HEALTH MANAGEMENT ASSOCIATES

MCO Partnerships for Million Hearts Population: Opportunities with AmeriHealth Caritas

Million Hearts Learning Collaborative April 20, 2022

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Presenters





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Agenda





- Care Management
- ■Health Education Programs
- □ Data and Value-Based Programs

POLLING QUESTIONS

Population Health Care Management

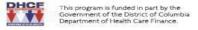
Care Management Overview

Rosalyn Carr Stephens, RN, MSN, CCM,

Market Clinical Director, Population Health Management









Integrated Model of Care...Available to all actively enrolled Members

- Complex Care Management
 - Blended model of care that integrates acute case management, disease management and behavioral health
 - Provides case management and care coordination to complex adult and pediatric members
- Bright Start Maternity Management
 - Focused on identifying and helping at-risk pregnant women have a healthy, full-term pregnancy
 - Provides case management services to newborns that require NICU admission
- Children With Special Needs/Early Intervention
 - Coordinates therapy services for children deemed eligible by OSSE

Multi-disciplinary Population Health Approach

- Care Managers
 - DC-licensed Registered Nurses and Social Workers
 - Experienced clinicians receive additional training e.g., motivational interviewing, traumainformed care, impact of social determinants, etc.
- Care Connectors
 - Non-clinical staff who support care management activities and the activities of the IHCM team
 - Non-licensed professionals with experience serving at-risk populations participate in training e.g. low risk assessments, Medicaid benefits, community resources, etc.
- Chief Medical Officer
 - Oversight of clinical processes including case and utilization management
- Chief Behavioral Health Medical Officer
 - Oversight of behavioral health programs and community partnerships
- Director, Pharmacy
 - Oversight of pharmacy benefit and coordination of pharmacy-related programs
- Director, Quality
 - Chief Quality Officer has oversight of all quality measures including HEDIS, EQRO, NCQA re-accreditation

Rapid Response Outreach Team

- Developed to address the urgent needs of members
- Consists of non-clinical Care Connectors with clinical support provided by a Nurse Care Manager
- Care connectors support Care Managers by completing tasks and reminder calls in support of the individualized plan
 of care
- Tasks include appointment scheduling and reminders, transportation support, member educational mailings and other administrative tasks assigned by care managers.

DC Population Health Management Departmental Structure

Bright Start Maternity Management Program

- Deemed Newborn authorizations Care Connectors
- NICU Graduate follow up through 12 mo. Care Manager

Early Intervention Program – Strong Start

- ❖ Authorization and coordination of care Care Coordinator
- ❖ Attendance at Individualized Family Service Plan (IFSP) meetings Care Manager/Liaison

Complex Case Management Program

- Case Managers engage enrollees with a variety of complex physical, behavioral and social needs
 - Chronic conditions including but not limited to asthma, diabetes, heart disease, HIV/AIDS, cancer/neoplasms
 - Acute care transitions including post-ED, post-hospitalization, new diagnoses, transitions into the health plan
- Peer Specialist follow up on SUD admissions and referrals including crisis placements and residential treatment program

Key Partnerships and Resources

- www.amerihealthcaritasdc.com
- ❖ AuntBertha.com search engine for resources
- Access2Care transportation vendor (Lyft/Uber)
- Mom's Meals condition-appropriate home delivered meals
- ❖ Food & Friends condition appropriate home delivered meals
- 2-Way Texting Program (HealthCrowd)
- ❖ Ginger Emotional Support App age ≥ 21
- ❖ MindRight Emotional Support App age 13-20
- Pharmacy delivery/Mail Order Service
- ❖ McClendon Center Post-BH admission follow up coordination
- Weight Watchers
- Gym memberships

Questions???





HEALTH EDUCATION PROGRAMS



Health Education Programs





- Diabetes Wellness Circles
- Spanish-language nutrition and diabetes classes
- Online diabetes prevention class
- Bright Start maternity care program
- Cooking classes
- Dietician services
- Home-delivered meals program
- Smoking cessation

For information or to sign up for one of our wellness programs, call **Community Outreach Solutions** at **202-216-2318**.

Get Fit At Home™

The Active&Fit® program helps you stay active no matter where you live or where you like to work out!

