2023 oahp PINNACLE AWARDS

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Hilton Columbus/Polaris Hotel

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2023 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 2023 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 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 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.

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,** State Director, National Federation of Independent Business
- **Loretta Medved,** Policy Analyst, Ohio Department of Insurance

Participants

Anthem

buckeye health plan

CareSource

MOLINA HEALTHCARE

2023 PINNACLE AWARDS: CELEBRATING INNOVATION AND EXCELLENCE

eConsults

Buckeye Health Plan

Buckeye recognizes that Medicaid members in Ohio face inequities related to accessing services, and we are committed to eliminating health inequities and offering innovative virtual care solutions for Ohioans.

We experienced a significant increase in utilization of telehealth services during the Public Health Emergency in 2020. Between April to October 2020, approximately 1 out of 17 (6%) Buckeye claims was a telehealth visit. One type of telehealth format, the electronic consult (eConsult), has been utilized by healthcare systems for many years as a way to help patients gain access to specialty care. eConsults are an asynchronous form of communication between referring provider and specialist through a shared EHR or web-based platform that entails the specialist reviewing chart data and replying with recommendations electronically. In 2022, Buckeye began exploring opportunities to help PCPs practice at the top of their license and keep more patients in Primary Care, reduce cost for specialty care, and improve specialty access while reducing specialty wait times. We partnered with ConferMed to support virtual care solutions and virtual provider-to-provider education, specialist consultation, and referral to increase capacity and access to care for our most vulnerable population in Federally Qualified Health Centers (FQHCs) in Ohio.

In a study, Primary care clinicians were randomized into a control or an intervention arm for referrals to cardiologists. Primary care clinicians were recruited from 12 practice sites in a community health center in Connecticut with mainly medically underserved patients. Thirty-six primary care clinicians participated in the study, referring 590 patients. In total, 69% of e-consultations were resolved without a visit to a cardiologist. After adjusting for covariates, median days to a review for an electronic consultation vs a visit for control patients were 5 and 24, respectively. A review of 6-month follow-up data found fewer cardiac-related emergency department visits for the intervention group. In conclusion, eConsult referrals improved access to and timeliness of care for an underserved population, reduced overall specialty utilization, and streamlined specialty referrals without any increase in adverse cardiovascular outcomes. [Ann Fam Med 2016;14:133-140. doi: 10.1370/afm.1869.] Some referrals to specialists may be avoided and managed more efficiently by using eConsults. Expanding the use of eConsults for Medicaid patients and reimbursing the service could result in substantial savings while improving access to and timeliness of specialty care and strengthening primary care. In a study conducted by a Community Health Center in Connecticut, Patients who had an eConsult had average specialty-related episode-of-care costs of $82 per patient per month less than those sent directly for a face-to-face visit. [December 2018 37:12 Health Affairs]

In 2023, through the Buckeye and ConferMed relationship, we were able to introduce the innovative idea of eConsults to the Ohio Association of Health Plans and the ODM All MCE Diabetes Quality Withhold Workgroup to rapidly implement an eConsult program to improve outcomes for patients with diabetes cared for by primary care providers in selected FQHCs in Ohio. The program provides access to expert guidance from ConferMED's endocrinology specialists regarding optimal management of patients with diabetes, with particular focus on the use of continuous glucose monitoring (CGM) and diabetes self-management education (DSME).

CareSource and Central State University Community Health Worker Certification Program

CareSource

The Covid-19 pandemic caused a major disruption in America's work force – something many have referred to as The Great Resignation. In 2022, more than 50 million workers quit their jobs, many of whom were in search of an improved work-life balance and flexibility, increased compensation, and a strong company culture. The last few years have seen some unprecedented challenges in the workplace and workforce. With this, a reality for CareSource. We knew we needed to think outside the box to address a specific skillset needed to serve the community, a Community Health Worker.

In the Winter of 2022, CareSource and Central State University announced a new pilot program providing training services to community members interested in becoming community health workers and patient navigators. The 12-week **Community Health Worker Certification Program** courseload began March 21, 2023 and concluded June 8. The inaugural class consisting of 28 students was sponsored through a $200,000 grant provided by CareSource. The next class begins in late August 2023 and is at capacity for the fall semester.

The goal of the community health worker certificate program is to establish health care related workforce development at Central State University. The target population for the program is a combination of Miami Valley and Dayton area adult workers and Central State University students seeking certificate credentials and career opportunities in the health care and social work fields."

A community health worker provides services that help communities manage health and wellness. As a member of a multidisciplinary health care team, the worker provides support services and helps build trust and opens lines of communication. They are trained advocates in communities where they are connected by culture, language or residence. Additionally, they empower individuals to gain access to health and community resources through education, outreach, home visits, mentoring and referrals.

