September 28 – 29, 2021 • Sheraton Columbus at Capitol Square

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2021 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 Pinnacle Awards.

The 2021 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 serves 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 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

2021 PINNACLE AWARDS: CELEBRATING INNOVATION AND EXCELLENCE

Member Connect

Anthem Blue Cross and Blue Shield

With 43 percent of seniors feeling lonely on a regular basis, senior loneliness is an epidemic. It increases mortality risk by as much as 45 percent – more than obesity, air pollution, and excessive alcohol use.

In 2018, Anthem Blue Cross and Blue Shield in Ohio launched Member Connect to address factors that contribute to senior loneliness and social isolation among Anthem's Medicare Advantage members. This is part of the health insurer's approach to addressing social drivers of health and whole-person care. The program has three goals for participants: help them re-engage in their healthcare, connect them with community-based organizations, and increase their physical activity.

Participants are connected with two Anthem associates – a social care partner and phone pal. Social care partners help connect the member to community-based services that address social needs and unmet health-related needs. Phone pals, who are volunteer Anthem associates, call these members on a weekly basis to check in and provide the social connection that may help the member with their isolation and loneliness. This program creates an advocacy mentality among Anthem associates who have a direct connection to members.

The engagement in Member Connect helps members reduce the feeling of isolation and loneliness, leading to improved health. In a survey, a majority of participants noted positive changes to their lives since joining the program:

- 78 percent agreed/strongly agreed that they have had more meaningful connections with people.
- 79 percent agreed/strongly agreed that they have had an increase in activities that bring them joy or a sense of purpose.
- 74 percent have changed something about how they take care of themselves.
- Participants identified the top three activities as increase in exercise, healthier eating habits, and increase in medication adherence.

With its implementation of Member Connect in Ohio, Anthem has engaged more than 5,500 members. While Anthem's volunteer phone pals come from around the country, nearly 100 of Anthem's Ohio associates have volunteered to be a social connection for participants.

One of those 5,500 members is Gaye Wannamaker, a retired teacher living in Columbus. Before Member Connect, Gayle was insecure about many things in her life – her dentures, her chronic health conditions, and her daily transportation challenges, among other things. Because of these insecurities, she did not want to leave her home, which led to isolation, inactivity, and an unhealthy lifestyle. She also lacked confidence to engage her healthcare team.

One day, an Anthem social care partner reached out to her, and over many weeks the two of them developed a relationship where Gayle began to trust Angelica. Gayle became increasingly open to the health-related guidance Angelica provided. Gayle also established a trusting relationship with her phone pal, Chimene, who helped her understand how to better interact with her healthcare team –giving Gayle health information and opportunities for role-playing appointments. Gayle credits Member Connect in helping her eat healthier, lose weight, better control her chronic condition, and take control of her lifestyle. Gayle's increased confidence has also led her to help other people by leading social groups.

Summary

Anthem Blue Cross and Blue Shield in Ohio launched Member Connect to address the factors that contribute to senior loneliness and social isolation among its Medicare Advantage members. Member Connect has three program goals for participants: help them re-engage in their healthcare, connecting them with community-based organizations, and increase their physical activity.

Buckeye Health Plan Creates Mobile On-Demand Diabetes Care Solution

Buckeye Health Plan

Ohio suffers from diabetes more than other states. Over 1 million Ohioans have diabetes with an additional 300,000 likely having it, but being unaware. In terms of health disparities, the death rate from diabetes is 77% higher for Blacks than Caucasian Ohioans.[1]

Too often individuals with diabetes are left on their own to understand their blood sugar readings, how to improve them, and how to navigate a complex health care system. Additionally, there are burdensome steps to keep up with the amount of supplies needed. Buckeye Health Plan created a mobile health solution for its members with diabetes to help alleviate common challenges.

Buckeye launched On-Demand in June 2020 as an opt-in program for members with elevated HgbA1c and/or a poor claims history. The program furnishes members with glucometers that provide real-time monitoring of biometric data with cellular and web-based technology.

