2022

oahp PINNACLE AWARDS

September 20 – 21, 2022 • Sheraton Columbus at Capitol Square

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2022 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 2022 OAHP Pinnacle Awards recognize health plans for their success in addressing the challenges of a shifting health care environment. 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 five submissions reflect the wonderful, innovative health care marketplace that is serving Ohio so well today.

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Judges

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

- **Melissa Wervey-Arnold,** Chief Executive Officer, Ohio American Academy of Pediatrics
- **Chris Ferruso,** Legislative Director, National Federation of Independent Business
- **Mary Gallagher,** Executive Vice President and Chief of Staff, Ohio Hospital Association
- **Loretta Medved,** Policy Analyst, Ohio Department of Insurance

Participants

Anthem Health. Join In.℠

buckeye health plan

CareSource

MOLINA HEALTHCARE

PARAMOUNT HEALTH CARE

2022 PINNACLE AWARD SUBMISSIONS: CELEBRATING INNOVATION AND EXCELLENCE

Concierge Care Disease Management Digital Engagement

Anthem Blue Cross and Blue Shield

Anthem Blue Cross and Blue Shield's Concierge Care Program is a comprehensive chronic disease management program delivered through an intuitive, member-facing app that syncs with Anthem's care management platforms. The digital program enables care managers to triage, monitor, and engage with individual members to build personalized care plans and help them achieve and sustain their health goals.

In today's world, we know that people want to be more connected to manage their chronic disease, while also realizing that to keep members engaged in their care, connections must be personal and easy.

In thinking about this, Anthem, through our digital subsidiary, created a multi-faceted disease management program that utilizes a digital app to connect with the member. Providing customizable programming and education to our members with the resources to help them meet their goals, and a care management portal to allow for access to a comprehensive look at a member's conditions, social determinant needs, and care plans. In building the Concierge Care program, we developed integrated disease management programs for our members with Crohn's disease, cancer, congestive heart failure, behavioral health disorders couple with a chronic health condition, COVID, type 2 diabetes and high-risk pregnancy. The goal of our Concierge Care program was to improve member confidence in managing their condition, provide additional channels of connection with clinicians, reduce unnecessary care, improve compliance with care plans, and improve the overall health for our members.

When a member is identified for a program, they enroll in the Concierge Care and have access through the app to a series of educational videos and tools specific to their managing their disease as well as tips on nutrition, exercise, mental health and stress relief. Through the app the member is also able engage with a dedicated care manager regarding their daily health status, questions or just overall care and emotional support. The member can access a nurse care manager who is available through text chat video or phone. There is also a component of remote patient monitoring for weight management for our members enrolled in the congestive heart failure concierge program. Concierge Care is intended to last 12 weeks with a continued maintenance option for those who complete the program.

These new outreach programs have garnered greater member engagement as well as improved health outcomes, member satisfaction and overall reduced healthcare costs.

For our Crohn's Concierge Care program we have seen multiple positive pre- and post-enrollment data trends that signal the program's successes six months after program completion:

- 57% reduction in Emergency Room utilization including an 88% reduction in IBD-related ER visits
  - 65% of those with ER visits in year prior to Concierge Care enrollment had NO ER visits in 6 months following enrollment
- 35% of members who complete the program continue to engage in the maintenance phase of the program
- 6% reduction in overall PMPM

Overall member satisfaction with the program has been high. You can learn more about the impact here.

Rural Nurse Navigator Program

Buckeye Health Plan

Buckeye partnered with The Family Navigator Program at Ohio University to expand services and meet maternal health needs in rural Athens, Jackson, Pike, Scioto and Meigs counties. The program provides on-site services for OB care and delivery with the goal of improving birth outcomes and reducing health disparities and infant mortality.

A lack of access to high quality maternal health services in rural communities is the result of many factors. Social determinants of health have contributed to disparities in maternal healthcare for rural women and their babies. Other challenges include access to transportation and access to healthcare facilities and providers. These challenges can negatively impact maternal and infant health including premature birth, low-birth weight, maternal mortality and morbidity, and increased risk of postpartum depression.

To decrease the risk of poor maternal or infant health outcomes, the Nurse Navigator program works with pregnant and post-partum women who have medical and social determinant needs. Services provided include educating women about their pregnancy, infant development and breast feeding and the risks of smoking/addiction during and after pregnancy. Navigators are advocates who help women access available services. They communicate with medical and social agencies on women's behalf and provide concrete supports such as access to healthy food, transportation, housing, clothing, infant care items, education and work opportunities.

After becoming a regional community resource, the Nurse Navigator program has shown to improve birth outcomes.

