

THE COLUMBUS RENAISSANCE HOTEL, HAYES BALLROOM

MAY 22, 2019

2019 OAHP Pinnacle Awards: Celebrating Innovation And Excellence

The Ohio Association of Health Plans and its member plans are working every day to help Ohioans "get well, stay well, and live well." Each year, OAHP draws much deserved attention to these efforts through the annual Pinnacle Awards.

The 2019 OAHP Pinnacle Awards recognize health plans for their success in addressing the challenges of a shifting health care environment through innovative programs. Despite the new challenges Ohio's plans face in this dynamic environment, they continue to inspire creativity and bring improvement to the healthcare delivery system. The Pinnacle Award serve as an emblem of excellence to plans who receive it.

Over the years, OAHP member plans have launched hundreds of programs demonstrating creative approaches to solving problems and improving services in operations, clinical services, disease management and community outreach in all sectors of the market – commercial, Medicare, and Medicaid.

As in years past, a panel of judges comprised of health industry professionals reviewed the submissions based upon stated criteria. This year, the judges identified two winners of the Pinnacle Award and wish to acknowledge and thank all health plans that made submissions to this year's competition. Together, all seven submissions reflect the wonderful, innovative health care marketplace that is serving Ohio so well today.

Judges -

The Ohio Association of Health Plans extends a special thanks to the judges for the generous contribution of their time and expertise.

- Mary Gallagher, Executive Vice President and Chief of Staff, Ohio Hospital Association
- Keith Lake, Vice President, Government Affairs, Ohio Chamber of Commerce
- · Loretta Medved, Policy Analyst, Ohio Department of Insurance
- Ann Spicer, Executive Vice President, Ohio Academy of Family Physicians

Participants -









2019 PINNACLE AWARDS: CELEBRATING INNOVATION AND EXCELLENCE

Anthem Cancer Care Solutions – Reducing Avoidable Admissions through Provider Collaboration

Anthem Blue Cross and Blue Shield

Background:

Some cancer treatment-related complications that result in inpatient admissions could be successfully managed in outpatient settings. Pro-active symptom support and management may reduce emergency room visits and hospitalizations.

Our Avoidable Admissions initiative leverages the strength of predictive analytics and provider partnerships to enable proactive provider-led outreach to members at risk for potentially preventable admissions during cancer treatments. By sharing actionable data with providers we are helping them to focus resources on members with higher risk for complications during treatment.

How it works:

- Each week, members with authorizations for upcoming chemotherapy are scored by a predictive model and categorized as high, moderate or low risk for having a future avoidable admission.
- Practice-level reports, which were developed in partnership with practicing oncology providers and include member risk for future avoidable admissions, are created and placed on Anthem's provider portal.
- Practices use the information about risk for avoidable admissions to determine where to offer additional check in and education with their patients.

Provider Experiences:

Cincinnati's Oncology Hematology Care (OHC) has been a program collaborator. OHC flags patients in their electronic medical record and proactively contacts patients, conducting assessments to check for any additional concerns or needs.

Cedars-Sinai in Los Angeles, California, has also partnered as part of this initiative. They stated that the "proactive identification of patients who were at high risk for readmission allowed us to better leverage our Patient and Family Support Program in order to better serve our patients."

Research:

Direct identification of avoidable or preventable hospitalizations in patients with cancer is challenging, and administrative measures are lacking. In a prior study, retrospective medical record review identified 19% of hospitalizations in patients with gastrointestinal cancer as potentially avoidable.

Brooks, G. A., Jacobson, J. O., & Schrag, D. (2015). Clinician perspectives on potentially avoidable hospitalizations in patients with cancer. *JAMA oncology*, 1(1), 109-110

Acute hospitalizations in patients with cancer are a major driver of the cost of cancer care, accounting for nearly half advanced cancer spending. 1 Reducing acute hospitalizations is a potentially important strategy for improving the quality, value, and patient-centeredness of cancer care.