The glucometer allows for proactive and reactive health coaching. Buckeye care managers have information that helps them work more individually with members.

From a population perspective Buckeye measures results such as average blood sugar levels, daily blood sugar levels, increases or decreases in supplies used, and adherence to monitoring. Buckeye then identifies which work flows lead to improvements and which sub-populations are most likely to benefit from the technology.

Our premise at the onset was that the tight linkage of supplies to monitored blood sugar checks along with available coaches and care managers would lead to more internal motivation for members to practice good self-care.

Goals and Objectives:
Lower average glucose values
Improve adherence to use of insulin and supplies
Improve monitoring of blood sugar

Experience to Date:

- 310 Buckeye Medicaid members are actively participating as of July 1, 2021
- Currently, all participants in the program average 20 glucose checks/month
- Average glucose value: 170 mg/dL
- Average validated A1c (for participants with validated A1c): 8.8%

Pre-post Intervention Analysis:
Buckeye and BioTel[2] conducted a comparison of pre-program HgA1c to post-program HgA1c (measured after the member enrolled in On-Demand)

- 24 members had a pre-program A1c >7.0, were enrolled for at least 90 days and had a subsequent A1c value
  - **Of these, 67% (16 members) had a reduction in A1c**
    - Average drop was 1.81 points (range: 0.40 – 4.90 reduction)
  - **The data shows a correlation between total tests (compliance) and improvement in A1c value**
    - Members that saw a decrease in A1c averaged **24.5 glucose readings/month**
      - Members that saw an increase in A1c averaged **12.6 glucose readings/month**

Success Story

A diabetes coach on-boarding a member realized they were using their Humalog and Lantus pens incorrectly. The coach retrained the member on how to add up the number of needed clicks and to contact his pharmacist for confirmation. The member called back to say how much he appreciated learning how to correct his dosing errors.

Next Steps

As Buckeye's initial testing showed positive outcomes the plan is now reaching out to our hospital partners with value-based contracts. This innovative no-cost mobile solution will likely be welcomed.

Sources

1- 2018 Ohio Diabetes Action Plan, accessed at Ohio Diabetes Action Plan 2018 on July 30, 2021.

2- BioTelemetry, Inc acquired On-Demand from Centene on July 29, 2020. Buckeye Health Plan and Envolve collaborated on this solution with its Centene employed co-founder beginning in January, 2016.

BioTelemetry, Inc. Acquires Remote Patient Monitoring Platform from Centene Subsidiary – BioTelemetry, Inc. (gobio.com)

Medication Reconciliation Post Discharge Program

Buckeye Health Plan

The Challenge

Medication reconciliation post-discharge (MRP) is an important aspect of patient safety. By creating a current, accurate and complete list of medications, MRP can prevent medication errors. It may also reduce the occurrence of adverse drug events, especially for individuals with multiple prescription medications.

Evidence shows that discharge medication lists may:

- Include medications that are duplicative and unnecessary
- Omit necessary medications patients were taking prior to the hospital admission
- Contain inappropriate dosages

MRP Goals and Objectives

Buckeye Health Plan implemented a comprehensive clinical program to follow up with members after an inpatient admission or an emergency department visit. The goal was to mitigate the potential negative consequences arising from discharge medication discrepancies.

To ensure that post-discharge medication lists are appropriate in light of the medications that members were prescribed before their hospital admission, clinical liaisons conducted in-home visits (virtually during the pandemic) with members. Leveraging this service allowed Buckeye to ensure our members' safety and well-being when they experience transitions of care.

Program Methodology

To evaluate the effectiveness of the MRP program, Buckeye analyzed pharmacy and medical costs for Medicaid members receiving medication reconciliation. The data covered six months pre-admission and six months post-discharge. Buckeye then compared the study group to a control group who did not receive a medication reconciliation post-discharge.

Pre and Post Intervention Analysis

The study group selected included 165 Medicaid members who were hospitalized in 2019 and received a medication reconciliation post-discharge consultation. These members were enrolled continuously at Buckeye at least six months before and after their hospitalization. The same parameters applied to the control group of Buckeye members who did not receive medication reconciliation post-discharge.