Aquatic Exercise • Athletic Conditioning Barre Fitness

- Barre Fitness for All Levels Cardio Blast Cardio Pump Cardio Quick Fix Chair Aerobics
- Chair Boxing Chair Dancing Chair Dancing Celebration Chair Pilates Chair Tai Chi •

Chair Yoga • Circuit Burn Diabetes Workout • Exercise • Exercise for the

Bedridden • High Energy Cardio • High Intensity Bootcamp • Lean Body Circuits • Pilates •

Strength & Stamina • Stress Management • Tai Chi • Tai Chi for Balance Total Body Workout

Upper & Lower Body Workouts
 Walking
 Yoga
 Your Best Body

Please visit www.ActiveandFit.com. If you have questions, call toll-free 1.877.771.2746 (TTY: 711), Monday through Friday, 8 a.m. to 9 p.m. Eastern time.

**Please talk to your provider before starting or changing your exercise routine.



Bright Start Maternity Care Program





The Bright Start® program provides care management for enrollees who are pregnant.

Bright Start can help you:

- Find an OB/GYN or midwife
- Schedule transportation to and from your appointments
- Get diapers, a car seat, a breast pump, and othersupplies
- Sign up for WIC
- Find breastfeeding support and childbirth classes
- Create a birth plan
- Sign up for home-delivered meals and other nutrition programs
- Help with family planning

Located on PAGE 32 of your Enrollee Handbook



CARE Card Rewards Program



EARN REWARDS FOR GOOD HEALTH!

You can earn rewards by doing things that help you stay healthy.

 Complete one of the recommended health screenings or tests.

You can use the rewards added to your CARECard at Walgreens, CVS Pharmacy, Rite Aid Pharmacy, and Walmart. You can buy products related to:

- baby care
- women's care
- diabetic supplies
- pain relief
- and more!

CARE Card Rewards Program

Better care, better rewards

Health Screen, Visit or Activity	Description	Reward Amount	Limit (Fiscal Year) October 1, 2021, through September 30, 2022
EPSDT/Well Child Visit	Annual Wellness Visit (Ages 12-20)	\$50	The annual fiscal year limit is a total of \$75 for any and all rewards/incentives, cumulatively. An individual can earn only one reward/incentive in each category per year.
Diabetic Blood and Urine Screening	Blood (HbA1c) and Urine (Kidney Health Evaluation) for Diabetes	\$25	The annual fiscal year limit is a total of \$75 for any and all rewards/incentives, cumulatively. An individual can earn only one reward/incentive in each category per year.
Diabetic Retinal Eye Exam	Retinal Eye Exam for Diabetics	\$25	The annual fiscal year limit is a total of \$75 for any and all rewards/incentives, cumulatively. An individual can earn only one reward/incentive in each category per year.
Maternity Prenatal Visit	Maternity – Prenatal Visit	\$25	The annual fiscal year limit is a total of \$75 for any and all rewards/incentives, cumulatively. An individual can earn only one reward/incentive in each category per year.
Maternity Postpartum Visit	Maternity – Postpartum Visit	\$25	The annual fiscal year limit is a total of \$75 for any and all rewards/incentives, cumulatively. An individual can earn only one reward/incentive in each category per year.

*certain terms and conditions may apply

MORE INFORMATION: https://www.amerihealthcaritasdc.com/iamhealthy/reward-program.aspx

AmeriHealth Caritas District of Columbia

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Your Urgent Care Options





1. RelyMD

- Use the RelyMD app on your mobile device.
- Call RelyMD at 855-879-4332.
- Visit relymd.com.

2. Urgent care clinic

• Visit our website or call Enrollee Services to find a clinic near you. We provide rides to urgent care centers at no cost.

3. 24/7 Nurse Call Line

• 1-877-759-6279

4. Ready Responders

• Get House Calls for Urgent Care. Please visit

www.getready.com or call 202-602-0814.

FIND AN URGENT CARE FACILITY NEAR YOU BY VISITING:

https://www.amerihealthcaritasdc.com/member/eng/medicaid/care/_emergencies.aspx

Scheduling a Ride





Routine medical appointments

Call to schedule your ride 48 hours in advance.

Urgent care

• Call to schedule your ride the same day.

Hospital discharges

Call when you are ready to be picked up.

The Transportation Services phone number for all enrollees is 1-800-315-3485.