Brooks, G. A., Jacobson, J. O., & Schrag, D. (2015). Clinician perspectives on potentially avoidable hospitalizations in patients with cancer. *JAMA oncology*, 1(1), 109-110.

Over the past 20 years, the role of the navigator has expanded to encompass cancer care across the continuum, from prevention to survivorship to end-of-life care. In many cancer programs, oncology nurses are functioning in the role of professional navigator secondary to their cancer-specific knowledge and clinical expertise. Benefits of a nurse performing the

role of the navigator include the skill to clinically assess patients, provide support and education, manage the complexity of the cancer diagnosis, and communicate and collaborate with other clinicians (Gilbert et al., 2011). Additionally, the oncology nurse in the role of navigator has the ability to proactively anticipate patients' needs, initiate appropriate referrals, and provide valuable education to equip patients with knowledge and understanding, thereby reducing anxiety and stress, which allows patients to feel more in control of their situation (Wilcox & Bruce, 2010).

https://www.ons.org/sites/default/files/ONNCompetencies_rev.pdf; Accessed January 31, 2019.

Panattoni/Hutchinson Institute for Cancer Outcomes Research (HICOR) presentation to ASCO Annual Meeting, June 2017 – "The Costs of Potentially Preventable Cancer and Chronic Disease-Related Emergency Department Use During Treatment: A Regional Study"

Buckeye Health Plan Launches Innovative Orthopedic Medical Review Program Buckeye Health Plan

In response to the growing number and cost of orthopedic surgeries and musculoskeletal services needed by our chronically ill and elderly members, Buckeye Health Plan launched an innovative, evidence-based Orthopedic Medical Review Program. The Goal of this program is to improve the quality of care, maximize safety and enhance our members' quality of life.

Audience

Buckeye's high-quality medical review and comprehensive support service targets dual eligible, aged, blind and disabled, Medicaid, Marketplace, and Medicare member beneficiaries meeting the criteria for orthopedic surgery.

Research and Key Objectives

Buckeye collaborated with nationally recognized orthopedic and spine clinical leaders to identify best practices and develop a program to improve the provision of care and achieve superior clinical outcomes.

Key Objectives of the program are to:

- · Determine the medical necessity and appropriateness of procedures through evidence-based utilization management policies
- Validate physician specialty to ensure that the ordering physician has the appropriate credentials and training to perform the requested surgery
- · Conduct careful comprehensive review that encompasses patient co-morbidity and risk factor management
- Apply implant/biologic best practices to ensure clinical appropriateness, FDA application, manufacturer and product quality as well as appropriate cost

To identify program candidates who meet all the necessary criteria for a successful orthopedic surgery, Buckeye utilizes evidence-based medical policies and expert medical staff during the prior authorization process. The program collaborates with requesting physicians and providers to validate the clinical appropriateness of the surgery, and reviews any risk factors or co-morbidities of the patient prior to any authorization for surgical services.

Evaluating Results

The program has positively and significantly impacted the quality of member outcomes as measured by post-operative factors such as:

- · Significantly reduced surgical revision rates
- Fewer emergency room (ER) visits post-surgery
- · Fewer inpatient hospital readmissions

By reviewing medical claims data before and after the program launch, Buckeye has identified the following results related to total knee and hip replacement surgeries.

Total Knee and Hip Replacement Outcomes

	Prior to Program (01/01/17 – 02/14/18)	Post Program Launch (02/15/18 – 10/31/18)	% Change
Revision Rates*	3.4%	2.3%	-33.5%
ER Visits**	16.9%	13.2%	-21.6%
Inpatient Readmissions**	5.2%	4.9%	-4.9%

^{*}Within 1 year post primary surgery

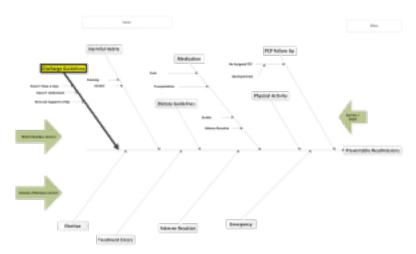
In addition to reductions in the post-operative factors above, the program has produced utilization behavior changes in over 30% of member surgeries. This continues to ensure that patients are receiving optimal care and reduces the costs of any unnecessary surgical services. Buckeye will continue to collect and measure post-operative quality outcomes to ensure their members are receiving the highest quality care possible.