In addition, Buckeye conducted a cost savings analysis on both the study and control groups. Included within the cost categories were: emergency department, inpatient, outpatient, primary care provider, specialist, pharmacy and other medical costs comprised primarily of home health and skilled nursing facility expenses. Additionally, hospital readmission rates and 30-day hospital readmission rates associated to the two groups were analyzed.

Results

Analysis of pharmacy and medical claims of both the study and control groups demonstrated that overall cost savings from MRP amounted to $3,432 per member ($p=0.42$, CI95 -$11,789 to $4,925) over the six-month post period.

The mean cost of the study group's pharmacy and medical claims decreased by $2,193 per member per month. The mean cost of the control group's pharmacy and medical claims decreased by $1,676. Therefore, the study group's pharmacy and medical claims decreased by $517 more when compared to the control group. While both groups' costs decreased, the control group's cost trend decreased by a marginally greater proportion from the pre-discharge/pre-medication reconciliation period (51% compared to 45%).

The hospital readmission rates yielded promising results for study group members who received MRP. During the post-MRP/discharge date period, the study group experienced 51% fewer hospital readmissions than the control group. Both the study group and the control group experienced similar proportions of 30-day hospital readmission rates, 33% to 25%, respectively.

CareSource Digital Equity Initiative: Broadband Access and Devices Support Telehealth, Eduacation and Employment

CareSource

With more than 24% of households in Dayton lacking access to the internet, CareSource sought to remove the digital divide by creating a partnership to bring high-speed Wi-Fi and connected devices to targeted housing communities. Initial success is measured by distribution volume, device usage and vaccine clinic outcomes.

MEMBER NEED

Dayton boasts an estimated population of 140,000[1]. Of that:

- 24% lack access to the internet.
- 15.7% do not have a computer.

This digital divide presented barriers to access public health and safety information, telehealth, and government resources, or participate in the economy during the “shelter in place” directives in 2020. Without internet access, individuals are forced to take more risks in navigating day-to-day life[2], possibly contributing to the disproportionate impact of COVID-19 on minority and low-income communities.

GOALS AND OBJECTIVES

CareSource sought to bridge the digital divide leveraging its ongoing public private partnerships (P3) and creating new connections to bring both high-speed Wi-Fi and connected devices to those in need.

IMPLEMENTATION

CareSource led the creation of the Dayton-Montgomery County Digital Equity Initiative, which was initially funded through a $2 million CARES Act Grant. The P3 included high-speed Wi-Fi access[3] and the distribution of Chromebook devices to residents at five low-income housing communities. CareSource committed $400,000 to support the long-term sustainability of the project and provided distribution volunteers[4].

EVALUATION & OUTCOMES

The program aimed to improve access to health care and heighten digital access to other social determinants like training and workforce development. The organization quickly pivoted as addressing digital literacy was needed first.

Success is measured by device usage and added vaccine clinics.

• 902 laptops distributed at eight events and at residents’ convenience.
• 66,695 hours of broadband usage consumed by 1,863 registered users.

Public Resource Website	Number of Visits
Montgomery County	2,330
Dayton Metropolitan Housing Authority	1,797
Public Health (COVID Info)	403
CareSource Members Only Access	400
CareSource.com	389
Dayton Metro Library	209
Ohio Means Jobs	102
RTA	89
Dayton YMCA	43
Metroparks	23

- COVID vaccination event held at one of the properties yielded:
  - Over 200 attendees: 76 members received their first vaccine dose with about half choosing the one dose vaccination.
    - 61 individual $25 gift cards used at onsite mobile grocery store.
    - 15 registrations for the Senior Farmers Market Nutrition Program for purchase of fresh produce.
    - 9 registrations for rental assistance.

FUTURE OUTCOMES

The program paused some of its initial evaluation to focus on vaccinations. We anticipate prioritizing a full care gap analysis identifying which communications are urging members to participate in their own health care.