Graduates of the certificate program will have diverse skills including interviewing, data collection, obtaining vital signs, mentoring, providing client advocacy, providing referrals to community resources, care coordination, promoting basic health skills and working with culturally diverse clients and community organizations.

Community health workers typically work in a variety of settings that may include hospital systems, non-profit and faith-based organizations, public and private clinics, educational systems, learning extension centers, public agencies or even serving clients within their own homes.

CareSource currently employs approximately 25 community health workers around the organization with the goal to continue building this workforce around the state. Additionally, CareSource hired a Clinical Health Worker from the inaugural Clinical Health Worker class at Central State. She will begin working in the community soon.

CareSource understands creating frictionless access to needed health services improves quality of life. Community health workers are trusted voices in their neighborhoods that can extend care and education to individuals of all walks of life. Central State University has been an incredible partner building a tailored workforce solution for this community and beyond.

CareSource/Central State University Community Health Worker Certification Program Nomination

Community Health Workers (CHWs) are trained public health workers who serve as a bridge between communities, health care systems, and state health departments. The CareSource/Central State University Community Health Worker Certification Program provides a pathway to creating a sustainable model for building resource streams of certification ready and eligible student to filled vacancies in an already strained healthcare resource system. Certified CHWs assist patients and their families navigate and access community services, healthcare resources, and adopt healthy preventative behaviors.

Our program engenders the community health worker with the communities they serve as a vital component of the healthcare team to build a more trusting model. As the CHW regularly engages with the patient, the CHW will be able to observe some of the barriers to effective healthcare outcomes and can then engage the patient's healthcare team or community resources to mitigate some potential negative outcomes. This model of trust can lead to better health outcomes could lead to both, reduced repeat emergency room visits and hospital readmissions. We believe this more trusting model of CHWs standing in the gap of healthcare, among many benefits, could also lead to reducing the existing strain on care sites and staff resources.

The Community Health Worker program also has a community engagement component by providing opportunities for an underutilized workforce, unemployed, and the under skilled population to gain additional skills and certification thus creating a pipeline for advance opportunities at higher pay levels than minimum wage.

In accordance with the certification requirements for the State of Ohio and the needs of the community being served, we added additional training modules such as NARCAN training because of the nationwide and statewide addiction rates.

It is critically important for our program to meet the needs of the target population served. This was accomplished by having a diverse and multicultural demographic of cohort students and a rich diverse mixture of trainers, instructors, guest speakers, and subject matter experts that included, but was not limited to: healthcare executives, medical physicians, nurse practitioners, registered nurses, clinical counselors, public health leaders, college professors and community faith leaders.

In addition, we utilized community partners who, recognizing the needs and importance of the program, collaborated with us to build the strongest program we could. This included representation from the Dayton Urban League, the State of Ohio Department of Health, Montgomery County Suicide Prevention, Montgomery County Jobs and Family Services, Montgomery County Social Services Department, Xenia Township Fire Department and Dayton Suicide Prevention Hotline.

Overall, the community collaboration we saw impacted the program in a positive way. The retention rate was 95%, with almost all the students staying throughout the program from start to finish with only losing one student due to personal family dynamics. The demographic diversity was exceptional in getting students in age groups from 20s to 60s and reaching multi-ethnic and gender populations. The richness of the various didactics and the diversity of trainers, instructors, and guest speakers was lauded by the students as exceptional. In addition to the didactics, students were able to get some hands-on experience through labs such as CPR, taking blood pressure, NARCAN administration, health screening, counseling awareness through group interaction and post activity reviews.

The funding and educational support was used to provide a classroom setting in a university educational environment and training aids included:

- **Trainers and Program Staff Contracted Fees** – Program staff, Project Manager, and instructors were provided compensation to teach and manage the program delivery and operations.
- **Books** – Textbooks were provided to each student, instructor, trainer, and program staff.
- **Didactic Training Material** – The program staff, instructors, and trainer, developed, produced, didactic material for each student and program staff.
- **CPR Training Aid** – The students were provided with a CPR mannequin for hands-on training and simulation for conducting CPR, and associated training material that would support each student's ability to receive CPR Certification.
- **NARCAN Training** – Students were trained and certified in the purpose, use, and dissemination of NARCAN to patient's experiencing life threatening overdose episodes.

One of the many highlights was "Career Day." During this class, instructors devoted their time to writing workshops, cover letters, mock interviews and updating resumes. Some students spoke candidly about fears of having lost skill sets on how to re-enter the workplace. Experts providing insight on how to best present themselves to potential employers was another highlight.

Like any first-year program, we also learned a great deal about challenges we faced and how we move forward in the future in order to benefit the students interested in becoming health care workers. Given that the first cohort of this program was essentially test case, many of the challenges were unforeseen.