Buckeye Health Plan Readmission Coaching Program

Buckeye Health Plan

Hospitalization is one of the most expensive forms of healthcare and accounts for nearly one-third of the total \$2 trillion spent on healthcare in the United States. In most cases, hospitalization is necessary and appropriate. However, a substantial percentage of all hospitalizations is due to patients returning to the hospital soon after their previous stay (within 30 days of initial discharge). These readmissions are costly, potentially harmful, and often avoidable.

Cause and Effect Diagram



Research

According to the Institute for Healthcare Improvement, the rate of avoidable readmissions can be reduced by improving core discharge planning and transition processes out of the hospital; improving transitions and care coordination at the interfaces between care settings; and enhancing coaching, education, and support for patient self-management.

Strategies

To reduce the rate of avoidable readmissions, Buckeye Health Plan developed a Readmission Coaching Program (RCP) in 2018. Peer coaches provide a "boots on ground approach" to address/ influence individual and community health. Coaches are non-clinical, frontline public health workers who often share some degree of common experience with their patients and have close ties to the community.

^{**}Within 90 days post-surgery

The coaches focus on:

- Member enrollment
- Assessment
- · Care team collaboration
- · Relationship building
- · In person consultation
- · Care plans /success plan
- · Evoking /collaborative effort to reach goals
- · Graduation to self-management

Audiences - Buckeye Medicaid, Marketplace, and Medicare members who have non-complex care requirements. Inclusion Criteria

- Preventable Readmissions Score from 50-69%
- · Member age 45 or above
- Post Discharge Assessment completed within 72 hours or 3 days of discharge

Exclusions (these exclusions may be phased in at a later time)

- Pregnancy
- · Psychiatric disorders
- · Developmental disorders
- · Members already enrolled in care management

Outcomes

Since implementation of the RCP, Buckeye has enrolled 51 members with an average savings of \$3,876.84 for all members and readmission rate of 29.4%. The members enrolled in the program all had readmission risk scores of at least 50% or greater prior to the program enrollment.

	Mean Cost 30-days Pre	Mean Cost 30-days Post	Mean 30-day Cost
	Prog Completion Date	Prog Completion Date	Difference
Inpatient	\$ 4,321.30	\$ 444.46	\$ (3,876.84)

Depression Action Work Group (DAWG)

Paramount Health Care

Background

According to the World Health Organization (WHO), Depression is a common illness worldwide, with more than 300 million people affected. Depression causes the person to suffer and function poorly at work, school and at home. At its worst, depression can lead to suicide. Close to 800,000 people die from suicide every year, the second leading cause of death in 15-29 year-olds.

Paramount's High Risk/Co-morbid Depression management program objectives had disappointing results in 2015. Utilization and cost data increased by a statistically significant margin. Paramount Advantage Case Management (CM) identified 6,310 members with high risk/co-morbid depression. Depression ER visits increased from over 6.3% to 14%.

Description

The purpose of the DAWG is to identify members with high medical/pharmacy utilization and poorly controlled physical illness amenable to enhanced behavioral health services. Members are identified from Quality Improvement (QI) data, CM

and disease management (DM) staff. The multi-disciplinary team is comprised of behavioral health (BH) leadership, clinical leadership, QI, and CM staff. The goal of DAWG is to review cases with a goal of developing innovative interventions to positively impact the member's health and wellbeing.