Goals and objectives:

Program Goals

- Improve Birth Outcomes
- Reduce Health Disparities
- Reduce Infant Mortality

Address Social Determinants of Health

- Provide education
- Provide emotional support and advocacy
- Increase access to medical care and services
- Provide concrete assistance to address poverty and basic needs

Program Flexibility

- Relies on data to identify trends and areas of increasing need
- Allows for county specific services
- Always based on client need and navigator discretion

Program Evaluation

Buckeye receives monthly reports that includes services provided and birth outcomes for our members. In addition, Buckeye receives a quarterly report of community members served. Our data analytics team compares the outcomes data with our claims data to validate the accuracy of reporting about our members.

Outcomes

From 7/1/2021 to 6/30/2022, Buckeye compared data on pregnant members within the same catchment area who were and were not enrolled in the program.

- Among the women who completed or were enrolled in the program, 0 had a NICU delivery. By comparison, among women who were never enrolled in the program 3.7% of births resulted in NICU.
- The program correlated with a 2.7% reduction in the low-birth-weight rate (8.3% versus 11% for the births in counties never enrolled).
- The preterm birth rate decreased by 3.9% for women who completed or were enrolled in the program (8.3% versus 12.2%).

CareSource Child & Family Health Collaborative Behavioral Health Respite Care Program

CareSource

INITIATIVE IDENTIFICATION

A child's home environment heavily influences the structures within the brain responsible for personality traits, learning processes and coping with stress and emotions. A disruption in the stable environment severely impedes their mental and emotional development and leads to poor health, education and social outcomes.

CareSource identified an opportunity to reduce disruption by producing strategies aimed at alleviating stress of families with members with behavioral health conditions. Specifically, through the creation of the CareSource/Child and Family Health Collaborative Behavioral Health Respite Care Program.

The program provides short-term, therapeutic relief to CareSource members and families with youth diagnosed with serious emotional disturbance. Behavioral health respite is arranged through temporary in-home or out-of-home care delivered by providers and caregivers.

GOALS AND OBJECTIVES

The CareSource/Child and Family Health Collaborative Behavioral Health Respite Care Program seeks to decrease the need for acute health care services, hospitalization and out-of home placements, while reducing health care costs.

EVALUATION

CareSource evaluates program effectiveness by tracking acute services (emergency department, behavioral health inpatient hospitalization, and day treatment) by youth utilizing respite as a service. The data is compared to the six months prior to their start in respite and then six months after they have been receiving or received respite.

INITIAL OUTCOMES

CareSource pulled data on 77 members receiving behavioral health respite services through the CareSource/Child and Family Health Collaborative Behavioral Health Respite Care Program between February 2021 and July 2021.

Emergency Department:

	Prior	Post	Outcome
Volume	138	64	↓54%
Spend	$21,535	$8,903	↓59%
PMPM	$48	$20	↓59%
Claims/1000 3,721 1,730 □54%			

Inpatient Services: (Behavioral Health)

	Prior	Post	Outcome
Volume	234	77	↓67%
Spend	$173,184	$40,186	↓77%
PMPM	$389	$91	↓77%
Claims/1000	6,310	2,081	↓67%

Day Treatment:

	Prior	Post	Outcome
Volume	881	567	↓36%
Spend	$132,645	$86,265	↓35%
PMPM	$298	$194	↓35%
Claims/1000	23,757	15,324	↓35%

Utilization and cost of services evaluated are trending down after comparing the difference between six months pre-enrollment and six months post-enrollment. CareSource is confident the data demonstrates the positive impact the intervention of behavioral health respite has on members and their families.

EXPECTED OUTCOMES

The initial data suggests the simple act of connecting families with respite care improves not only the health of the member, but also the health of the relationship between the caregivers and members. The program also boasts many stories of avoided out-of-home, and even out-ofstate placements.

CareSource is collaborating the Ohio Department of Medicaid and OhioRISE to continue to offer the CareSource/Child and Family Health Collaborative Behavioral Health Respite Care Program as they build their unique respite care benefit.

The program continues to help families and caregivers avoid acute care by providing space, time and resources to heal from within.

MANAGED CARE PRECEPTS

The program addresses managed care precepts for behavioral health intervention through preventative services and care management to improve members' health.

Member and Provider Concierge Programs

Molina Healthcare

Using the voice of the customer from members and providers to identify and execute program improvements are a key component of Molina Healthcare's overall population health strategy. Molina's outreach efforts and steadfast commitment to incorporating the voices of members and providers leads to innovative program improvements to do more for the people we serve.

Molina At Your Service programs are led by high functioning, cross functional member and provider centric committees with a deep understanding of Molina's member and provider experience journey maps and use data to drive process improvements. The programs focus on listening to the voice of the members and providers while collecting feedback through a multifaceted approach to proactively design and enhance programs, ultimately, improving quality of care.

A cornerstone of Molina At Your Service includes a weekly review of the members and providers who frequently contact Molina. The collective teams use innovative systemic tools and resources to identify member and provider touchpoints within the previous 60 days.

