused on patients who have not had an annual wellness visit in 2 years.

Outcome: The program was expected to increase annual wellness visits 20% by the end of 2022.

Project Title: **Meeting the Patient Where They Are**

Organization: State of Franklin Healthcare Associates

Topic: Integration of Care

Project Contact: Amanda Clear, Chief of Payer Relations & Value Contracting (amandaclear@sofha.net)

Project Overview: State of Franklin Healthcare Associates (SoFHA) providers identified senior patients who often delayed seeking medical treatment due to mobility issues, lack of caregiver support, frailty or altered mental states such as Alzheimer's or dementia. Out of this discovery, the Home Visit Team was established in 2016. The HVT's nurse practitioners or physician assistants provide appointments at the patient's home or assisted living facility, with coordinated care from the patient's primary care provider, social workers and clinical pharmacists.

Innovation: The HVT provides continuity of care for patients and builds trusting relationships with patients.

Outcome: The HVT has improved patient experience and reduced health care costs for medical transportation; in addition, compliance for 7-day hospital discharge follow-up appointments has improved. SoFHA has also seen an increase in medication adherence, since social workers can help patients enroll in patient assistance programs from the drug manufacturers to lower medication cost.

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Topic: Integration of Care

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Project Title: **How a Re-design of an Integration of Care Model Produces Life-Changing Results**

Organization: Healthy Blue Louisiana

Topic: Integration of Care

Project Contact: Cheryll Bowers-Stephens, MD, MBA; Plan Performance Medical Director and BH Medical Director (foley.nash@healthybluela.com)

Project Overview: Healthy Blue's Integrated Collaborative Care Model (ICCM) is a value-based program that rewards collaboration entailing biopsychosocial integration of evidence-based practices and care coordination, while mitigating barriers to care, especially for vulnerable populations that can be high need or high cost. ICCM rewards HEDIS performance, SDOH assessments, community-based organization referrals and successfully getting the help needed for referred members.

Innovation: Navigators, empowered by ICCM providers, focus on members at risk of biopsychosocial needs, comorbid or chronic conditions or concurrent BH/PH diagnoses. ICCM provider workflows include assessments on intake, same day navigation or telehealth service referrals during scheduled appointments, inclusive outreach, and warm transfers. Navigation services consist of motivational interviews, discharge planning, medication reconciliation, person-centered planning, screening for anxiety, depression, ADHD and adverse childhood experiences, along with successful fulfillment of holistic SDOH care and ongoing health literacy education.

Outcome: A combination of evidence-based practices has resulted in a 17% reduction in ER and an 8% reduction in inpatient visits, year over year, since 2018.

Patient/Family Engagement

Project Title: **Meeting the Social Needs of Our Members: Addressing Social Isolation and Loneliness**

Organization: Molina Healthcare

Topic: Patient/Family Engagement

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

Project Overview: Molina Healthcare members have complex medical and social needs that affect the health care they receive. Molina works with members to address their social, physical and mental health needs using creative and innovative approaches. One approach includes using a technology-enhanced application through Pyx Health that allows members to access companionship and support at all hours of the day, 7 days a week. This program has let our members at risk of loneliness and social isolation get the help they need.

Innovation: During the case management or care coordination assessment, members respond to questions related to social isolation, loneliness and depression. If the member is at risk for any of these issues, the case manager is able to enroll the member into the program. Molina helps members at risk of loneliness engage in the technology and supportive resources to reduce their risk. Caregivers are also able to receive support from this program,

Outcome: Of all members enrolled in the pilot program, 41% improved their loneliness scores and 82% also improved their depression scores. In addition, 57% of these members had a reduction in medical costs. Molina is expanding the program nationally to its existing markets'

Project Title: **Schuyler Hospital Gaps in Care Committee**

Organization: Schuyler Hospital Primary Care

Topic: Patient/Family Engagement

Project Contact: Jackie Collins, LPN; Clinical Informatics and Quality Incentives Specialist (Collinsj@schuylerhospital.org)

Project Overview: Schuyler Hospital established the "Gaps in Care Committee," which includes administrative and clinical individuals from various functional units in the organization, charged with identifying gaps in care and barriers to care through review and analysis of objective, comprehensive clinical quality data, self-reported patient demographics and SDOH data. The goal of the Committee is to recommend and implement effective and sustainable solutions to reduce gaps and eliminate barriers in support of improving health and wellness .

Innovation: The committee reviews health record data and clinical quality outcomes monthly, and recommends and implements actions for improvement. The committee is tasked with identifying and prioritizing gaps and barriers, assessing the current process and workflow, performing indicated community and patient outreach and making recommendations for improvement.

Outcome: Year-to-date results demonstrate an increase in preventive screenings, including a 7% increase in depression screening, a 7% increase in colorectal screening and a +18% increase in mammography screening. A real time survey of patient access metrics demonstrated positive results, with 94% of patients scoring a 5 on a scale of 1–5.