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Value Based Partnerships for Million Hearts Population: Opportunities with AmeriHealth Caritas

Kelli Johnson, AmeriHealth Caritas DC Value Based ProgramManager



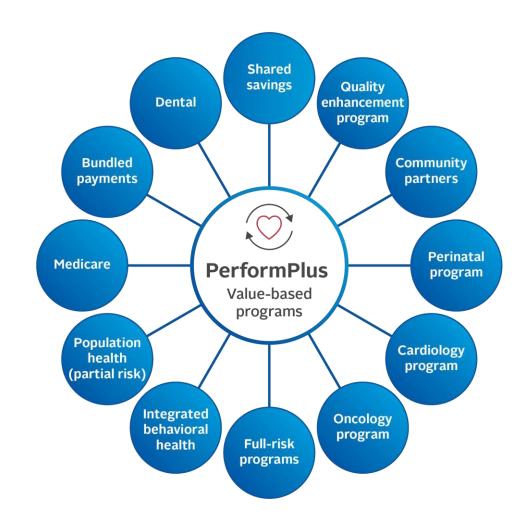


PerformPlus® Portfolio of Programs



AmeriHealth Caritas Perform Plus® valuebased portfolio is designed to advance our company's vision for quality.

Our suite of valuebased programs offers a wide array of valuebased programs focused on partnering with health care providers for quality improvement.



AmeriHealth Caritas Value-Based Strategy



Goal

Build effective collaborations with health care providers to help individuals access care, stay well, and build healthy communities.

Innovative provider partnership and payment models

Practice supportand resources

Specialized programs to improve health outcomes

Local Joint
Operating
Committees

Key components of a successful strategy.

Tailored value-based reimbursement programs

Market-specific practice transformation support

Timely and actionable dataat point of care

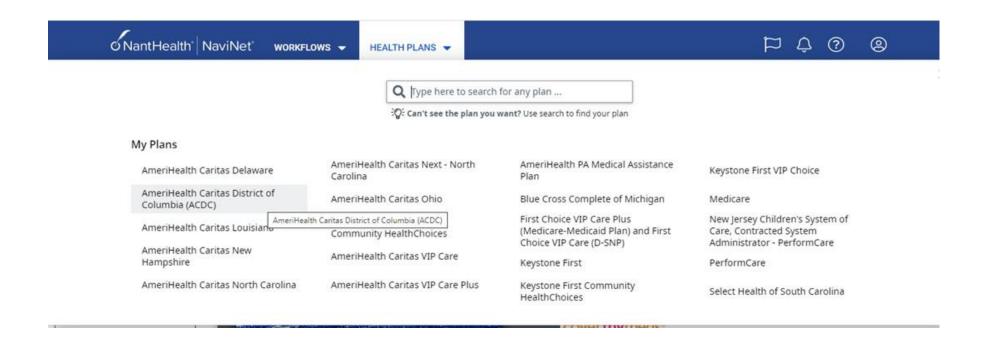
Multi-stakeholder engagement

Data Made Easy



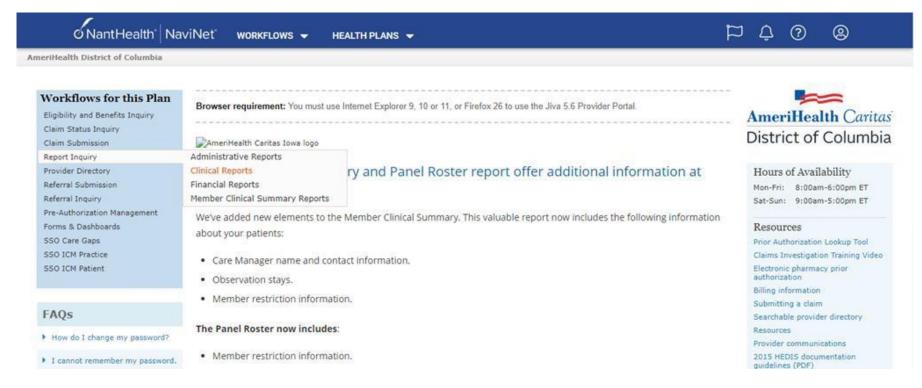
Log into NaviNet: select the appropriate Health Plan





From the ACDC Plan Central page: Workflows for this Plan Report Inquiry then "Clinical Reports"