Collaboration

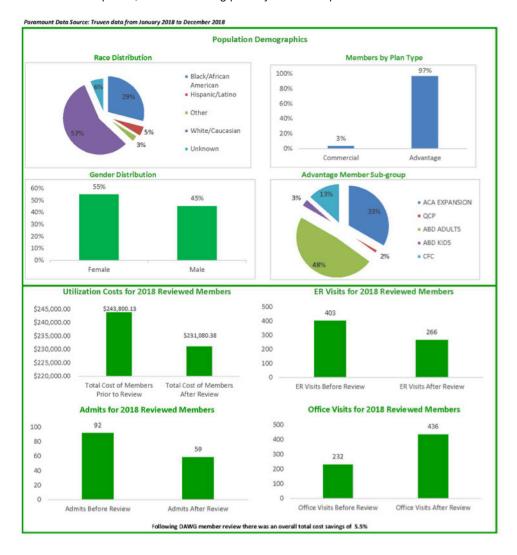
DAWG meets to review Paramount members that have high utilization, co-morbid depression, and frequent ER visits. Often these members are reluctant to engage in CM. Case Managers present cases, focusing on history of utilization, gaps in care and barriers to engagement. DAWG reviews the case, provides feedback/recommendations to assist staff in improving utilization and quality of life. CM/DM staff proceeds to implement the plan including engaging primary care, specialists, Federally Qualified Health Centers, ER's, family, and community resources.

Expected Outcomes and Actual Outcomes

The expected outcomes were to reduce utilization (ED visits and hospitalizations) and total utilization expense while simultaneously improving the member's quality of life. Case management was in contact with 61 of the 62 DAWG members who were identified and reviewed in 2018. One unexpected anecdotal but important outcome lies in the support given to CM's handling very difficult circumstances, which may have contributed to their diligence in working with our members.

For 2018, the DAWG team reviewed 62 cases. The outcome data demonstrates a 5.5% decrease in overall expense compared to utilization up to 6 months pre and post DAWG intervention.

The outcome data does demonstrate that post DAWG review, there was a significant decrease in ER utilization, acute hospital admissions and total medical expense, while increasing primary care and specialist office visits.



ProMedica Food Clinics: A Prescription for Better Health

Paramount Health Care

As a system, ProMedica and its subsidiaries began to look at social determinants of health (SDOH). We identified the relationship between food insecurity (hunger) and health as a SDOH to explore. We reviewed the Center for American Progress's 2011 report, Hunger in America. The report's findings revealed that over a three-year period (2007-2010) health care costs increased by a total of \$32.1 billion as a result of food insecurity. In early 2014, ProMedica used these findings to pilot a project to screen patients for food insecurity using the validated two question Huger Vital sign.

ProMedica's first food clinic opened in Toledo in April 2015; in January of 2016 a second location opened in Sylvania; a third was opened at ProMedica's Bay Park Hospital. ProMedica's Food Clinic operates under the principle that food is medicine. Patients are screened at ProMedica hospitals, ProMedica primary care physician (PCP) offices, and through Paramount's Care Managers and Disease Managers. Paramount staff screen for food insecurity during members' initial needs assessments, and on every start of care or next case review assessment. If a member is identified as having a food insecurity they are directed to ask their PCP for a referral or staff can obtain a referral on the member's behalf. The referral has information about the member's nutritional needs, conditions the member has, food allergies or intolerances, vitamin deficiencies, and food/medication interactions. When a member visits the clinic their PCP is notified.

Once the member receives the referral they can to go to the closest ProMedica Food Clinic to select a supplemental supply of healthy food, approximately 2-3 days' worth, for their household. Members are also provided with nutrition education and free nutrition counseling with a dietician. The mission of ProMedica's Food Clinic is to increase access to healthy food for food insecure patients. Each referral lasts for 6 months and can be used once every 30 days. If at the end of 6 months the member is still in need, they can go back to their PCP to obtain another referral. Paramount also provides transportation to and from the food clinics for Medicaid members.