Use of Technology

Project Title: **Advancing Health Equity Through Provider Education on My Diverse Patients.com**

Organization: Elevance Health

Topic: Use of Technology

Project Contact: Linda Palmer, Licensed Producer, Clinical Quality Program Manager
(linda.palmer@elevancehealth.com)

Project Overview: Elevance Health developed an online tool, designed as an innovative and user-friendly learning environment for health care providers to improve cultural humility and the quality of care delivered to their diverse patient populations. Continuing medical education credits are available to health care providers who complete trainings, through a partnership with the American Academy of Family Physicians.

Innovation: Elevance designed My Diverse Patients.com as a free, easily accessible resource. Providers can obtain continuing medical education credits for completing courses. In each course, a menu option offers multiple pages of resources. A recommended reading and tools hyperlink offers a wealth of information to expand and reinforce understanding. There is essential information on effective techniques that can be used when communicating with a patient to demonstrate cultural humility and sensitivity. A provider may also choose to explore the materials and sources used in the creation of the course. The provider can reprint the certificate of course completion. A dedicated team reviews provider feedback, which helps enhance website services to the provider community.

Outcome: As of June 1, 2022, there had been 44,000 transactions. Although there is no demonstrated direct relationship between completion of courses and reduction in care gaps and improvement in member experience, Elevance believes My Diverse Patients is a significant contributor in advancing health equity.

Project Title: **Maternal Child and Women's Health Predictive Modeling**

Organization: Healthy Blue

Topic: Use of Technology

Project Contact: Christy Valentine Theard, MD, MBA; President (christy.valentine@healthybluela.com)

Project Overview: In April 2021, Healthy Blue enhanced the predictive modeling for maternal child and women's health to include race and evidenced-based information on pregnancies for all women. Modeling is particularly beneficial for early intervention for Black and Indigenous people and People of Color during pregnancy. The introduction of predictive modeling allows the plan to begin early detection for members who may be at higher risk of developing complications or adverse outcomes during pregnancy.

Innovation: The predictive model's algorithm has multiple components that allow Healthy Blue to identify high-risk members based on their probability of having an NICU infant, risk of preeclampsia, substance abuse risk and risk of caesarean section due to diabetes. It allows the health plan to identify first-time Black mothers who may not have been previously identified. Identified members are paired with a nurse case manager who collaborates with them on all aspects of care throughout their pregnancy.

Outcome: In calendar year 2021, 1,660 members were automatically enrolled into OB case management due to the algorithm. The predictive model provides the opportunity for mothers to receive crucial care early in their pregnancy. Predictive modeling provides the opportunity to engage members and help them proactively make decisions regarding their reproductive life plan.

Project Title: **Remote Patient Monitoring**

Organization: Simply Healthcare Plans

Topic: Use of Technology

Project Contact: Vonda Forrester, RN, CCM; Director, Health Care Management (vonda.forrester@anthem.com)

Project Overview: Case management identified that a high percentage of utilization was being generated by a small number of members. In response, Simply Healthcare initiated the Simply Healthcare Remote Patient Monitoring program. Members selected for the program are identified as having COPD, CHF, DMII or a combination. The program aims to educate members on daily self-monitoring, symptom identification/ management and medication/care compliance. Case management and care coordination is standard with transition services upon discharge from the program. Transition services reinforce skills acquired during the program and offer support upon exit.

Innovation: Members are provided a case manager for the duration of the program. From the partner home health agency, they are provided with monitoring equipment, daily control center access to download vitals and communication, with follow-up, if needed. The case manager educates the member about medication and provider compliance, and reinforces use of home monitoring equipment. The case manager also reinforces skills learned in the program until the member is independent, by engaging with the member's providers (e.g., specialist, therapy, PCP, telemonitoring partner) as needed, and resolves barriers to care, recognizes achievements and milestones, resolves SDOHs and presents at case rounds with medical directors.

Outcome: 2020 participants showed a 39.6% savings. The before-program per member per month cost was $4,355.31; during the program, it was $2,628.63; after the program, it was $4,066.63 (6.6% savings).

Project Title: **Utilizing All of a Person's Available Health Resources to Drive Toward Positive Health Outcomes with Personalized Health Programs**

Organization: League

Topic: Use of Technology

Project Contact: Michelle Irwin, RN-MSN; Director, Health Solutions and Digital Health Content (mirwin@league.com)

Project Overview: Personalized health programs promote health literacy and facilitate behavior change through educational and skill-building activities rooted in behavior change theory, clinically vetted and editorially engaging. Health programs combine several data points from a person, their interaction with the app and health benefits and programs that are available via their employer and employer-sponsored health plan. Delivering personalized health information that is relevant and in sync with not only a person's needs but also their available health benefits creates a synergy and a higher likelihood of success in managing health.

Innovation: Health Programs empower people to reach their health goals with bite-sized information delivered over 7–14 activities. Programs address a variety of topics. Each leads a person through a series of activities informed by principles of behavior change theory. Extrinsic and intrinsic motivational strategies incentivize people as they progress through health programs and work toward their goals. At the end of each program, outcomes and success are measured by asking people to self-report on theory-based constructs of behavior change. People are also asked questions to understand overall satisfaction and likelihood of retention to facilitate behavior change.