- Next steps include:
  - Integrate CareSource Connect to increase telehealth options
  - Provide digital literacy training in late August 2021
  - Enable text messaging capabilities for engagement

MANAGED CARE PRECEPTS

Managed care precepts include preventive services, care management, disease management, improving the health of plan members, telehealth, and infant and maternal health.

1 United States Census Bureau data, https://www.census.gov/quickfacts/fact/table/daytoncityohio/INT100219.

2 CDC COVID-19 Guidelines for participating in outdoor and indoor activities.

3 This free Wi-Fi is currently sustained through 2023 while the partners work to identify ways in which the free broadband access can be sustained and possibly expanded to other areas.

4 CareSource provided 200 hours of time: 32 IT professionals to set-up the Chromebooks and serve as expert tech support. An additional 38 non-IT experts also volunteered their time.

Humana's Covid Outreach Partnership Program

Humana Inc.

Humana's Covid Outreach Partnership program focused on high-risk members identified by 1-6 chronic conditions that faced additional challenges meeting their care needs, while also minimizing their risk of exposure. Dedicated nurses provided telephonic outreach to these members, in collaboration with our provider partners.

Humana established a partnership with the Cleveland Clinic (CCF) during the height of the Covid 19 pandemic, to provide outreach to our shared members that were identified as high risk. The program began on 4.21.2020 and concluded on 9.4.2020. The members were selected based on their co-morbidities. The goal of the program was to meet the membership's medical or social needs in their homes, avoiding unnecessary trips to their physician's office or hospital, by providing weekly outreach calls conducted by Humana nurses to their assigned members. The dedicated assignments established trusting relationships and continuity of care. The team provided their assigned members with the nurse's direct contact numbers, insuring they could reach the Humana team directly if any health or social needs arose prior to their next scheduled call. The nurses maintained direct communication with CCF daily to address members' concerns, conduct follow up calls, and help arrange referrals and telehealth visits with their CCF PCPs within 1-2 days. This access allowed for prompt attention and quick response times to any issues communicated, and provided avenues to avoid additional exposure risks while addressing their health issues.

Humana achieved an 86% retention rate with 1460 members. The team submitted 356 referrals to CCF to address symptoms, urgent medication needs, appointments, referrals and DME. The team also submitted 285 referrals internally to Humana's case management teams regarding medication costs, food insecurity, transportation needs and over the counter benefits. Members were subsequently able to utilize benefits, for which they were previously unaware their plan offered. The program was a great success. Our members felt much less isolated knowing they would be receiving the weekly calls, and also felt that someone cared. The team received responses such as "Oh, it is my friend!," "I talk to you more than I talk to my family!" and "The brightest part of my day is you calling me." The team also learned from our members as they shared their stories, allowing the nurses glimpses into their lives, families, and accomplishments.

Success Story: A nurse was speaking to a member who informed her that he had experienced back pain, left arm pain and chest pain 2-3 days prior that lasted approximately 45 minutes, but stated that he felt fine that day. The nurse informed the member that she wanted to provide a referral to CCF, but first wanted to call his Cardiologist with him to schedule an appointment. The Humana nurse called the Cardiologist's office and spoke with that nurse, while the member was also on the line. The office instructed the member to go directly to the ED the next time he experienced anything like this again. An appointment was able to be scheduled with the Cardiologist on 6.5.2020, which was 7 days after this call. The member was ultimately admitted to the hospital on 7.9.2020, to undergo open heart surgery. As of 8.26.2020, he was at his daughter's home and doing well. He is now able to drive a car and returned to his own home the following week.

Mom & Baby Bundle Innovative Partnership

UnitedHealthcare Community Plan of Ohio, Inc.

MBB: Through innovative partnership, UHC and MetroHealth are advancing member-centric care management strategies, specifically for mothers and babies, in the greater Cleveland area. The Mom & Baby Bundle program brings providers and community-based organizations together to support pregnant women and their infants who are at higher risk for poor birth outcomes.