We performed a retrospective review of Paramount members who received referrals for the food clinic. Preliminary findings indicate a correlation between the use of the food clinic program and improved outcomes, fewer emergency room (ER) visits (-28.6%) one year after using the program compared to the year before. We also saw a 5.1% reduction in the total per member per month insurance cost one year after using the program compared to the year before. In 2018 there were 10,072 household visits to the Food Clinic with approximately 78,255 days' worth of food provided to recipients.

Our goal is to decrease food insecurity so patients can focus on staying healthy, which may ultimately drive down healthcare costs and non-primary care utilization. We anticipate providing contributions to the limited research currently available by developing research projects to examine other health and cost outcomes and focus on condition-specific interventions and outcomes.

Telehealth In Complex Chronic Condition Management

UnitedHealthcare Community Plan of Ohio, Inc.

Dating back to almost two decades, the case for using telehealth as a tool to enhancing disease management for chronic medical conditions has been studied and put forward as a potential solution. The amount of research and data that has accumulated since then is significant. There is, however, still a need to test this technology and its application in Medicaid and Dual-Eligible populations given the complexity of their needs, both clinical and social. UnitedHealthcare Community Plan of Ohio, recognizing this opportunity, and in order to supplement an existing complex care management model, conducted a 6-month long pilot project in 2018. The goals of this project were to demonstrate the utility of using telehealth in enhancing disease management for members living with multiple co-morbid conditions to achieve improvements in quality of life, self-management skills, clinical outcomes and reducing emergency department (ED) and inpatient (IP) utilization.

With these goals in mind, 25 members being served by UnitedHealthcare's Medicaid or MyCare Ohio products were enrolled in a telehealth program in collaboration with an in-network Nurse Practitioner led, primary care provider group. The members

were selected based on the presence of several criteria including diabetes plus at least 2 chronic conditions, living at home, being able to handle and operate telehealth tools such as blood glucose and pressure monitors, video conferencing or teleconferencing equipment, ability to actively participate in care management and high utilization of ED or IP settings. Once enrolled, the members were given a brief orientation and then engaged in ongoing disease management that included coordinated care between the health plan's care management team and the nurse practitioner provider team. Visits were either over the telephone or a video-conferencing smart tablet based application, and occurred on a recurring basis throughout the 6 month period. Clinical data was collected using Bluetooth or Wi-Fi enabled devices that were given to the members as part of the pilot program. Claims data and notifications received by the health plan were used to monitor ED and IP utilization. Regular and frequent communication protocols between the health plan and the provider group were established. Data was analyzed midway through the pilot and again at the end of the pilot.

Members in the pilot experienced the following outcomes: 44% reduction in ED or IP utilization compared to the 6-month period prior to enrollment, 90% indicated increased knowledge of disease self-management and improved quality of life. Clinical outcomes of note were a 4.75% reduction in average Systolic Blood Pressure, 5% reduction in average blood sugar and 0.9% average HbA1c reduction. All of these are clinically significant reductions, which if sustained, could have a measurable impact on the likelihood of long-term complications and outcomes. In addition, enrollment in the pilot revealed several additional previously undiagnosed behavioral health conditions.

In summary, this telehealth pilot successfully demonstrated the value of telehealth as a valuable tool in care management of members with complex chronic conditions. We intend to expand this pilot to 50 additional members in 2019.

UnitedHealthcare PreCheck MyScript

UnitedHealthcare Community Plan of Ohio, Inc.

For too long, a lack of actionable, real-time information has hindered the optimal distribution of prescription medications to the patients that need them.