Those barriers included the groups decision to use eBooks based on cost and current convention, several students expressed a preference for traditional paper textbooks which we will consider for future cohorts. Also, there were various Interactive activities interspersed throughout the program, participants expressed a desire for more interactive activities such as group discussions and role play which will be increased as we adjust curriculum going forward. Finally, some of the students did not have laptops or tablets to use when they were not in the classroom setting.

The future of our program is bright for many reasons. Both CareSource and Central State University are committed to providing interested students the very best for the program. While thrilled to know the program is at capacity for the fall semester, we also want to make sure this program grows not only in size, but to look for opportunities to expand the program to meet the needs of our partners and the community. We believe this expansion is pivotal to bridging current gaps in community-based healthcare.

Our plan is to run at least one cohort during the fall and spring at our Dayton Workforce Development location and at least one cohort on the Central State University campus aimed at students and Wilberforce-Xenia community members during the academic school year. Our intent is to position the program as an entry that could lead to the development of additional programs such as a state tested nurse aid (STNA) and/or Nursing program.

In partnership with our Land Grant Extension services, we are exploring options for delivering the community health worker training in various parts of the state where we have a Land Grant Extension presence. We have already received interest in partnering from with a large healthcare organization in Northeast Ohio. We hope to have a state expansion in place by the end of this calendar year. We will continue to explore pathways for extending our training regionally. The program has already received an inquiry from a Chicago area healthcare organization interested in collaborating to provide training there as well.

Complex Discharge Planning and Social Determinants of Health Program

Elevance Health / Anthem, Inc.

Medical literature documents that significant unmet social needs drive a higher level of health condition instability and risk of readmission to an IP facility. Further, literature indicates that the risk of readmission, for a person with significant unmet social needs, can be reduced by up to 25% with even one in-home visit. Our experience, based on telephone calls with our highest risk Medicare Advantage members, reinforced that a startling number of our vulnerable members have social needs, that if left unmet would be likely to result in their being forced to access the healthcare system for relief. In collaboration with local home care agencies, we developed the Complex Discharge Planning and Social Determinants of Health Home Visit Program.

The goals and objectives of the program are to leverage the members healthcare benefits and local agencies to ensure that the member has sufficient resources to go home and stay home safely, ensure a stable post-discharge environment, resolve member specific social issues and care gaps that predict readmission risk, and to close STAR gaps. The complex discharge planner works with the facility discharge planner as well as the member and/or the caregiver to ensure a safe and appropriate discharge plan then refers the member to the home visit program. The home care nurse collaborates with the health plan team to assess and address access and alignment to a primary care physician/specialist, a safe environment/relocation to a safe environment, fall risk, food insecurities, medication reconciliation and medication access, transportation challenges, homes that are at risk due to infestation, mold, leaks, damage, identify resources for utility payment.

After the member has agreed to the in-home visit, a registered nurse is deployed to where the member is located. This program consists of an initial two visits by the nurse. If additional visits are needed, that request is made and evaluated. The nurse completes a comprehensive health risk assessment including STAR gaps, HEDIS measures, Medication Reconciliation, Fall Risk, and member specific social issues and creates a tailored care plan. As many gaps as possible are closed during the visit. The nurse documents unresolved issues and collaborates with the health plan case manager, social worker, or medical director for continued member support. Urgent concerns result in a call to the Primary Care Physician.

Elements we use to evaluate the program are avoided readmissions for target members, just in time interventions, and member satisfaction with improving their health. The program yielded a net savings of $1,570 PMPM though improving access to care, connecting members to the appropriate care provider in the community, closing care gaps and avoiding inappropriate or emergency utilization.

This program was developed by members of our care management team in collaboration with our home visit program, to focus on disease management to improve the health of our members using evidence- based medicine. The program, that was developed for our Ohio Medicare Advantage population, has expanded to all Elevance Medicare Advantage members.

Concierge Care

Elevance Health / Anthem, Inc.

Concierge Care combines leading technology, clinical and case management support, educational tools, and gamification to assist individuals in better managing their health. Modularization within the app provides holistic support of physical health, behavioral health (such as mindfulness and meditation), pharmacy/medication tracking, and social needs. Program participants can:

- Track health data and daily symptoms (77% of participants use the app for this)
- Link data from personal devices to the app
- Set personal goals and develop customized care plans
- Set medication reminders
- Earn points for completing daily missions
- Research condition through a rich library of curated educational materials (articles and videos)
- Do self-directed health exercises (such as breathing, mindfulness) on their own schedule

What's most valuable for many is the real-time, on-demand contact with their care manager whenever they have a question or need support. 57% of program participants initiate chats with our care team. Care managers triage, monitor, and engage with members to build personalized care plans and help them achieve and sustain their health goals. We leverage "health personality types" to personalize outreach and have seen increased self-directed member management of their own care. 52% of participants remain active in "maintenance mode" after the final program week.