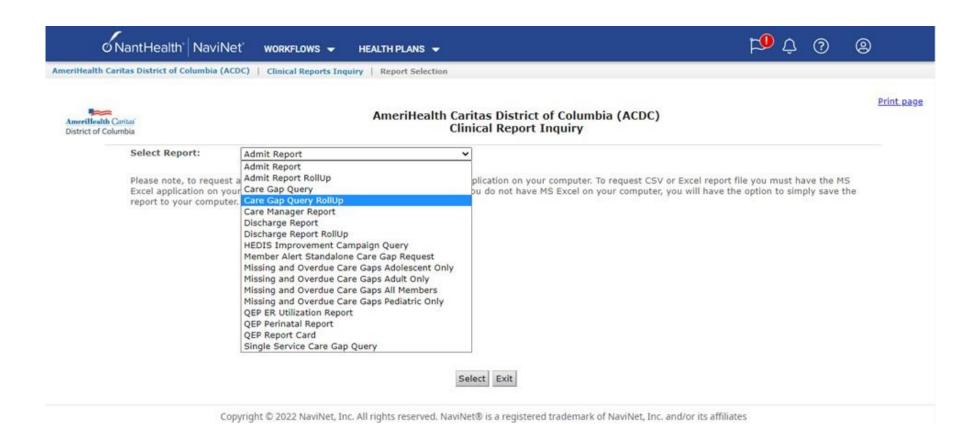




You will be presented with a screen that requires you to select the appropriate Clinical Report.



Select the report entitled "Care Gap Query Rollup"



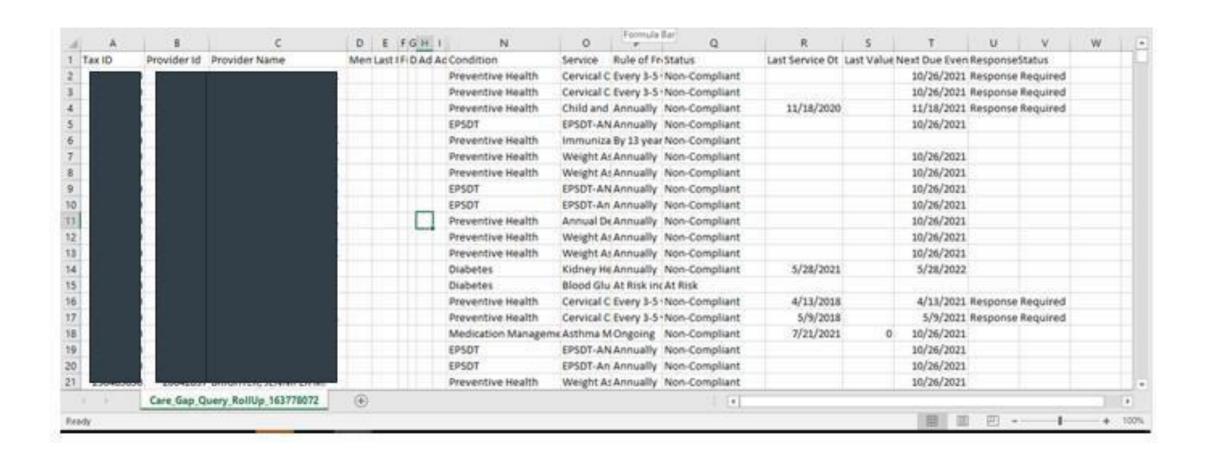






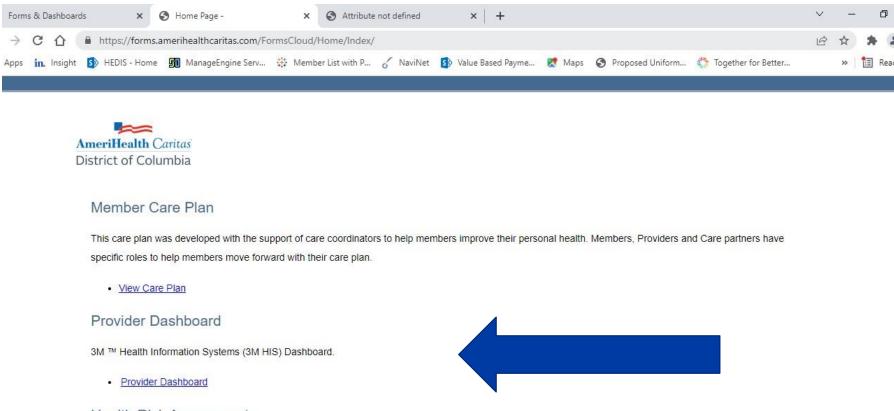


At that point the report will run and will look like this (NOTE that I have hidden all of the Member PII)