Advancing Maternal and Infant Health through Innovative Partnership

Through an innovative partnership, UnitedHealthcare Community Plan of Ohio (UHC) and MetroHealth are advancing member-centric care management strategies, specifically for mothers and babies, in the greater Cleveland area.

Racial/ethnic disparities in infant and maternal mortality remain a significant challenge in Ohio. According to the Ohio Equity Institute Infant Mortality Scorecard, the overall preterm birth rate in Cuyahoga County 2017-2019 was 11.9%, with notable disparity by race. The overall low birth weight rate for Cuyahoga County 2017-2019 was 10.6%, with notable disparity by race. Birth outcomes among African American women in Cuyahoga County compared with their Caucasian counterparts are significantly worse and UHC member data confirms this persistent and widening gap.

To address this disparity, UHC is aligning to the Ohio Department of Medicaid's (ODM) vision of a new model of care that aims to better integrate community-based services into the traditional healthcare system. Based on this data, the goal of the UnitedHealthcare partnership with MetroHealth's Mom & Baby Bundle is to test innovative, novel, and measurable solutions designed to better meet the individual, whole-person needs of MetroHealth/UHC pregnant women and enhance clinical-community coordination to ultimately improve outcomes and promote equity.

Advanced through intensive partnership and investment, this three-year collaboration expands initiatives targeted at high-risk pregnant mothers and medically complex patient populations. The Mom & Baby Bundle advances needed medical and non-medical services by seamlessly providing or connecting participants to wrap-around services such as housing support and food assistance, as well as financial and employment resources to improve health outcomes.

The Mom & Baby Bundle program brings providers and community-based organizations together to support pregnant women and their infants who are at higher risk for poor birth outcomes, including those with opioid use disorder and those experiencing housing insecurity. The program ensures:

- Timely identification and risk stratification of pregnant members.
- Enhanced provider-led care coordination including assessment of patient/member physical, behavioral, and social needs through a dedicated multi-disciplinary team approach.
- Connection to community-based services and supports through the Pathway Community HUB Model of care and established partnering entities.

By working closely with providers to advance innovative, targeted care strategies grounded in data analysis, UHC is promoting better outcomes for maternal and infant members.

STOP COVID

UnitedHealthcare Community Plan of Ohio, Inc.

Closing health care gaps for underserved populations is critical to the mission of UnitedHealthcare Community Plan of Ohio (UHC). Through the STOP COVID Initiative, UHC invested $1.5 million in a partnership with community-based organizations and Federally Qualified Health Centers (FQHC) providers to address health and healthcare disparities with minority communities.

This innovative program focused on supporting the infrastructure of the community and meeting individuals where they are to address local testing and food access needs. The program was a five-week initiative that took place at three churches in high-needs neighborhoods on Cleveland's east side. The goal of the program was to support the community in testing, prevention, intervention, and overall health and wellness. UHC firmly believes that the health of the community directly impacts the health of all members, so it is vital to support these trusted community efforts.

Additionally, the program supported need through direct connection with local FQHCs. The establishment of this connection to local providers is important for ongoing care and wellness.

UHC hired locally to ensure staffing the event in neighborhoods reflected a strong, local presence. Individuals from the target neighborhoods were hired to do registration and distribute food and sanitizing kits. Many of the nurses and other medical providers who performed the actual tests also lived in the neighborhoods where the events occurred.

In total, the program supplied 3,504 COVID tests, 2,579 health kits, and 1,953 food boxes. By elevating testing numbers, providing clinical guidance, and supporting social needs, the needs of individuals and community were met through this challenging time. For individuals who accessed these services, UHC ensured they received education to reduce COVID infection and received referrals to social agencies and health care providers to receive essential care. The connections made through STOP COVID will yield better health outcomes long beyond the five weeks of the project, including greater connection to primary care.

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:
Lori Johnston, Paramount Health Care

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Michelle Stoughton, Anthem

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Ex-Officio Members:
Dale Block, CareSource
Travis Garrison, Humana
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.

Your OAHP Team

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