The app syncs to a cloud-based care management platform and connects the individual's entire care team to monitor symptoms reported in the app and reach out to participants if any red flags/concerns, thus proactively helping members address health issues. Experienced care managers also assist members in staying compliant with recommended protocols and finding appropriate resources to manage their condition. They connect members with providers, nutritionists, labs, and behavioral health specialists to ease patient burden.

Preliminary claims analyses (difference in difference analysis) show a 39% decrease in outpatient ER utilization and 60% reduction in chemotherapy side-effect-related admissions for Oncology. Based on member self-reported data in the app, we are seeing a 25% improvement in Crohn's Disease symptoms and flares, lower anxiety/depression levels for members in the BH Concierge Care program, and lower hemoglobin A1c scores for Type 2 Diabetes.

Program participants say they can manage their conditions better because the program is more convenient, fits into their schedule/life better, and their personal care manager motivates, guides, and holds them accountable along the way. The readily available resources and tools in the app, coupled with real time, on-demand care manager support, empower members to manage their symptoms and stress while also improving energy levels and nutrition.

Concierge Care provides a digital, asynchronous channel for closing care gaps and helping members manage Crohn's Disease, Oncology, Heart Failure, Behavioral Health, COVID, Type 2 Diabetes, High-Risk Maternity, and readmission risk post discharge. We are activating a digital service model for lower risk maternity and post discharge members; future digital programs include Asthma, COPD, Coronary Artery Disease, Hypertension, Long COVID, and Ulcerative Colitis.

Recent Media

- Concierge programs can help manage care for those with chronic conditions
- Concierge Care program lowers costs, improves health for people with chronic conditions (go to 30 minute mark)

Member Testimonials

- BBC Video
- T2Diabetes
- Oncology

Molina Serious Mental Illness & Severe Emotional Disturbance (SMI/SED) Care Model and the Helping Other People Through Empowerment (HOPE) Program

Molina Healthcare

Molina's SMI/SED Care Model and HOPE Team is designed to provide a specialized support program for both adults with a SMI diagnosis, and for children 0-17 with SED diagnosis, including education and empowerment for members and their caregivers to effectively manage their condition, assist during transitions in care, and ensure co-occurring conditions are appropriately screened, treated, with any risk of suicide addressed.

Molina expanded its behavioral health program to include a specialized team to work with Molina members struggling with severe and persistent mental illness (SPMI). The behavioral health and substance use team members bring a variety of expertise from different clinical backgrounds (i.e., community mental health centers, hospitals, forensic settings). The team is passionate about helping members while empowering them and instilling hope, which is often lost when a person is suffering from a mental illness or addiction issue, feeling isolated.

Members have benefited from the advocacy, integrated care, education, and creative solutions the HOPE Team care managers bring to their lives. The HOPE program ensures a member's complex behavioral, physical, and psychosocial health needs are met, improving the member's quality of life.

Managed Care Precepts

Members diagnosed with SMI/SED conditions are more challenging to engage in treatment because of cognitive symptoms. Our care model and HOPE Team addresses the importance of developing an alliance with members, applying concepts of trauma informed care and motivational interviewing, facilitating engagement. The team focuses on developing a member alliance which is important with the SMI/SED population because of unique symptoms, challenges, and comorbidities.

Goals, Objectives, and Program Design

The HOPE team establishes the member's defined recovery and resiliency goals focused on health, home, purpose, and community, including the following during member care planning:

- Member / Family Education
- Suicidal Risk Screening
- Behavioral Health Medication / Treatment needs
- Physical Health Care, Medication / Treatment needs for Co-occurring conditions, substance abuse or chronic diseases.
- Social Connectedness
- Supported Education / Employment Needs
- Food Insecurity, Housing, and Income Needs
- Crisis Safety Planning

Molina's model has 3 fundamental program goals; to provide support and assistance to members that improve health outcomes, address social determinants of health, and improve functional impairments / overall well-being.

Program Evaluation and Data Collection

Molina evaluates program effectiveness by tracking acute services (crisis, ER, or IP stays), and use of these services unnecessarily. In addition, Molina monitors:

- Member self-management (through education/coaching/treatment adherence)
- Ability to use personal safety plan in case of crisis.
- Regular outreach to treatment/provider/identified supports.

Outcomes:

In 12 months, post enrollment:

- The HOPE team exceeded member enrollment numbers in the program.
- SMI high/high and high/moderate risk members experienced a reduction in unnecessary utilization of services, resulting in an 8% savings rate.
- For members enrolled at implementation, Molina realized a 30.5% decrease in per member per month cost of care.

About OAHP

The Ohio Association of Health Plans (OAHP) represents 18 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.

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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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