For physicians picking up the pen to prescribe medications for their patients, this lack of relevant data presents significant challenges. While doctors may have had sufficient information regarding a medication's clinical efficacy and safety, too often prescribers have lacked insight into the other elements essential to high-quality patient care and service. These elements include patient-specific drug benefit limitations, out-of-pocket costs, and factors affecting drug utilization and adherence, and lower cost alternatives. From the patient's perspective, this lack of insight into their member-level information would often result in unnecessary delays. Worse yet, it could leave them unable to get their prescription filled at the pharmacy counter. Or, consider the case where a physician is blindly prescribing the most expensive drug in a class when less expensive, but clinically identical alternatives exist. This creates a cost burden for both the patient and the plan sponsor.

Created by UnitedHealthcare and OptumRx, PreCheck MyScript is a digital health care program and app that doctors can use to write and renew prescriptions efficiently for their patients during a patient's visit. The program is accessed through Link, UnitedHealthcare's physician health portal, and enables doctors to run a trial pharmacy claim before prescribing a medication to get real-time prescription pricing and coverage details for patients who have UnitedHealthcare benefit coverage. The tool allows care providers to check current prescription coverage and pricing, including out-of-pocket prescription costs, for UnitedHealthcare members at their specific selected pharmacy, get information on lower-cost prescription alternatives (if available) to help save people money, see which prescriptions currently require prior authorization (or are not covered or non-preferred), request prior authorization and receive real-time approvals for the medications their patients need.

PreCheck MyScript eliminates administrative hassle by providing clarity and simplicity to physicians while simultaneously helping patients at the point of care. With PreCheck MyScript, care providers immediately know what a prescription costs and potentially see lower-cost alternatives they can discuss with their patients. If a medication requires prior authorization, they can quickly request approval using the app, reducing delays so the patient can have access to the medication sooner. For patients, this accelerates the process of accessing the right medications and receiving the proper treatment while avoiding

costly surprises at the pharmacy counter. For doctors, the efficiency of PreCheck MyScript gives them more time to spend with patients, resulting in increased trust between care providers and their patients.

PreCheck MyScript is now available to about 115,000 prescribing physicians, and has generated more than 4 million transactions, resulting in patients changing to a lower-cost drug more than 20 percent of the time. By the end of 2019, the app is expected to reach 80 percent of UnitedHealthcare in-network physicians who prescribe medications electronically.



About OAHP

The Ohio Association of Health Plans (OAHP) represents 15 member plans providing health insurance coverage to over 9 million Ohioans. Ohio's health plans include commercial insurers, Medicaid managed care plans and Medicare Advantage Plans. OAHP also partners with Affiliate and Supporting members to further support the mission of the association.

As the statewide trade association for the health insurance industry, OAHP actively promotes and advocates for quality health care and access to a variety of affordable health care benefits for all consumers in Ohio.

Our Board of Trustees

The OAHP Board of Trustees is made up of representatives from member plans elected by the Delegates. Board members serve three-year terms and the Board elects its officers each year.

Chair:

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Vice Chair:

Michelle Stoughton, Anthem

Secretary:

Rob Mullen, AultCare

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Board Members:

Bradley Fischer, Aetna, Inc. Travis Garrison, Humana Kurt Lewis, UnitedHealthcare Stephen Ringel, CareSource

Our Focus

Legislative & Regulatory Issues

Through OAHP, member health plans have a significant voice in the development of state health care policy. OAHP members offer innovative benefits to over 9 million Ohioans through employer-sponsored coverage, the individual market, and public programs such as Medicare and Medicaid. OAHP is an active visible leader in developing public policy solutions to health care access, affordability and quality.

Partnerships & Opportunities

OAHP actively engages in coalition building with diverse stakeholders and advocacy groups to foster cooperation and a better understanding of the important role of providers, health plans, and consumers in Ohio's health care system. In addition to collaborating with stakeholders to address common areas of interest, OAHP also serves as the public voice for the industry in Ohio.

Educational Programs

OAHP sponsors educational programs that provide valuable, up-to-date information about national trends, policy implementation and best practices. The most prominent educational event of the year is the Annual Convention and Trade Show.

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e industry, OAHP actively promotes buckeye health plan





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