Outcome: Of the people who completed the pulse check at the end of a program, 79% reported moderate to high levels of task self-efficacy to incorporate the skills and strategies they learned, beyond their participation

in the program; 57% reported moderate to high intentions to engage in the targeted behavior; 69% reported the program was helpful.

Project Title: **Advancing Health Equity Through Provider Education on My Diverse Patients.com**

Organization: Elevance Health

Topic: Use of Technology

Project Contact: Linda Palmer, Clinical Quality Program Manager (linda.palmer@elevancehealth.com)

Project Overview: Elevance Health developed an online tool, designed as an innovative and user-friendly learning environment for health care providers to improve cultural humility and the quality of care delivered to their diverse patient populations. Continuing medical education credits are available to health care providers who complete trainings, through a partnership with the American Academy of Family Physicians.

Innovation: Elevance designed My Diverse Patients.com as a free, easily accessible resource. Providers can obtain continuing medical education credits for completing courses. In each course, a menu option offers multiple pages of resources. A recommended reading and tools hyperlink offers a wealth of information to expand and reinforce understanding. There is essential information on effective techniques that can be used when communicating with a patient to demonstrate cultural humility and sensitivity. A provider may also choose to explore the materials and sources used in the creation of the course. The provider can reprint the certificate of course completion. A dedicated team reviews provider feedback, which helps enhance website services to the provider community.

Outcome: As of June 1, 2022, there had been 44,000 transactions. Although there is no demonstrated direct relationship between completion of courses and reduction in care gaps and improvement in member experience, Elevance believes My Diverse Patients is a significant contributor in advancing health equity.

Project Title: **MedStar Health COVID-19 Remote Patient Monitoring Program (RPM)**

Organization: MedStar Health

Topic: Use of Technology

Project Contact: Ethan Booker, MD, Chief Medical Officer, Telehealth, MedStar Health (mi2info@medstar.net)

Project Overview: MedStar Health has offered remote patient monitoring (RPM) as a care option for years, supporting access and quality. RPM helps patients monitor and manage their health—and easily connect with their care team—using telehealth tools to extend the continuum of care beyond traditional health care facilities. RPM connects patients with a health care team through an online platform that allows real-time sharing of physiologic data, symptoms and additional patient-reported data such as medication compliance or barriers to care. MedStar Health offers RPM as a telehealth tool to support patients with chronic conditions (e.g., hypertension, congestive heart failure, diabetes); maternal-fetal medicine care (e.g., weight and blood pressure during pregnancy); home care; and other specialized needs. RPM serves as an agile tool for early detection of disease prevention and self-education for patients.

Innovation: MedStar Health rolled out this care option for COVID patients who were discharged from EDs, as well as monoclonal antibody infusion sites and certain inpatient settings. Participating patients remained under monitoring for up to 16 days, with daily prompts to collect heart rate and oxygen saturation, answer questions about symptoms and reach out to the care team if needed. Recovering at home was most likely to be in the patient's best interests, to avoid the medical, social and financial risks of hospitalization while maintaining surveillance for late worsening of illness.

Outcome: There were more than 10,600 patient enrollments in the program; most participants were able to safely recover in their homes. As of spring 2022, the number of COVID-19 community cases had decreased and demand for the COVID-19 RPM program had similarly declined, so MedStar Health decided to sunset the offering.

Project Title: **Community Paramedicine**

Organization: UniCare Health Plan of West Virginia

Topic: Integration of Care: Serving High-Need, High-Cost Populations

Project Contact: Rebecca Tate, RN, BSN; CCM Manager, Case Management (rebecca.tate@anthem.com)

Project Overview: UniCare Health Plan of West Virginia, in partnership with Kanawha County Emergency Ambulance Authority, developed an outreach visitation program that engages hard-to-reach, high-cost, dual diagnosis Medicaid members with case management. KCEAA dedicates three community paramedicine providers to locate and engage targeted members. performing face-to-face assessment in the member's home. UniCare case managers are available telephonically; as a team, they coordinate the immediate health needs of members, including scheduling provider office visits, assessing social drivers of health and offering solutions. Additionally, they educate members on community resources and health education, and provide a safety check for smoke detectors, CO_2 detectors and overloaded electrical circuits.

Innovation: Once a home safety assessment and medication reconciliation are complete, the case manager and member build a care plan based on the member's self-identified needs. The case manager outreaches/ provides appropriate resources, referrals to local resources, connects to PCPs/specialists and works with internal healthcare team for additional support. If a member does not have an identified PCP, the case manager helps them locate a provider. If the member is a veteran, the case manager helps them connect with the Veteran Health Administration to talk about benefit eligibility.

Outcome: Since 2018, more than 1,300 members have been assessed by this program. In 2021, this intervention resulted in an annualized savings of more than $1 million and a cost reduction of $516.21 per member per month.