Through Molina's white glove approach, those identified through this data driven approach receive individual outreaches to:

- Assist in navigation through the managed care program
- Confirm issue resolution where applicable
- Listen for opportunities to better serve members and providers in the future
- Obtain feedback on overall experience with Molina
- Provide additional guidance and education

Using reports, and dashboards along with the data collected from the member or provider from the outreach calls, actions may consist of:

- Updates to Molina member/provider materials
- Assignment of a Molina Case Manager
- Molina system or process enhancements
- Promotion of resources and online tools
- Coaching of Molina staff

The Molina At Your Service program tracks execution of improvements and utilizes dashboards to monitor applicable key performance indicators.

Below highlights some Molina At Your Service Program successes to date:

- Nearly 1,000 member and provider outreach calls have been completed utilizing the repeat call dashboard. Of those engaged:
  - Member Retention rate of 90%
  - ER utilization is 15% less when compared to the overall Molina Medicaid membership
  - 12% decrease in calls received
- Multiple process and system improvements based on voice of the customer; examples include:
  - Implementation of a real-time claims adjustment pilot in Ohio beginning third quarter 2022
  - Molina member and provider portal enhancements
  - Provider Dashboard Creation that is used during provider Joint Operating Committees to drive further discussions to enhance experience
  - Implemented the review of a health equity dashboard (to include repeat ER, PCP
  - and BH Visits) to support data driven decision making
- Molina At Your Service Program is a best practice and being expanded across Molina markets nationally.

Molina continues to be inspired by the outcomes of these programs. Developing ways to enhance the service Molina provides is the foundation of Molina's Vision, Mission and Values. Molina is committed to ensuring Molina members and providers receive the service they expect and deserve through these and other innovative programs.

Improving Health Outcomes in Real-Time: Paramount's CareSignal Pilot

Paramount Health Care

Recognizing the lag time in data collected through claims, Paramount set out to test a new approach to identifying members for Disease Management outreach. CareSignal is an evidence-based, deviceless, remote monitoring platform that engages members and identifies those who need help managing their chronic condition. Identification occurs in real-time via data that is collected directly from members. With goals of improving member engagement and health risk levels to reduce in unnecessary hospitalizations and ED visits, Paramount began a pilot of the CareSignal platform in September of 2021.

Eligible members are invited to enroll over the phone. During enrollment members can choose between text messages and automated phone calls and when they'd prefer to receive those communications. Once enrolled, members receive regular texts or calls asking them to report condition-specific information by responding to the text messages or entering numbers on their touchtone phone. Based on chronic condition prevalence among members, Paramount elected to support Medicaid members through Depression, Diabetes, and Social Determinate of Health (SDOH) programs. Medicare members are supported through Chronic Heart Failure and COPD programs. Data collected from members for each program includes:

- Depression – Mood ratings and PHQ-9 scores
- Diabetes – Blood sugar levels
- SDOH – Needs for food, transportation, or financial resources
- Chronic Heart Failure – Symptoms associated with heart health problems
- COPD – Breathing trends to identify members in early exacerbation

Response data is collected in the CareSignal platform and real-time alerts identify members whose condition is worsening. This allows Paramount's Disease Management team of RN Health Educators to provide outreach within 24 hours, when members need it most. Responses are also used to assign members a health risk level and track risk level changes. Health Educators provide additional outreach to high and medium risk members on a regular basis to provide extra support. At each outreach, Health Educators follow Disease Management standard operating procedures, assessing member needs and developing care plans as appropriate.

Currently, 890 Paramount members are enrolled in the pilot, a 15.5% enrollment rate. Early data shows promising progress, with improvements in member health risk levels. The following percentages of members classified as high risk had improvements in their risk level during enrollment in CareSignal:

- Depression – 70%
- Diabetes – 56%
- Chronic Heart Failure – 100%
- COPD – 57%

This improved condition management is anticipated to result in fewer unnecessary hospitalizations and ED visits. Once enough time has passed to generate the necessary data, a detailed claims analysis will be completed to fully evaluate the impact of CareSignal on member health status and care utilization.

Along with promising health outcomes, CareSignal provides Paramount with an additional opportunity to demonstrate its commitment to the health of members and improve communication with them. Enrolled members are regularly asked to complete satisfaction surveys on their experience with CareSignal. The majority of members agree that with the CareSignal pilot they are getting the best care possible from Paramount and that the messages have improved their communication with Paramount.

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

Vice Chair:
Ami Cole, Molina Healthcare of Ohio

Secretary:
Steven Province, Buckeye Health Plan

Treasurer:
Michelle Stoughton, Anthem

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Travis Garrison, Humana
Beejadi Mukunda, MD, CareSource
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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