Single sign on function from Navinet to 3m





Health Risk Assessment

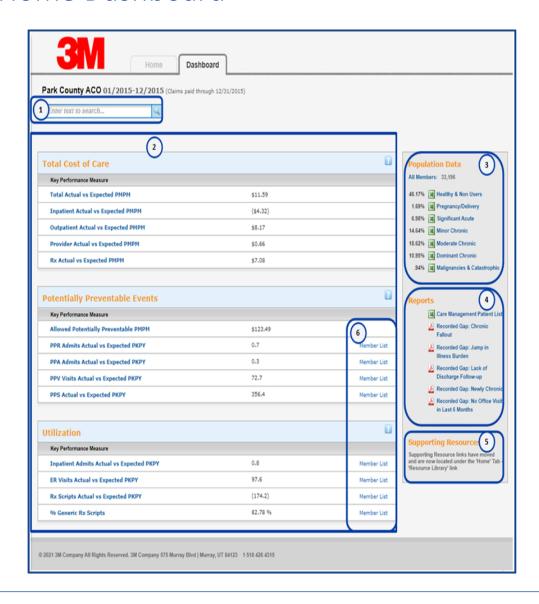
This Health Risk Assessment (HRA) collects information on Member health history, self-perceived health status, readiness to change, language preference and identifies Social Determinants of Health that may be impacting the Member's health outcomes.

View Health Risk Assessment Form



Medical Home Dashboard



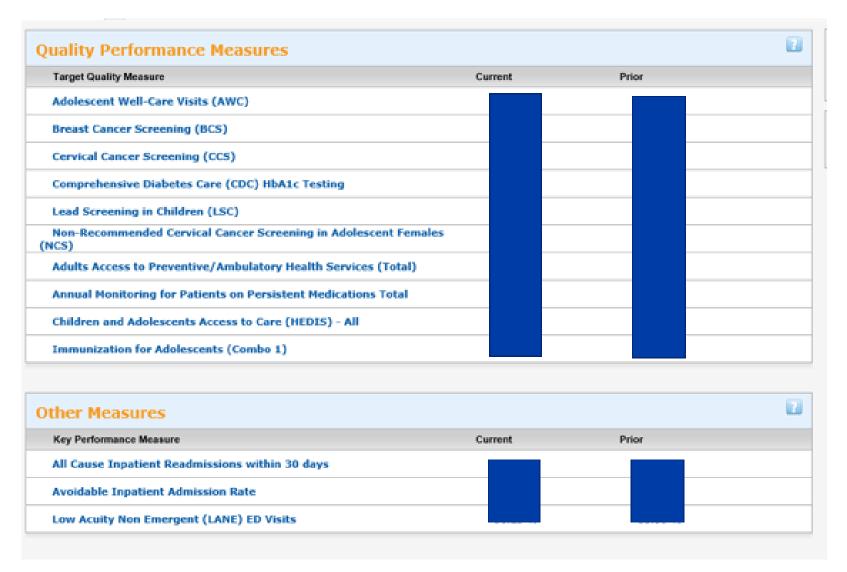


The 3M Medical Home Dashboard supports the implementation of accountable care programs, medical homes and other programs by providing users with quick, easy access to critical key performance indicators.

- 1. Provider Search
- 2. Key Performance Indicators
- 3. Population Data
- 4. Reports
- 5. Supporting Resources
- 6. Member Lists

QEP dashboard





PICS Data Example Components



Socio-Medical cost and Medication determinants of **Care Coordination** adherence (MPR) utilization health **Hospital Dominant** Travel distance Morbidity & Frailty between member Lab/Clinical Values Risk severity/RUB Conditions and provider Potentially Adjusted Clinical Comorbidities Groups (Overall (Major Chronic preventable Poverty status Disease Burden) Diseases) adverse events

PICS Overview – Risk Percentile and Risk Levels



- ➤ PICS Score is the summation of the scores from all ranking fields. It is used to generate PICS Percentile from 1 to 100 in the descending order.
- ➤ The PICS Percentile is then used to stratify member population into 5 risk buckets or groups called PICS Group. These include top 1%, top 2-5%, top 6-15%, top 16-35% and non-top 35%.
- ➤ Similarly, these 5 groups are also placed into 5 risk levels following their respective PICS group categories. These PICS Risk Levels are Very High, High, Moderate, Low, and Very Low risk Levels.

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